Choosing Wisely: Gastroenterology

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Disclosure

- The views expressed in this presentation are those of the author and do not necessarily represent those of the United States Navy, Uniformed Services University, or the Department of Defense
- I have no financial disclosures

http://patientspatienceandpaces.blogspot.com/2012/04/choosebut-choose-wisely.html

Colorectal Cancer (CRC) Screening

CRC Screening

- Don’t recommend cancer screening in adults with life expectancy of less than 10 years.[1]
- Avoid colorectal cancer screening tests on *asymptomatic patients* with a life expectancy of less than 10 years *and* no family or personal history of colorectal neoplasia.[2]
- Don’t perform routine cancer screening for dialysis patients with limited life expectancies *without signs or symptoms.*[3]

[1] Society of General Internal Medicine
[2] American College of Surgeons
[3] American Society of Nephrology, American Society of Transplantation

CRC Screening

- Do not repeat colorectal cancer screening (*by any method*) for 10 years after a *high-quality* colonoscopy is negative in *average-risk* individuals.
- Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, *completely removed* via a *high-quality* colonoscopy.

American College of Gastroenterology

Colon Cancer Screening

- Goals of screening:
  - CRC *prevention*
  - Reduction of CRC morbidity and mortality
- Colonoscopy is the gold standard
- Colonoscopy reduces:
  - CRC incidence
  - CRC mortality

Only 2 issues with CRC Screening…

- Screening those unlikely to benefit
- Failing to screen those likely to benefit
- So who ARE these people?

Unlikely to benefit

- Previously screened middle elderly (> age 75) without significant findings
- Those with short life expectancy
- Those at average CRC risk with a recent (< 10 years) normal screening exam

van Heijningen EM. Gut 2015

Likely to benefit

- Those at high risk
- Those at average risk with long life expectancy (> 10 years)
- The middle elderly who have never been screened*

*Van Hees F. Annals Intern Med 2014.

Predicting Life Expectancy

- There is an app for that!
- www.realage.com[1]
- http://gosset.wharton.upenn.edu/mortality/perl/CalcForm.html
- Lee Index[2]
- Your clinical impression!

[1]Hobbs WR. PLOS one 2014.
[2] Cruz M. JAMA 2013.

Nutrition

Nutrition and Feeding

- Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.[1]

[1]American Academy of Hospice and Palliative Medicine, American Geriatrics Society

PEG Tubes in Advanced Dementia

What Benefit Do We Seek?

- Survival
- Quality of life
- Decreased aspiration
- Healing of pressure ulcers

- None
- None to decreased
- None
- None to decreased

Goldberg LS. Clin Intervent Aging 2014.

Downside of PEGs

- More ER visits
- Increased skilled nursing needs
- Procedural risks

Upside of Hand Assisted Feeding

- Increased interaction
- Pleasure of oral intake

EASY

HARD

Except…

Additional Considerations

- Ethical considerations
- Religious beliefs
- Cultural background
- Emotional factors
- Legal/financial concerns

Cervo FA. Geriatrics 2006.

What Can You Do?

- Advanced directives
- Family meetings
- Understand context
- Address the elephants

Ulcer Prophylaxis

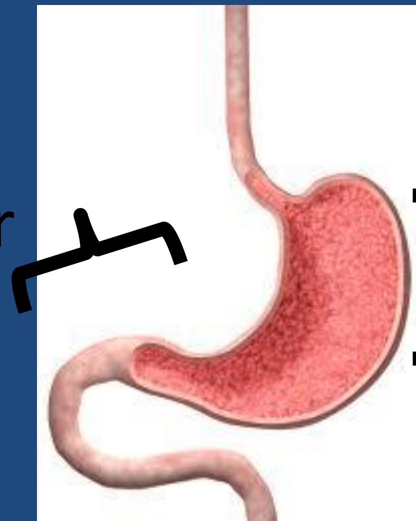
Ulcer Prophylaxis

- Don’t prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications.

Stress Related Mucosal Disease

- Ischemic condition of body/fundus
- Occurs almost exclusive in critically ill
- Highest risk: respiratory failure, coagulopathy
- Likely decreased by the use of enteral feeding

NSAIDS/Helicobacter



SRMD

Non-ICU Patients

- 0.1% risk of clinically significant GI bleeding
  - NNT 900!
- Error carried forward
  - 60% of ICU patients leave ICU on PPI
  - 31% leave the hospital on PPI
- Perceived low risk of therapy is a key reason

Barletta JF. Pharmacoeconomics 2014.
Herzig SJ. Arch Intern Med 2011.
Cook. NEJM 1994.

Risks of Long Term PPI Use

- Enteric infection
- Fractures
- Hypomagnesemia
- Interstitial nephritis
- Perhaps:
  - ↓ B12, iron, calcium
  - pneumonia

Masclee GMC. Drugs Aging 2014.
Moayyedi P. Nat Rev Gastroenterol and Hepatol 2012.

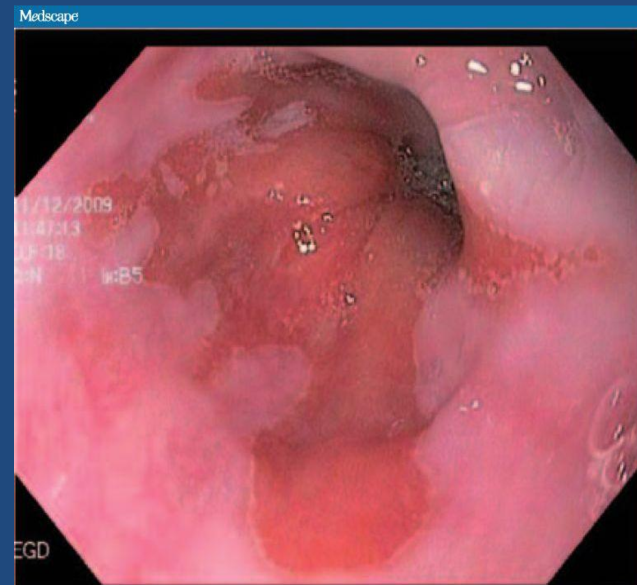
Gastroesophageal Reflux Disease (GERD)

GERD

- For pharmacological treatment of patients with GERD, long-term acid suppression therapy should be titrated to the lowest effective dose needed to achieve therapeutic goals.

Therapeutic Goals in GERD?

- With Barrett's Esophagus
  - Prevent progression to dysplasia or cancer[1]
- With other complications (e.g. strictures)
  - Allow healing
  - Prevent recurrence[2]
- Uncomplicated GERD
  - Manage symptoms[3]



[1] Singh S. Gut 2014.
[2] Ruigoméz A. Am J Gastroenterol 2006.
[3] Vasiliadis KV. Am J Gastroenterol 2010.

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Masclee GMC. Drugs Aging 2014.
Moayyedi P. Nat Rev Gastroenterol and Hepatol 2012.

Functional Abdominal Pain Syndrome (FAPS)

FAPS

- For a patient with FAPS (as per ROME III criteria) computed tomography (CT) scans should not be repeated unless there is a major change in clinical findings or symptoms.

FAPS: Rome III Criteria

D. Diagnostic Criteria* for Functional Abdominal Pain Syndrome

Must include *all* of the following:

1. Continuous or nearly continuous abdominal pain
2. No or only occasional relationship of pain with physiological events (eg, eating, defecation, or menses)
3. Some loss of daily functioning
4. The pain is not feigned (eg, malingering)
5. Insufficient symptoms to meet criteria for another functional gastrointestinal disorder that would explain the pain

**Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis*

Sperber AD. Aliment Pharmacol Ther 2011.

Symptoms

- History alone gives you 75% of needed info
- Directed physical exam adds 10-15%
- Serious causes that are not apparent after initial evaluation seldom emerge later.
- Having multiple symptoms is the norm

Kroenke K. Ann Intern Med. 2014.

Risk of Testing

- Low pretest probability = low likelihood of detecting serious disease
- As low as 0.5% to 3.0%
- Example:
  - A diagnostic test with 90% sensitivity and 90% specificity
  - 4 to 13 false (+) for every true (+) !

Kroenke K. Ann Intern Med 2014.
Rolfe A. JAMA Intern Med 2013.
http://blog.myesr.org

take away
IDEAS
LLÉVATE UN INTERIORISTA A CASA

Take Away Ideas

- CRC Screening only for those likely to benefit
- Minimize tube feeding in the demented elderly
- Decrease meds for acid suppression where possible
- Most inpatients do NOT require acid suppression
- If you think someone has FAPS, you are probably right!

ASK
QUESTIONS

NATIONAL CAPITAL CONSORTIUM
1995
Graduate Medical Education