**Acing the Hepatology Questions on the GI Board Exam: The Ultimate Crunch-Time Resource**

Brennan M.R. Spiegel and Hetal A. Karsan  
Slack Incorporated, 2012  
$77.70-$87.95

This 260-page book is the second book in the series by Dr. Spiegel and was written with a focus on hepatology-related GI board exam questions. The book’s aims are to provide an emphasis on key concepts in liver disease. This knowledge will then guide both clinical practice and successful completion of the Internal Medicine GI board exam. The book is divided into four chapters including: 1) a description of the liver questions on the boards, 2) clinical vignettes, 3) board review style questions based on an understanding of “clinical thresholds,” and 4) a sample self-test with questions and scoring guide. While this book is written for adult trainees, many of the concepts are also applicable for pediatric gastroenterologists.

The first chapter provides an overview of what liver questions will be covered on the GI board exam. This overview describes what topics should receive highest priority.

The clinical vignettes are succinct and followed by answers and explanations which provide not only the correct diagnosis, but also expand the understanding of other pertinent issues which should be considered with similar patients. This aspect helps the reader/clinician to form associations to the clinical problem and to be prepared for similar questions during the exam, or patient care issues in life. Other helpful features are the illustrations and figures, which provide a visual aid to clarify key points and reinforce the concept being addressed. Finally, each vignette utilizes a standardized summary to emphasize what the author views as the key point or points from each scenario.

Chapter 3 provides nearly 5 pages of “clinical threshold values” that should be engrained before the test. These are the values that should be known and understood through constant clinical care, and this presentation can help emphasize what values are important in specific clinical situations. This is valuable information, but the student will need to be disciplined to focus on the concise presentation. Ideally, this information will be re-emphasized by going through the vignettes mentioned above. Consistent review and application of these numerical values appears key to using this chapter effectively.

Finally, the self-test focuses on the key concepts that should have been learned through the use of the book. These questions are short, succinct, and if the student makes a true effort to write the answers and then confirm his knowledge, the results should serve as a good indicator of his preparedness for the examination. Anyone who purchases this book should consider the test before studying this book as a self-assessment which will further motivate the examinee to focus each time the book is opened. This practice test will help identify areas in each individual’s knowledge base that require further emphasis. This book is a succinct, readable text that can help hepatologists and gastroenterologists prepare for and pass their board exam.

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**Controversies in Hepatology: The Experts Analyze Both Sides**

Editor: Donald Jensen  
SLACK Incorporated  
ISBN: 978-1-55642-950-7  
$58.95 [275 pages]

The book “Controversies in Hepatology” edited by Donald M. Jensen is a 275-page book that presents the points and counterpoints of everyday challenges in the field of liver diseases. The authors present brilliant discussions in every chapter and figures and tables that are easy to read. More importantly: at the end of every presentation, the key points of the available information are displayed for the reader to compare the “pros” and “cons” of a particular diagnostic or therapeutic approach.

The purpose of this book is to discuss seventeen different controversial topics in hepatology and to present the available evidence to diagnostically or therapeutically approach each of them. The way the chapters are written includes a format of points and counterpoints (otherwise known as “pros” and “cons”). Each chapter presents a single controversy discussed by a team of three authors. One author presents evidence in favor of a certain treatment, while the second author...
discusses the available evidence against a treatment or diagnostic test. As a corollary, all the chapters include the position of an expert of the specific field who comments on the previous discussion giving his/her personal point of view.

The information used in the writing of this book is state of the art, and the fluidity of the text in most of the chapters is superb. Controversy is translated into academic debate and as a consequence, the book represents a starting point for further discussion of specific and hard-to-approach liver diseases.

Some principles used in the writing of this book include: (1) discussion stimulates thinking; (2) information should be categorized to know what is a “gold standard” as opposed to “polished brass” when discussing diagnosis and treatment of hepatology problems; (3) guidelines differ over time; and (4) individualizing general knowledge to the particular patient will guide practitioners in making “correct choices” for patients.

This book stimulates further reading and discussion of the controversies in hepatology that we might find during our daily practice as academicians and teachers of future generations of specialists and subspecialists.

This is, with certainty, a book to be recommended to all clinicians who are interested in liver disease and to all trainees in internal medicine, gastroenterology and hepatology.

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Inflammatory Bowel Disease: Diagnosis and Therapeutics (Second Edition)
Editor: Russell D. Cohen (from the series Clinical Gastroenterology, Editor: George Y. Wu)
Humana Press, 2011
ISBN 978-1-60327-432-6
$219 [322 pages]

In the modern, rapidly advancing medical world, medical students are frequently told that textbooks provide information that is likely out of date at the time of publication. The editors of textbooks have the unenviable task of ensuring their books are relevant in the current reality of instant access, frequently updated journal articles, wikis, blogs and podcasts. The best textbooks should continue to offer concise, cohesive overviews, and offering comprehensive reference lists should the reader wish to investigate the topic further. Dr. Cohen has ensured that his textbook of inflammatory bowel disease (IBD) counts itself among the best overviews on the topic, while only rarely feeling dated in its content. Additionally, with a historical overview of IBD by Joseph Kirsner representing the foreword (in honor of his centennial birthday), this book opens with a personal and wise voice.

The book’s presentation is superb, with a high-quality hardcover and easily legible typeface. It also features many tables and figures, with vivid color photographs featured in the Pathology Slideshow chapter. More importantly, the content of the book is clear, concise and provides an excellent overview of the pathogenesis, diagnosis and treatment of IBD. In particular, the therapeutics portion of the book has been extensively expanded from one chapter in the book’s first edition, to five chapters in the current version. Additional highlights include the focused chapters on special populations (children and women) and the detailed review of the burden and economics of IBD. Each chapter represents a review article on an important topic in IBD management, with authors representing major North American, Canadian and European referral centers. Nevertheless, some chapters betray an American-centric approach. For example, the use of exclusive enteral nutrition, a frequently-used induction therapy in European pediatric centers, is addressed by only a few sentences in the chapter focused on pediatric IBD. Additionally, the availability of biologic therapies in other countries is not addressed. Nevertheless, the majority of the content is highly applicable to all regions and multiple options for therapy and investigations are presented in an evidence-based, critical manner.

A number of improvements could be made to future editions, including expanded discussion of the epidemiology and management options in developing nations, as well as expanded multimedia supplementation. While the pathology slideshow was a welcome addition, linked endoscopy videos and radiology slides could be included in an online supplement. Most importantly, in this world of electronic media, an eBook version is almost a necessity. The first edition of this book was available in Amazon Kindle format. At this time, however, the second edition is only available as a Springer electronic book in PDF
book reviews

format at the unreasonable price of $24.95 per chapter ($474.05 if all chapters are downloaded). However, this book represents a highly relevant, updated review of the complex topic of IBD management and is an excellent resource for new gastroenterology trainees, nurse practitioners and clinical staff. Considering the degree of improvement from the first edition, I see a bright future for future versions.

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**Crohn’s Disease: The Complete Guide to Medical Management**

Editors: Gary R. Lichtenstein and Ellen J. Scherl
Slack Incorporated, 2011.
$99.95

*Crohn’s Disease: The Complete Guide to Medical Management* offers a clear and comprehensive resource guide for gastroenterologists who manage patients with Crohn’s disease. Through the efforts of its editors, Gary Lichtenstein and Ellen Scherl, as well as the input many nationally and internationally renowned experts in the field of inflammatory bowel disease (IBD), this 469-page book pragmatically reviews the epidemiology, clinical research, and medical therapies currently available to clinicians involved in treating and caring for patients of all ages with Crohn’s disease. The text is published as a companion to an all-inclusive book by the same editors about ulcerative colitis containing similarly useful information, *Ulcerative Colitis: The Complete Guide to Medical Management*.

As a guide book, *Crohn’s Disease: The Complete Guide* is easy to read, meticulously indexed, and clinically friendly. The text begins with a historical prologue of Crohn’s disease, and concludes with a 3-page stand-alone appendix that provides a practical approach to the management of infliximab infusion reactions. The majority of the book is divided into three sections. Although there is a primary focus on adult patients, the editors make a noteworthy effort to integrate information about pediatric clinical studies and related data, including a chapter entitled, “Pediatric Considerations in Medical Therapy with Inflammatory Bowel Disease.”

In Section I, “General Information,” the authors delve into the natural history and various epidemiologic factors associated with Crohn’s disease and offer interesting insight into various clinical and drug research trials involving patients with inflammatory bowel disease. In a manner especially geared to clinicians, this section also reviews the strengths and limitations of several of the classic animal models used in elucidating the pathophysiology of colitis.

The second section, “Medications,” outlines medical therapies available for patients with Crohn’s disease and discusses much of the clinical research that provides an evidence basis for their use (e.g. SONIC, ACCENT I and ACCENT II trials, etc), including two chapters which cover novel therapies. Many chapters contain helpful pharmacologic pathways summarizing the metabolism of various medications. The third section of the book provides very practical clinical information regarding the care and management of specific clinical scenarios (e.g. management of enteric or perianal fistulae, treatment of steroid resistant disease, post-operative medical management and prevention of disease recurrence, management of upper intestinal Crohn’s disease, etc). This section does repeat some of the medication data from Section II, but in general, the text succeeds in summarizing and weaving in previously presented information without feeling redundant. This section also contains a few chapters, such as “Chapter 32: Gastroduodenal/Proximal Crohn’s Disease,” that are illustrated with helpful endoscopic color images.

In a second edition of the text, one would hope to see more endoscopic images, such as more photographs of lower tract findings in Crohn’s disease.

In summary, this book provides an excellent, concise review for any clinician overseeing the care of patients with Crohn’s disease. It is well-written and will serve as an excellent reference guide for gastroenterologists facing the many clinical quandaries that can encompass the spectrum and care of patients with Crohn’s disease.

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John Pohl, M.D., Book Editor, is on the Editorial Board of *Practical Gastroenterology*. 
Cap Polyposis Update In Reference to Therapy

Seven patients were diagnosed with cap polyposis at the Asian Medical Center between December 1999 and August 2010. All were women, with a median age of 42 years and all were histologically confirmed as having cap polyposis in specimens obtained by colonoscopic polypectomy.

Medical records in these patients were retrospectively reviewed, with baseline parameters including the nature and duration of symptoms, diagnosis and treatments prior to final diagnosis, and laboratory test data. Endoscopic photographs were reviewed by two colonoscopists and histologic slides were reviewed by a GI pathologist for confirmation.

Clinical courses and treatments after diagnosis were reviewed. The caps were characterized by fibrinopurulent exudates covering the surface of the polyp and clinically, mucoid diarrhea was produced and was histologically associated with inflammatory granulation tissue covering the top of the colon.

Classifications of the lesions in reference to their morphology were carried out and reported. Despite cap polyposis having relatively distinct clinical, endoscopic and histologic characteristics, its pathogenesis remains uncertain, and no effective or standard therapy has been identified to date. The clinical condition has been reported to range from spontaneous remission to surgical resection, and little is known about long-term followup.

Spontaneous remission has occurred among these, and a trial of therapy with steroids was carried out in this group.

It was concluded that the clinical course and outcome of seven patients with cap polyposis, including five that were treated with steroids, with long-term followup was analyzed as a demanding, but treatable disease with a relatively benign clinical course. Additional studies are required, with a larger number of patients.


Diabetes and Risk of Hepatocellular Carcinoma

Using population-based, representative insurance claims data, the risk of developing hepatocellular carcinoma (HCC), among DM patients and to determine whether DM medications alter that risk, were investigated utilizing the Taiwan National Health Insurance Research Database.

A total of 19,349 newly diagnosed DM patients 20 years and older, and 77,396 comparison subjects without DM were identified from claims from 2000 to 2005. The incidences of HCC at the end of 2008 and the risks associated with hepatitis B and hepatitis C were determined, as were the effects of metformin and thiazolidinediones.

The incidence of HCC was twice higher in the DM group, compared with the non-DM group (21.0 vs. 10.4 per 10,000 person/years), with an HR of 1.73, using multivariable Cox proportional hazard regression. Male sex, cirrhosis, hepatitis B and hepatitis C were significant independent factors that predict HCC with HRs of 2.32, 8.65, 2.52, and 5.61, respectively. In the stratified analysis, the HR increased to 72.4 among patients with DM, cirrhosis, and hepatitis C. HCC risk reduction was greater for diabetics taking metformin than those taking thiazolidinediones (51% vs. 44% reduction).

It was concluded that comorbidity with cirrhosis and/or hepatitis appears to be associated with an extremely increased risk of developing HCC among DM patients. The use of metformin or thiazolidinediones may reduce the risk of developing HCC.


Murray H. Cohen, D.O., “From the Literature” Editor, is on the Editorial Board of Practical Gastroenterology.
FDA Clears Apollo Endosurgery’s SuMO(TM) Endoscopic Tissue Access and Resection System

SuMO System Allows Physicians to Perform Scarless Surgery to Remove Large Flat Pre-Cancerous Lesions During Colonoscopies and Upper Endoscopies

TEXAS - Apollo Endosurgery Inc. announced that the U.S. Food and Drug Administration (FDA) has granted 510(k) clearance for its SuMO(TM) endoscopic tissue access and resection system. Apollo Endosurgery designed the scarless surgery system to help surgeons remove large, flat precancerous gastrointestinal lesions and polyps during endoscopy procedures.

“Early detection and removal of flat, precancerous lesions may help prevent development of invasive esophageal or colon cancer, however, until recently, most patients with these lesions had to undergo significant surgeries, often involving resection of large segments of non-diseased esophagus or the colon,” said Lee Swanstrom, MD, director of the Oregon Clinic’s Division of Gastrointestinal and Minimally Invasive Surgery (GMIS). “Endoscopic submucosal dissection, or ESD, is an established technique that allows for effective resection of the pre-cancerous tissue without the need for an esophagectomy or colectomy. However, even with newer advanced endoscopic tools, the procedure is very challenging, particularly for larger areas of tissue.”

“With the SuMO technology, large submucosal dissections of pre-cancerous tissue can be done quickly and efficiently,” Dr. Swanstrom continued. “The SuMO procedure represents a novel and significant advance in therapeutic endoscopy that may allow increasing numbers of patients to avoid or delay major surgery.”

In 2010, Apollo Endosurgery received a $5 million award to support development and commercialization of the SuMO system from the Cancer Prevention and Research Institute of Texas (“CPRIT”). Apollo Endosurgery was the first company to receive this prestigious grant.

“We are extremely thankful to CPRIT for their generous support of the SuMO technology and the development of tools that enable scarless endoscopic alternatives to procedures that previously required major open surgery,” said Dennis L. McWilliams, Apollo Endosurgery President and CEO. “Technologies that enable endoscopic alternatives to invasive surgery for mucosal lesions, such as Barrett’s esophagus, have received significant attention from the medical and financial community in recent months. Together with our newest generation OverStitch(TM) device, Apollo Endosurgery now can offer surgeons access to the latest flexible endoscopic tissue access, resection and suturing technologies that make a new era of surgery a reality.”

SuMO, which stands for Sub-Mucosal Operation, was developed through a partnership between Apollo Endosurgery and the Mayo Clinic, Johns Hopkins University, the Medical University of South Carolina, and the University of Texas Medical Branch. The SuMO system is comprised of flexible devices including injection needles, unique balloons and cutting tools that help the surgeon tunnel underneath the lesion and then resect, seal off and remove the unwanted tissue through a traditional endoscope. In preclinical proof-of-concept studies, gastrointestinal tissue up to 7 cm in diameter has been removed en bloc endoscopically.

About Apollo Endosurgery(R), Inc.

Apollo Endosurgery(R), Inc. is dedicated to revolutionizing patient care through the development of scarless surgery, which is emerging from the convergence of laparoscopic surgery and therapeutic gastroenterology. Scarless surgery minimizes the trauma of surgical access by taking advantage of natural

(continued on page 42)
orifices to deliver surgical tools to targeted areas. All of Apollo’s products are compatible with existing flexible endoscope platforms. Apollo Endosurgery(R) was co-founded with the Apollo Group, a unique collaboration of physicians from the Mayo Clinic, Johns Hopkins University, Medical University of South Carolina, the University of Texas Medical Branch and the Chinese University of Hong Kong.

Merck Announces Initiation of Clinical Development Collaboration with Roche To Evaluate Investigational Combination Regimens for the Treatment of Chronic Hepatitis C Genotype 1 Infection New Clinical Trial Will Evaluate an Investigational Therapeutic Regimen with VICTRELIS™ (boceprevir)

NEW JERSEY - Merck (NYSE: MRK), known as MSD outside the United States and Canada, announced that Merck, in collaboration with Roche (SIX: RO, ROG; OTCQX: RHHBY), has initiated the first of a series of planned clinical trials to examine novel combinations of marketed and investigational medicines to expedite the availability of potential new treatment regimens for patients with chronic hepatitis C virus (HCV) genotype 1 infection. Clinical development collaboration is part of the overarching strategic agreement between Merck and Roche to improve treatment, diagnosis and awareness of chronic HCV in developed and emerging markets.

“VICTRELIS is the first in a new class of medicines for the treatment of chronic HCV genotype 1 infection, and when used in combination with peginterferon alfa, can significantly increase a patient’s chance of achieving undetectable levels of the virus,” said Eliav Barr, M.D., vice president, Infectious Diseases Project Leadership and Management, Merck Research Laboratories. “The start of this new study is an important milestone in our collaboration with Roche as we work to build on the innovative platform VICTRELIS provides by evaluating it in combination therapy with new investigational medicines for the treatment of chronic HCV genotype 1 infection, and also emphasizes our ongoing commitment to seeking novel treatment options for patients with chronic HCV.”

The first trial is designed to provide clinical data on the use of VICTRELIS™ (boceprevir), an oral HCV NS3/4A protease inhibitor, in combination with mericitabine (RO5024048), Roche’s investigational oral HCV NS5B nucleoside polymerase inhibitor, Pegasys® (pegylated interferon alfa-2a) and Copegus® (ribavirin), in adult patients with chronic HCV genotype 1 infection who had a null response to prior peginterferon alfa and ribavirin therapy (less than a 2 log HCV-RNA decline at treatment week 12). The Phase II study, called DYNAMO 1, plans to recruit patients at 25 sites globally. For further details of the clinical trial please visit www.clinicaltrials.gov, or contact (888) 662-6728

Lubiprostone Meets Primary Endpoint in Phase 3 Clinical Trial for Opioid-Induced Bowel Dysfunction (OBD) Aim to File for Approval of Lubiprostone as First Oral Drug for Prescription-based Treatment of OBD Anticipate sNDA Filing in US in First Half of 2012

BETHESDA, MD, and DEERFIELD, IL, - Sucampo Pharmaceuticals, Inc. (NASDAQ: SCMP) (SPI) and Takeda Pharmaceuticals U.S.A., Inc. announced that lubiprostone met the primary endpoint in a phase 3 clinical trial for the treatment of opioid-induced bowel dysfunction (OBD) in patients with chronic, non-cancer pain, excluding those taking methadone.

Patients received lubiprostone 24-mcg capsule or placebo capsule twice daily for 12 weeks. The primary endpoint was the overall spontaneous bowel movement (SBM) response rate. The response rate for lubiprostone-treated patients was 26.9% (n=219) versus 18.6% (n=220) for placebo-treated patients (p=0.035).

M. Mazen Jamal, M.D., M.P.H., Chief of Endoscopy, Long Beach Veterans Affairs’ Medical Center, Long Beach, California, Professor, Department of Medicine, University of California College of Medicine at Irvine, an investigator in the trial, said, “The results from this Phase 3 trial demonstrate that lubiprostone has the potential to be the first FDA-approved orally administered medicine with the indication to treat OBD in non-cancer, non-methadone patients. OBD can be a painful and debilitating side effect affecting many of non-cancer pain patients taking opioids chronically. There are more than 200 million prescriptions for opioid use in the U.S. annually and a substantial portion of these prescriptions are for non-cancer chronic pain. Many patients are not getting the desired relief and there is a significant need for a new medicine to treat this condition.”

Ryuji Ueno, M.D., Ph.D., Ph.D., Chairman and CEO of SPI, commented, “These data confirm the results from a previous phase 3 trial of lubiprostone in OBD patients and together with data from the
associated long-term safety trial, complete what we believe are the data requirements to support the submission of a supplemental New Drug Application (sNDA). We expect to submit the sNDA to the U.S. Food and Drug Administration (FDA) in the first half of 2012. In addition, we will discuss the potential for priority review, as we believe that physicians and their patients are actively seeking new therapies to address this condition. If approved, lubiprostone could be the first orally-administered medicine with the indication for OBD, providing another option for patients who need it and further differentiating lubiprostone from the competition.”

About this phase 3 trial of lubiprostone in OBD

This phase 3 trial was a randomized, placebo-controlled double-blinded trial of the efficacy and safety of lubiprostone in patients with opioid-induced bowel dysfunction. The trial enrolled and treated a total of 439 patients in the U.S. and Europe. Patients were evenly randomized to receive either placebo or lubiprostone 24-mcg gel capsule twice daily throughout the 12-week treatment period. Eligible patients must have been treated for chronic, non-cancer related pain with any opioid other than methadone for at least 30 days prior to screening, and continued opioid therapy throughout the study. Patients were confirmed to have OBD, which is defined as having an average of fewer than three SBMs per week during the three-week screening period and at least one of the following for at least 25 percent of SBMs during each week of the screening period: hard or very hard stools; sensation of incomplete evacuation; moderate to very severe straining associated with SBMs.

Responders were determined based on patients’ daily record of bowel movements. In order to be defined as a treatment responder, patients were required to demonstrate at least ≥1 SBM improvement over baseline SBM frequency for all treatment weeks for which observed data were available, and must additionally have demonstrated a full response (≥ 3 SBMs per week) for at least 9 of the 12 treatment weeks. An SBM was defined as any BM that does not occur within 24 hours after rescue medication use.

There were no drug-related serious adverse events reported for patients taking lubiprostone. Overall, the percentage of patients discontinuing treatment due to adverse events was 5.9% for the lubiprostone group compared with 2.3% in the placebo group. The most common treatment-related adverse events (experienced by >5 percent of patients) were diarrhea (9.6% vs. 1.4%), nausea (8.2% vs. 2.7%), and abdominal pain (5.5% vs. 0.0%) for lubiprostone vs. placebo, respectively. A majority (91.7%) of lubiprostone patients who reported diarrhea described the events as mild to moderate in severity. The incidence rates of severe nausea were 1.4% for placebo-treated patients and 0.9% for lubiprostone treated patients.

“We at Takeda are pleased that this study met its primary endpoint and will continue to work closely with...”

When activated or open, the ClC-2 chloride channel allows chloride to flow out of the epithelial cells lining the gut. The flow of chloride out of the epithelial cells also promotes sodium and water secretion into the intestines, which play a large part in determining the state of fecal material.

Images Courtesy of Sucampo Pharmaceuticals, Inc.
our partner, Sucampo, in preparing for the anticipated sNDA filing this year,” said Gilles Delecoeuillerie, M.D., Ph.D., Executive Medical Director for Gastroenterology at Takeda.

Results of this Phase 3 trial will be submitted for presentation at an appropriate medical meeting and for publication in an appropriate peer-reviewed journal.

Signal Genetics Announces Publication of Meta-Analysis of its Colon Cancer Test-Previstage™ GCC Confirming Prognostic Capabilities in Patients with Colon Cancer

NEW YORK - Signal Genetics, a privately held personalized medicine company focused on cancer, announced the presentation of a paper entitled “Guananyl Cyclase C (GCC) Lymph Nodes (LN) Classification as a Prognostic Marker in Patients with Stage II Colon Cancer: A Pooled Analysis” at the 2012 American Society of Clinical Oncology Gastrointestinal Cancer Symposium held in San Francisco, CA January 21, 2012. The data from the paper demonstrate the value of implementing Previstage testing in patients with colorectal cancer to identify those patients at risk of relapse.

The paper is the culmination of the work conducted by a team of researchers and collaborators from several centers, including: Rhode Island Hospital, Brown University, University of Massachusetts Medical School, University of North Carolina, Lahey Clinic, Brigham and Women’s Hospital, British Columbia Cancer Agency and DiagnoCure Inc. These researchers conducted a pooled individual data analysis on 310 patients to confirm whether molecular detection of GCC in Lymph Nodes indicates high risk of disease recurrence and poor survival in untreated stage II colon cancer.

GCC is a colon-specific biomarker normally found in gastrointestinal epithelium whose expression is preserved in primary and metastatic colorectal cancer cells. Studies to date have suggested that the presence of GCC gene expression in lymph nodes increased the likelihood of disease recurrence in stage II colon cancer patients, independent of traditional high risk features. The results of this study suggest that detection of GCC mRNA in lymph nodes is associated with risk of disease recurrence in stage II colon cancer patients not treated with adjuvant chemotherapy. The findings are consistent with several other studies conducted over the past 10 years.

Based on GCC levels, the estimated 5 year recurrence risks were 11% and 32% for the low and high risk groups respectively, clearly showing that GCC is a strong prognostic marker that effectively stratifies patients between those that are essentially cured from those at risk of disease recurrence. Higher detection levels of GCC in lymph nodes is also significantly associated with increased risk of all-cause mortality, disease-specific survival, and disease-free survival.

According to Joe Hernandez, President and CEO of Signal Genetics, “This paper represents further validation of GCC as a strong prognostic test that provides physicians and their patients an important insight that helps them make critical treatment decisions.”

About Signal Genetics

Signal Genetics, the parent company of Myeloma Health, Respira Health, and CC Health, is a privately held personalized medicine genetic testing company focused on bringing novel insights to physicians and their patients with various types of cancer. The goal of Signal Genetics is to provide information regarding disease status, stage, odds of relapse, predicting response to therapy, and prognosis through an array of proprietary tools to help guide physicians to the optimal treatment for each individual patient. Additional information is available at www.signalgenetics.com.

Answers to this month’s crossword puzzle:

Interactive Crossword and Answers can also be found on our website: www.practicalgastro.com

PRACTICAL GASTROENTEROLOGY • FEBRUARY 2012
MEETINGS CALENDAR

May 10, 2012
Ohio Viral Hepatitis Summit
Columbus, OH. Join us at the Quest Conference Center for this “must attend” event for anyone working with those who are infected with or affected by viral hepatitis. Continuing education credits for physicians assistants, nurses, social workers, and addictions professionals are available. For reservations, call Pat Snyder at (614) 841-9100 and mention group code “Hepatitis Foundation” www.hepatitisfoundation.org

May 18-23, 2012
SGNA 39th Annual Course
Phoenix, AZ. The Society of Gastroenterology Nurses and Associates 39th Annual Course is a chance for you to join and collaborate with your fellow GI/endoscopy professionals, resulting in professional growth and development. Learn more about the following opportunities you can take advantage of: Unique networking opportunities, Exciting general sessions, Business meetings and ABCGN certification. SGNA is a professional organization of nurses and associates dedicated to the safe and effective practice of gastroenterology and endoscopy nursing. SGNA carries out its mission by advancing the science and practice of gastroenterology and endoscopy nursing through education, research, advocacy, and collaboration, and by promoting the professional development of its members in an atmosphere of mutual support. For more information visit: www.sgna.org

May 19-22, 2012
Digestive Disease Week
San Diego Convention Center, San Diego, CA. DDW is the largest international gathering of physicians, researchers and academics in the fields of gastroenterology, hepatology, endoscopy and gastrointestinal surgery. An average of 15,000 medical professionals attend the meeting each year. Jointly sponsored by the American Association for the Study of Liver Diseases (AASLD), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and the Society for Surgery of the Alimentary Tract (SSAT), DDW showcases thousands of abstracts and hundreds of lectures on the latest advances in GI research, medicine and technology. For more information visit: www.ddw.org

July 27-29, 2012
7th Postgraduate Course on Gastrointestinal Motility and Neurogastroenterology in Clinical Practice (Live Demonstrations and Interactive Meeting with the Experts) & Young Investigator Forum (Abstract deadline April 4, 2012)
Hyatt Regency, Chicago, IL. American Neurogastroenterology and Motility Society. For more information visit: www.motilitysociety.org

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PRACTICAL GASTROENTEROLOGY CROSSWORD PUZZLE

by Myles Mellor

DOWN

1 It’s responsible for more neonatal deaths than all other birth defects combined, for short
2 Jaundice color
3 Back muscle (abbr.)
4 Like some vaccines
5 Time period, for short
6 Mucous from eyes or nose
7 They are used in 39 across
8 Right-to-left shunting
9 Auto ___
13 Highest point
14 Form of cancer
17 Painkiller
21 Stuck
22 “Lord of the Rings” evil warrior
23 A hydrocarbon radical (C6H5)
24 Menteric ___
25 ___ts of Langerhans
27 Humor with a twist
30 Dosage amount
31 Bone cavity
32 Finger or toe
34 “___ Tuck”
35 Help cry
36 Blood amounts
37 Negative
38 Indiana neighbor
39 It provides pictures of the body in slices
40 Blood-typing system
41 Clover, alfalfa, etc.
42 ___mentary

ACROSS

1 Pleural effusion resulting in nutritional complications
8 Center for Disease control and prevention, for short
10 Organ with a canal
11 Type of cell in the pancreas
12 Veins to the heart
14 Coalesce
15 Tape ___
16 It provides visual images
18 Dietary measurement
19 Test
20 Abnormal particles circulating in the blood
26 The NG in NGT
28 Exist
29 Medical show
31 Hurt a lot
33 Key examination in diagnosing gastro problems
37 Negative
38 Indiana neighbor
39 It provides pictures of the body in slices
43 Inc., in Britain
44 Bassen-Kornzweig syndrome

(Answers on Page 46)

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