**GI and Liver Disease During Pregnancy: A Practical Approach**  
Editors: Kim Issacs, MD, PhD, Millie D. Long, MD, MPH  
Publisher: SLACK Inc. 2013  
ISBN: 978-1-61711-023-8  
Price: $45.95

Few patient encounters generate the anxiety and uncertainty in gastroenterologists and internists such as the pregnant patient. Drs. Issacs and Long, with the help of several contributors, very eloquently and concisely address the care of the pregnant patient with GI and liver diseases in this very readable and easy to follow pocket guide—*GI and Liver Disease During Pregnancy: A Practical Approach*.

This informative 215 page pocketbook is extremely well organized and laid out in 12 short and succinct chapters. Each chapter is organized into subsections including epidemiology, pathophysiology, presentation, evaluation and management. Moreover, the Key Points boxes after each subsection summarize the take home messages on the material provided in that section—making needed information quite easy to access.

The content of each individual chapter is comprehensive, deals with contemporary issues, and is extremely evidence based. The book covers topics ranging from GERD/nausea and vomiting, along with constipation and irritable bowel syndrome (IBS) to safety of endoscopy and gastric bypass/surgical management and pregnancy. Inflammatory bowel diseases, pancreatitis/biliary issues and liver diseases are also appropriately outlined in individual chapters. As such, the information in these chapters aims to effectively answer most questions that arise in the clinic dealing with GI issues in pregnancy.

The most valuable asset that clinicians will derive from this book, however, is the particularly well organized and detailed listing of medicines (along with their FDA safety ratings) used to treat various GI diseases in pregnancy. Each chapter has tables that outline, by class, all the medicines used to treat the diseases mentioned in that chapter. This aspect makes the usually arduous and worrisome task of prescribing medications to pregnant women, very simple. The use of these tables allows the clinician to clearly weigh the utility and risks of various medications and make the appropriate choice for the patient in front of them.

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The only criticism of the book is that it is text heavy and there are not many illustrations, algorithms or figures. Decision trees are often useful in pocketbooks, and more figures would have made this wonderful text even easier to use. The organization and ease of access to information far outweigh the minor deficiencies of the text.

Overall, the concise text serves as a comprehensive and evidence based review of various gastrointestinal diseases during pregnancy. This book will be highly beneficial reference for internists, family medicine physicians, obstetricians/gynecologists, gastroenterologists or any other providers that see pregnant patients.

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Atlas of Dermatological Manifestations of Gastrointestinal Disease
Editors: Wu GY, Selsky N, Grant-Kels JM
Publisher: Springer, 2013
ISBN: 978-1-4614-6190-6
Price: $59.00 (Amazon) $111.20 (Kindle edition)

The relationship between gastrointestinal maladies and cutaneous manifestations has been recognized for thousands of years. The Atlas of Dermatological Manifestations of Gastrointestinal Disease is a 196-page hardcover text with a stated purpose “to produce an atlas that will provide a comprehensive compendium of digestive tract diseases with dermatological manifestations.”

The atlas is well organized into nine parts based upon gastroenterological symptoms. Within each part are diseases that present with that specific symptom. For example, there are fifteen diseases under the section ‘Gastrointestinal Bleeding’ such as ‘blue rubber bleb nevus syndrome’ and ‘Churg-Strauss syndrome.’ Each disease entity is presented in paired chapters. The first outlines gastrointestinal features, and the second, dermatologic features. The information presented is not exhaustive; rather, each chapter is standardized with information summarized in bullet points, including clinical signs, pathogenesis, pathologic features, diagnosis, differential diagnosis, and treatment. Each chapter also includes several color images, including endoscopy, clinical appearance of the skin lesion or rash, and often histologic images. Most of the images are of high quality and are clear, although some of the histologic images are blurry or at too low of a magnification to see any detail.

As a dermatologist, I enjoyed reading through this atlas, especially the gastrointestinal features of a particular disease matched with its typical endoscopic and pathologic features. The editors and authors are to be commended for this handy and unique atlas. The book is comprehensive, succinct, and provides quick reference information for practicing clinicians, residents, and fellows. The preface states “We think this text will provide an important resource for the dermatologist, gastroenterologist, or internist struggling with what appear to be unrelated digestive and skin complaints.” Agreed – this text does just that.

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Extraesophageal Manifestations of GERD
Editors: Anthony J. DiMarino, Jr, MD, Sidney Cohen, MD
Publisher: SLACK Incorporated, 2013
ISBN: 978-1-61711-621-6
Price: $42.99

Numerous studies and manuscripts have dealt with the common manifestations of gastroesophageal reflux disease (GERD), primarily esophagitis. More recently, many human ailments have been attributed to GERD, ranging from halitosis and asthma in adults to
the Sudden Infant Death Syndrome in young infants. However, in searching PubMed for the specific topic, extraesophageal manifestations of gastroesophageal reflux disease, only 125 references can be found, dating back from 1989. This book, *Extraesophageal Manifestations of GERD*, published earlier this year and edited by Drs. Anthony DiMarino and Sidney Cohen, is a succinctly written and informative review of many of these other manifestations of GERD. The pathogenesis of these manifestations is discussed using three categories: 1) symptom association, 2) observed mechanistic studies, and 3) response to treatment. Both editors are well-respected, senior members of the division of Gastroenterology and Hepatology at Thomas Jefferson University Hospital, and have published widely in this field.

This book is divided into seven chapters written by 17 contributing authors of varying experience and rank, including several fellows. The initial two chapters are devoted to the pathophysiology of extraesophageal reflux and the evaluation of GERD. These chapters are excellent reviews for anyone interested in this field, including gastroenterologists, pulmonologists, and other specialists. The remaining chapters review specific manifestations of GERD, including pulmonary, ear, nose, and throat, sleep, oral manifestations, and a final chapter dealing with pediatric manifestations. Each chapter is well-written and includes one or more paragraphs dealing with controversies in the field. This is particularly evident in the chapter dealing with ear, nose, and throat manifestations. This chapter has sections written both by an otolaryngologist and a gastroenterologist, including a table which lists the quality of evidence for association with GERD of specific otolaryngologic symptoms, followed by a point-counterpoint by the editors. As a pulmonologist, I was particularly interested in the pulmonary manifestation chapter. In this chapter, the authors effectively outline the known associations between asthma and GERD, and correctly conclude that “GERD therapy may improve asthma outcomes in selected patients.” This association is confirmed in the pediatric population, although the mechanism of the association is unclear, perhaps as a cause and effect phenomenon versus simply the coexistence of two common pediatric diagnoses.

The book is easy to read and can be read in a single sitting. A number of pictures and figures are included and all are of good quality. Tables are also easy to understand although some appear repetitive. References are complete and most are quite recent. Several specific treatment algorithms are also included and appear logical and useful.

In summary, this book is a valuable contribution to this field and nicely summarizes these other manifestations of a very common condition. I would certainly recommend it to anyone who frequently cares for patients with GERD.

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Pruritus in Cholestatic Disease: A Difficult Dilemma

Alagille syndrome is associated with extremely problematic pruritus as a result of chronic cholestasis. Medical management is usually initiated, although pharmaceutical intervention is associated with variable response. Surgical management may be necessary, in extreme cases, including partial external biliary diversion or liver transplantation. All children with Alagille syndrome that were followed using a database at the Paediatric Liver Centre at King’s College Hospital were evaluated for clinical response to pruritus using medical or surgical management. Alagille syndrome was diagnosed on the basis of bile duct paucity on liver biopsy, characteristic facies, cholestasis, and possible skeletal, cardiac, or eye abnormalities. Efficacy of antipruritic drug therapy was documented on a 5-point scale.

A total of 62 children were included in the database with an age range of 5 months to 18 years (median, 7 years 8.5 months). Most patients (82.3%) experienced pruritus of which the majority of symptoms were defined as “severe”. Ursodeoxycholic acid was the most commonly prescribed drug for treatment followed by rifampicin, cholestyramine, naltrexone, alimemazine, non-sedating antihistamine agents, ondansetron, and phenobarbital. The majority of patients (70%) required multiple drug therapies to treat pruritus. Most patients had “some” symptom relief using ursodeoxycholic acid, but “good” or “very good” response was minimal. Most patients given rifampicin or naltrexone had “good” or “very good” response. Cholestyramine was associated with “some” improvement of symptoms, but there was poor compliance with this medication due to side effects, mainly due to medication taste. Most patients given alimemazine or non-sedating antihistamines had “some” improvement of symptoms while most patients given ondansetron had a “good” response (although only 5 patients were on this medication). One patient required a molecular adsorbent recirculation system for severe pruritus and had a “good” outcome. Liver transplantation eventually was needed in 11 patients due to various complications of Alagille syndrome, and all patients who underwent surgical therapy had complete resolution of pruritus.

The authors comment that the majority of patients required multiple drugs to control pruritus which indicated that use of single agents was associated with a high therapeutic failure rate. This finding suggests pruritus associated with cholestasis in Alagille syndrome is likely caused by multiple mechanisms. All patients who underwent liver transplantation had resolution of symptoms suggesting that step-up treatment guidelines are needed to treat the difficult issue of pruritus in this patient population.

**Hepatopulmonary Syndrome For Transplantation**

HPS (hepatopulmonary syndrome) independently increases mortality regardless of the cause or severity of liver disease. To evaluate the long-term survival with the use of liver transplantation (LT), a large consecutive series of HPS patients specifically addressing survival related to the degree of hypoxemia and the era in which LT was conducted was evaluated from 106 HPS patients at the Mayo Clinic from 1986 through 2010. Survival was assessed using Kaplan-Meier methodology.

LT was accomplished in 49 HPS patients. Post LT survival (1, 3, 5, and 10 years), does not differ between groups based on baseline partial pressure of oxygen (PaO2) obtained at the time of HPS diagnosis. Improvements in overall survival in those patients transplanted after 01/01/2002 (N = 28) were respectively 92%, 88%, and 88% at 1, 3, and 5 years, as compared with those transplanted prior to that time (N = 21) at 71%, 67%, and 67%, respectively. Those findings did not reach statistical significance.

MELD exception to facilitate LT was granted to 21 patients since 01/01/2002 with post-LT survival of 19-21 patients and one wait list death.

It was concluded that long-term outcome after LT in HPS is favorable with a trend toward improved survival in the MELD exception era since 2002 as compared to earlier HPS transplants. Survival after LT was not associated with PaO2 levels at the time of HPS diagnosis.

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**Refractory Hepatic Encephalopathy/Spontaneous Portosystemic Shunts**

Large spontaneous portosystemic shunts (SPSSs), had been suggested to sustain HE in cirrhotic patients to retrospectively assess the efficacy and safety of patients treated with embolization of large SPSSs for the treatment of chronic therapy refractory HE in a European multicentric working group and to identify patients who may benefit from this procedure.

Between July 1998 and January 2012, 37 patients with refractory HE were diagnosed with single large SPSSs that were considered eligible for embolization. On a short-term basis (within 100 days after embolization), 22 out of 37 patients (59.4%), were free of HE versus before embolization, of which 18 (48.6% of patients overall), remained HE-free over a mean follow-up period of 697 days (median).

There was improved autonomy, decreased number of hospitalizations, and severity of the worst HE episode after embolization in 3/4 of the patients.

Logistic regression identified the MELD score as the strongest positive predictive factor of HE recurrence with a cutoff of 11 for patient selection. There was one major nonlethal procedure-related complication. There was no significant increase in DeNovo development or aggregation of preexisting varices, portal hypertensive gastropathy, or ascites.

It was concluded that there is a role for large SPSSs in chronic protracted or recurrent HE, and this substantiated the effectiveness and safety of embolization of these shunts, provided there is sufficient functional liver reserve.

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**Autoimmune Hepatitis: Predictors of Poor Outcome**

AIH can lead to cirrhosis, hepatic failure, and death. To identify the predictors of advanced liver fibrosis at presentation, predictors of incomplete response to initial immunosuppression, and predictors of poor liver-related outcomes in the population-based AIH cohort from Canterbury, New Zealand were reviewed.

Cases diagnosed after 1980 that fulfilled standard diagnostic criteria were included and were censored at death or liver transplantation and had a median follow-up of nine years. Analyses were performed with Cox proportional hazards regression and logistic binary regression. The times to event outcomes were summarized using Kaplan-Meier curves.

A total of 133 AIH patients were included. Predictors for advanced liver fibrosis at diagnosis were age at presentation of 20 or less years, or greater than 60 years, serum albumin less than 36 g/L, platelet less than 150,000, and INR greater than 1.2. The only independent predictor for incomplete normalization of ALT at 6 months was age at presentation less than 20 years.

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Independent predictors of poor liver-related outcomes were incomplete normalization of ALT at 6 months, serum albumin less than 36 grams per liter and age at presentation at 20 or less years of age or greater than 60 years.

Kaplan-Meier estimates showed a 10-year adverse liver event-free survival was 80% for age at presentation less than 20 years and greater than 60 years, and 93 and 100% for age at presentation between 20 to 40 years and 41 to 60 years, respectively.

It was concluded that incomplete normalization of ALT at 6 months, low serum albumin concentration at diagnosis, and age at presentation at 20 or less years of age or greater than 60 years were significant independent predictors of liver-related death or requirement for liver transplantation.

Histologic cirrhosis at diagnosis was not associated with poor prognosis and did not influence the response to initial immunosuppressive treatment.

Ngu, J., Garry, R., Frampton, C., Stedman, C. “Predictors of Poor Outcome in Patients With Autoimmune Hepatitis: A Population-Based Study.” Hepatology 2013; Vol. 57, pp. 2399-2406.

Treatment of Combined HCV and HBV

The durability of hepatitis B and C clearance in coinfected patients was investigated in a 5-year follow-up study. Patients with active HCV genotype 1, both HBV-coinfected (N = 97), and HBV-monoinfected (N = 110), underwent 48 week combination therapy with PEG Interferon Alfa-2A plus ribavirin. In patients with HCV genotype 2 or 3, both HBV-coinfected (N = 64) and monoinfected (N = 50) patients underwent 24-week combination therapy. A total of 295 (91.9%) patients completed treatment and 24 weeks post treatment follow-up, 264 (89.5% of patients) agreed to receive additional follow-up for up to five years after the end of treatment.

After a median follow-up of 4.6 years, 6 of the 232 patients achieving SVR developed HCV RNA reappearance, including 5 HCV genotype 1/ HBV-coinfected patients and one HC genotype 2/3-monoinfected patient.

Subgenomic analysis of the HCV core gene indicated that five patients developed delayed recurrence of HCV infection.

Overall, the cumulative recurrence rate of HCV infection was 2.3% with cumulative HBsAg seroclearance 40% with 43.1% in the 48-week combination group and 24.3% in the 24-week therapy group.

It was concluded that PEG Interferon Alfa-2A and ribavirin therapy provides good HCV SVR durability and a high cumulative HBsAg seroclearance rate in patients who are coinfectected with HCV and HBV.


Tattooing and HCV

A large, multi-center, case-controlled study was carried out, analyzing demographic and HCV risk factor exposure history data from 3871 patients, including 1930 with chronic HCV infection and 1941 HCV-negative controls. Crude and fully-adjusted odds ratios (ORs) of tattoo exposure by multivariate logistic regression in HCV-infected versus controls were determined.

As expected, IDU (injection drug use) 65.9% vs. 17.8%; blood transfusion prior to 1992 (22.3% vs. 11.1%), and history of having one or more tattoos (OR 3.81), were more common in HCV-infected patients than in control subjects.

After excluding all patients with a history of ever injecting drugs and those who had a blood transfusion prior to 1992, a total of 1886 subjects remained for analysis (465 HCV-positive patients and 1421 controls).

Among these individuals without traditional risk factors, HCV-positive patients remained significantly more likely to have a history of one or more tattoos after adjustment for age, sex, and race/ethnicity (OR 5.17).

It was concluded that tattooing is associated with HCV infection, even among those without traditional HCV risk factors such as IDU and blood transfusion prior to 1992.


Murray H. Cohen, D.O., “From the Literature" Editor, is on the Editorial Board of Practical Gastroenterology.
Patients with spinal cord injuries commonly have a slowed gastrocolic reflex.

Patients with Irritable Bowel Syndrome can have either a slowed or extremely rapid reflex.

Also, with regard to motility/electrical activity and contractions of the colon, if the contractions are irregular and spastic, abdominal pain/cramping may occur with diarrhea; on the other hand if there is poor electrical activity, constipation results. Motility studies of the colon have demonstrated activity in the colon as early as 15 minutes after a meal.

4. How is Gastrocolic reflex treated?

Always discuss treatment options with a physician. Your doctor will ensure there are no alarm symptoms (such as infections, weight loss, blood in stool, significant family history of Inflammatory Bowel Disease or GI tract malignancies, etc) that may require further work-up prior to initiating treatment. Treatment can be similar to that of irritable bowel syndrome.

For diarrhea predominant symptoms:

- Eating smaller, more frequent meals is advised.
- Eat meals low in fat.
- Add soluble (vs insoluble fiber) vs trial of low fiber diet
- Proton pump inhibitors: Several reports have described that inhibition of gastric secretion (i.e. gastrin) may control the diarrhea and postprandial urgency associated with IBS or functional diarrhea, probably by diminishing the gastrocolic or gastroenteric reflex.
- Anti-diarrheal agents, such as Loperamide (Imodium) or diphenoxylate (Lomotil) have been used to impede the gastrocolic reflex
- Peppermint/Peppermint oil can be taken after a meal to reduce indigestion and colonic spasms by reducing the gastrocolic reflex
- Antispasmodic medications (Dicyclomine, Hyoscyamine)
- Anti-anxiety medications (as they help control certain neuropeptides)

For constipation predominant symptoms, the opposite rules apply:

- Increase water content in meals
- Increase fiber content in meals

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- Metamucil (psyllium)
- Laxatives (Miralax)
- Medications that increase colonic motility (Amitiza, Linzess)

5. How is Gastrocolic reflex managed?

See above

6. How is Gastrocolic reflex related to IBS?

Patients with irritable bowel syndrome may have symptoms of diarrhea, or constipation, or alternating symptoms of diarrhea and constipation. Perhaps resulting from an exaggerated or dampened gastrocolic reflex. These patients have hypersensitive GI tracts due to multiple factors, such as a heightened autonomic response, release of certain neuropeptides, poor visceral response to stretch, all resulting in altered responses to ingested meals and symptoms of diarrhea, constipation, abdominal pain, bloating, and gas.

For more information contact Jeff R. Jacomowitz: jrjacomowitz@lazarpartners.com 646-871-8481
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RUTGERS NURSING SCHOOLS AIM TO TRANSFORM URBAN HEALTH CARE

Mobile health care program and community wellness center team up to dramatically expand reach

The new Rutgers, combining nearly 250 years of academic excellence with a renewed commitment to medical education, is inspiring faculty, students and staff to form innovative partnerships in academic research and public service. In an online series, Rutgers Today examines the new ways that members of the university community are collaborating, across a wide range of disciplines, to better meet the needs of the people of New Jersey and beyond.– The Editors

One Rutgers, A World of Discovery

It’s Cindy Sickora’s job to make sure that every weekday, the Rutgers School of Nursing’s health care van is there to help the people who need it. Its patients, mostly from Newark, are elderly residents in buildings without elevators, gunshot victims in need of follow up care, and children booked for vaccines in a city with one of the nation’s lowest vaccination rates.

Many are public housing residents with no health insurance or primary care doctor. Although the traveling clinic treats more than 1,500 patients a year, the city’s need for affordable, accessible health care is overwhelming.

Sickora, an associate professor at the Rutgers School of Nursing, part of the former University of Medicine and Dentistry of New Jersey, was searching for a way to reach more people.

She found it when she met Suzanne Willard. On the other side of Newark, Willard had opened FOCUS Wellness Center last fall on Broad Street. The wellness center is part of the Rutgers College of Nursing, which was founded at the university in 1955. By joining forces, Willand and Sickora hope to accomplish a shared mission: transforming urban health care.

Both began working together as Rutgers was preparing to integrate with most of the schools, centers and institutes that made up UMDNJ. Their new partnership allows both facilities to share resources and serve patients far better than they could on their own. For instance, the center has a social worker on staff for patients with mental health needs. The mobile clinic, which has no social worker, can now refer patients to the center.

“We have the potential to help a whole lot of people,” says Sickora, who directs the School of Nursing’s community health program. “Our mobile clinic can make inroads in educating people to use FOCUS, which could be a health care hub, especially for areas of the city we don’t cover.”

“Nurses have a reputation for cutting through red tape and getting things done,” says Willard, Associate Dean of Rutgers College of Nursing advance practice program. “There is a solidarity among nurses,” Willard says.

The center’s first patient was a referral from Sickora. Because mobile clinic staff couldn’t provide gynecological exams at the time, they sent her to FOCUS. “Cindy said, “I’ve got someone who’s had problems accessing services and your center would be perfect,” recalls Willard. Days after the visit, mobile care nurses checked in on her at home to make sure her symptoms had subsided.

Newark has one of the most underserved populations for basic health care in the United States. Many residents, who lack reliable transportation, must take multiple buses to see a primary care doctor, if they have one at all. Some wait days, even weeks, for appointments. Others are prescribed expensive medication they can’t afford.

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Studies show that nurse-managed care can be just as effective as physician-administered care, according to Willard and Sickora. Nurse-managed care is especially successful at providing treatment continuity, as well as a personal touch, at a much lower cost. “Our approach is more holistic,” says Willard. “Nurses look at patients and think of their overall ability to improve health outcomes, that’s how we’re wired. We ask, “What do I need to do to help them take care of themselves when they leave?’ We want to keep them out of the emergency room.”

The FOCUS Wellness Center, funded with federal and local grants, is designed to meet the multifaceted needs of patients who are often grappling with mental health issues and neighborhoods filled with violence, aggravating conditions that are common throughout inner cities: diabetes, hypertension and asthma.

Willard recalls one patient who said her father had been murdered when she was 7. “I thought, “How can you just treat the physical symptoms with a patient whose father was killed in front of her when she was that young?” We have a lot of case histories like that,” Willard says.

The FOCUS staff includes a licensed clinical social worker in addition to students and faculty from the College of Nursing, School of Social Work and the Rutgers’ Ernest Mario School of Pharmacy.

As word has begun to spread about the Broad Street center, more walk-ins have been arriving and many have returned. “They tell us, “You actually treat us like people,” says Willard. That hasn’t always been their experience. “Once you form an emotional attachment, they come back.”

Sickora’s staff also has formed bonds with patients since her program, otherwise known as the New Jersey’s Children’s Health Project, began in 2007 with major support from the nonprofit Children’s Health Fund - a national organization co-founded by singer Paul Simon to help children living in poverty.

The nursing school’s mobile clinic is part of a larger network, based on a pioneering health care model, in which residents work closely with nurses, says Sickora. The nerve center of the program is Rutgers’ Jordan and Harris Community Health Center, headquartered at the Hyatt Court public housing complex in Newark. It’s staffed by two nurses who make house calls to shut-ins and serve as liaisons between patients and outside health care providers. They also refer patients to the mobile clinic, which makes additional stops in Newark at La Casa De Don Pedro Community Center, serving low-income Hispanic residents, and the Covenant House for homeless youth.

Community health workers in Sickora’s program are trained to pinpoint residents in need, schedule appointments and coordinate follow up care. “They knock on doors, they’ll say, “We need to make sure the babies get their measles vaccine.’ They’re the reason we’re able to see so many patients,” says Sickora, who partnered with Hosseinali G. Shahidi, an emergency medicine specialist at Rutgers New Jersey Medical School, when she applied for funding.

Sickora and her staff, which includes nursing students, have worked hard to form relationships with residents, many of whom rely on them to treat chronic conditions.

During a recent physical exam, Andrew Jackson, a resident of Terrell Homes, was diagnosed with high blood pressure. Since his Medicaid was cut off last year, he’s made weekly visits for checkups and advice. “They tell me to go slow on the salt,” says Jackson, 42. No other mobile health care program in the nation, according to Sickora, uses the community health worker model, which she believes can be a valuable source of data for researchers. Two nurse scientists are already involved in evaluating programs.

Says Sickora, “We’re really asking the question: Can we change health care for underserved populations?”

By Carrie Stetler

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MEETINGS CALENDAR

November 1-5, 2013  The Liver Meeting®
At its core, The Liver Meeting® is the place for state-of-the-art science in the field of hepatology. Plenary and parallel sessions provide the avenue for specialists to learn about cutting-edge research. Courses, workshops, and symposia provide clinicians with the latest in treatment techniques and options. Exhibits and poster sessions provide networking opportunities for attendees of all experience levels. For those considering a specialty in hepatology, the meeting provides an unparalleled forum in which to network and make an informed decision about a career in hepatology. The study and treatment of liver disease is a collaborative effort that reaches across disciplines and professional backgrounds. Physicians, scientists, surgeons, fellows, nurses, mid-level providers and industry representatives all have a place at The Liver Meeting® For more information visit: www.aasld.org

December 12-14, 2013  Advances in Inflammatory Bowel Diseases, Crohn’s & Colitis Foundation’s Clinical & Research Conference
The Westin Diplomat, Hollywood, Florida – Advances in IBD is the premier conference for healthcare professionals and researchers who study and manage patients with inflammatory bowel diseases. Endorsed by the ACG, AGA, and NASPGHAN, this three-day conference offers exciting workshops and a two-track format designed for clinicians, researchers, allied health professionals, nurses, and pediatric gastroenterologists. Located beachside at the Westin Diplomat in Hollywood, Florida, this is the educational get-away worth attending. For more information visit: http://advancesinibd.com
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ACROSS

1. Sub-specialty of gastroenterology  
2. Prefix meaning molding or forming surgically  
3. Attempt  
4. Purgative  
5. Kind of radiation  
6. Epidermis  
7. He discovered the gastroscope  
8. Squat  
9. Score used in achalasia testing  
10. Throat section  
11. Relating to secreting membranes  
12. ___ patient  
13. Beverage server  
14. Before meals abbreviation  
15. Bone cavities  
16. Take into a hospital  
17. Outburst that can be a reaction to pain  
18. Nurse, for short  
19. Intravenous cholangiography, abbr.  
20. Modify  
21. ___ islands  
22. Disorder affecting the lining of the esophagus  
23. Occasional referred pain for gastroenteritis sufferers  
24. Extensor muscle  
25. It’s important after Hpylori treatment  
26. Craze, like some diets  
28. Ouch!  
30. Cup part  
32. Acronym for fatty acid  
34. Damaged in a way  
35. Browicz-______ cells  
37. And in Latin  
38. He discovered that stomach juices contain hydrochloric acid  
39. Prolapse of the wall between the rectum and the vagina  
40. Prefix denoting three  
41. Medical quantities  
42. Checks

DOWN

1. Ancient Greek who attributed digestion to concoction  
2. Prefix meaning molding or forming surgically  
3. Attempt  
4. Purgative  
5. Kind of radiation  
7. He discovered the gastroscope  
8. Squat  
9. Score used in achalasia testing  
13. Beverage server  
14. Before meals abbreviation  
16. Little kid  
20. Band-___  
21. ___ islands  
22. Disorder affecting the lining of the esophagus  
23. Occasional referred pain for gastroenteritis sufferers  
25. It’s important after Hpylori treatment  
27. Not edible any more  
29. One of the doctors who discovered the Helobacter pylori and its role in peptic ulcer disease  
31. Doc, for short  
33. Have an influence on  
36. Instrument for exploring body cavities  
38. What a postdoc already has  
39. Tear

(Answers on page 59)