

GI TAKE HOME MESSAGES and CLINICAL PEARLS

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- IM training @ MSSM
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Disclosures

- None relevant to this presentation



GI Take Home Messages

- Whopping dose of GI information
- How will you metabolize all this?
- ~~Acronyms?~~
- ~~Pathways?~~
- Clinical vignettes?
- Systems-based approach



Esophagus

- GERD is quite common
- Treatment includes lifestyle changes and acid suppression (H₂RA / PPI) or sometimes surgery
- EGD and pH testing (alarm / new symptoms, treatment failure)
- Long-term effects of PPI need further investigation



Esophagus

- Barrett's esophagus is a result of GERD and a precursor of adenocarcinoma
- Progression rate is much lower than initially thought
- Screening indicated when multiple risk factors present
- Surveillance indicated as treatment for dysplasia is effective



Esophagus

- Eosinophilic esophagitis is an increasingly recognized allergic disorder most commonly presenting as dysphagia
- PPI therapy, elimination diet, food allergy testing and swallowed steroids are mainstays of therapy



Esophagus

- Motility disorders can be difficult to diagnose
- Must rule out structural causes of dysphagia
- High resolution manometry can distinguish amongst the dysmotility disorders and direct therapy

Peptic Diseases

- PUD most commonly caused by NSAIDs or H pylori (or both - synergistic)
- NSAIDs often under-reported in the history
- PPIs have a more rapid response in healing peptic ulcers than H2RAs
- Restrictive transfusion regimen for bleeding PUD
- 2° ASA should be re-started within one week



Peptic Diseases

- Most recent H pylori guidelines favor a test and treat strategy for non-ulcer dyspepsia, ITP, iron deficiency anemia and prior to long-term NSAID use
- Treatment algorithm for H pylori hinges upon macrolide exposure / PCN allergy
- Bismuth, clarithro, levofloxacin based regimens; sequential regimens



IBD

- UC and Crohn's
- Clinical parameters to define severity of disease
- Goals of therapy
 - Induce remission (clinical and biologic)
 - Steroid free therapies
 - Avoid surgery/hospital



IBD

- Paradigm shift: step-up therapy replaced by top-down
- Treat early in moderate to severe disease
- Dual therapy – immunomodulator and biologic mAb
- Be aware of long-term complications – osteoporosis, cancer risk (highest in pan-colitis), need for surveillance



Liver

- HBV
 - Risk-based screening
 - HBs Ag & HBs Ab, or HBc Ab as a first step
 - Two dose (one month apart) vaccine has higher seroconversion rate
- HCV
 - Universal screening (HCV Ab)
 - Age > 18, not just boomers
 - Direct acting anti-virals high sustained virologic response (oral regimens)
 - Treat acute HCV

Screen for HCC with AFP and U/S every 6 months



Liver

- Decompensation occurs in the majority of patients with cirrhosis
- Ascites > jaundice > encephalopathy > variceal bleeding
- New ascites warrants paracentesis (SAAG > 1.1 = pHTN)
- Treatment – Na restriction, furosemide/spironolactone (single daily dosing); LVP/TIPS



Liver

- Hepatorenal syndrome
 - Renal impairment that does not respond to holding diuretics or volume expansion
 - Type 1: acute, precipitated by SBP, alcoholic hepatitis, surgery
 - Type 2: chronic, refractory ascites, Cr > 1.5
 - Poor prognosis
 - Albumin/Octreotide/Midodrine
 - TIPS



Liver

- Varices
 - Screening indicated; if seen, then non-selective beta blocker or banding for esophageal
 - Acute hemorrhage managed in ICU, banding, early TIPS for CPT B/C
 - Gastric variceal hemorrhage: BRTO (IR), coiling/glue (GI)



Liver

- Transplant
 - MELD score
 - Highly predictive of 3 month mortality, used to triage transplantation, MELD > 15
 - OLT at MELD > 15 and decompensation
 - Allocation is regional – variation
 - LDLT
 - Exclusions



Pancreas

– Acute Pancreatitis

- Most commonly due to gallstones or alcohol
- 2/3 criteria: typical pain, amylase/lipase $> 3 \times$ normal, imaging
- Severity graded on presence of local complications and degree of organ failure
- Early, moderate fluid hydration, Lactated Ringer's
- Oral feeding $>$ enteral feeding, avoid TPN; NGT $\approx$ NJT



Pancreas

– Acute Pancreatitis

- ERCP only in patients with concomitant cholangitis or evidence of ongoing biliary obstruction
- Antibiotics for cholangitis, but not for prophylaxis of severe AP
- Cholecystectomy in the same hospitalization if biliary pancreatitis without necrosis



Pancreas

– Chronic Pancreatitis

- Toxic/Metabolic, Idiopathic, Genetic, Auto-Immune, Recurrent, Obstructive
- Exocrine pancreatic insufficiency treated with pancreatic lipase
- Opioid sparing pain regimen
- Steroids for AIP



Diarrhea

- Acute
 - Viral > bacterial
 - Norovirus, Rotavirus
 - COVID-19: 33% of hospitalized patients reported diarrhea
 - Salmonella (avoid abx), Campylobacter, C Diff, EHEC (avoid abx)
 - O&P only with > 14 days of symptoms, travel or exposure



Diarrhea

- Chronic
 - Inflammatory
 - Medications
 - EPI
 - Celiac disease
 - Microscopic colitis



GI - Take Home

