

Continuing Medical Education Exam: November 2018

Karthik Ravi, MD, William Ross, MD, Ara Sahakian, MD, Brian Weston, MD,

Co-Editors, CME Section

Prasad G. Iyer, MD, Amit Rastogi, MD, Editors, CME Section

Michael B. Wallace, MD, MPH, Editor-in-Chief, Gastrointestinal Endoscopy

Instructions:

The GIE: *Gastrointestinal Endoscopy* CME Activity can now be completed entirely online. To complete do the following:

1. Read the CME articles in this issue carefully and complete the activity:

Davison JM, Shah MB, Deitrick C, et al. Low-grade dysplasia diagnosis ratio and progression metrics identify variable Barrett's esophagus risk stratification proficiency in independent pathology practices. *Gastrointest Endosc* 2018;88:807-15.

Nagata N, Ishii N, Kaise M, et al. Long-term recurrent bleeding risk after endoscopic therapy for definitive colonic diverticular bleeding: band ligation versus clipping. *Gastrointest Endosc* 2018;88:841-53.

Kudo T, Saito Y, Ikematsu H. New-generation full-spectrum endoscopy versus standard forward-viewing colonoscopy: a multicenter, randomized, tandem colonoscopy trial (J-FUSE Study). *Gastrointest Endosc* 2018;88:854-64.

Vilmann AS, Norsk D, Svendsen MBS, et al. Computerized feedback during colonoscopy training leads to improved performance: a randomized trial. *Gastrointest Endosc* 2018;88:869-76.

2. Log in online to complete a single examination with multiple choice questions followed by a brief post-test evaluation. Visit the Journal's Web site at www.asge.org (members) or www.giejournal.org (nonmembers).
3. Persons scoring greater than or equal to 75% pass the examination and can print a CME certificate. Persons scoring less than 75% cannot print a CME certificate; however, they can retake the exam. Exams can be saved to be accessed at a later date.

You may create a free personal account to save and return to your work in progress, as well as save and track your completed activities so that you may print a certificate at any time. The complete articles, detailed instructions for completion, as well as past Journal CME activities can also be found at this site.

Target Audience

This activity is designed for physicians who are involved with providing patient care and who wish to advance their current knowledge of clinical medicine.

Learning Objectives

Upon completion of this educational activity, participants will be able to:

1. Contrast the risk stratification of Barrett's esophagus with low-grade dysplasia in a general pathology versus subspecialty gastrointestinal pathology practice.
2. Compare the long-term efficacy of endoscopic band ligation versus clipping for management of colonic diverticular hemorrhage.
3. Demonstrate the potential utility of the FUSE system in increasing adenoma detection rates.
4. Evaluate computerized feedback during simulation-based colonoscopy training.

Continuing Medical Education

The American Society for Gastrointestinal Endoscopy (ASGE) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The ASGE designates this Journal-based CME activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Activity Start Date: November 1, 2018

Activity Expiration Date: November 30, 2020

Disclosures

Disclosure information for authors of the articles can be found with the article in the abstract section. All disclosure information for GIE editors can be found online at <http://www.giejournal.org/content/conflictinterest>. CME editors, and their disclosures, are as follows:

Prasad G. Iyer, MD (Associate Editor for Journal CME)

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Ara Sahakian, MD (CME Editor):

Disclosed no relevant financial relationships.

Brian Weston, MD (CME Editor):

Disclosed no relevant financial relationships.

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Minimum Online System Requirements:

486 Pentium 1 level computer (PC or Macintosh)

Windows 95,98,2000, NT, or Mac OS

Netscape 4.X or Microsoft Internet Explorer 4.X and above

16 MB RAM

56.6K modem



Continuing Medical Education Questions: November 2018

QUESTION 1 OBJECTIVE:

Contrast the risk stratification of Barrett's esophagus with low-grade dysplasia in a general pathology versus subspecialty gastrointestinal pathology practice.

Low-grade dysplasia diagnosis ratio and progression metrics identify variable Barrett's esophagus risk stratification proficiency in independent pathology practices

Question 1:

A 60-year-old man returns to a community gastroenterology practice for routine surveillance endoscopy after detection of a Prague classification C3M4 nondysplastic Barrett's segment 3 years prior. Repeat endoscopy again shows a C3M4 Barrett's segment. Biopsy specimens are interpreted by a general surgical pathologist who evaluates 10 Barrett's cases a year. A diagnosis of Barrett's with focal low-grade dysplasia is made. Which of the following is true regarding the diagnosis of low-grade dysplasia in this patient?

Possible answers: (A-E)

- A. If confirmed by an expert gastrointestinal pathologist, the risk of progression to high-grade dysplasia or adenocarcinoma is still lower than if initially diagnosed by an expert gastrointestinal pathologist.
- B. The annual volume of Barrett's cases evaluated by the pathologist does not affect risk of progression to high-grade dysplasia or adenocarcinoma in this patient.
- C. The ratio of all Barrett's cases diagnosed with low-grade dysplasia by the pathologist does not predict risk of progression to high-grade dysplasia or adenocarcinoma.
- D. The risk of progression to high-grade dysplasia or adenocarcinoma is similar to that of nondysplastic Barrett's by the same pathologist.
- E. The risk of progression to high-grade dysplasia or adenocarcinoma is similar in this patient to one in which Barrett's with low-grade dysplasia is made by an expert gastrointestinal pathologist.

Look-up: Davison JM, Shah MB, Deitrick C, et al. Low-grade dysplasia diagnosis ratio and progression metrics identify variable Barrett's esophagus risk stratification proficiency in independent pathology practices. *Gastrointest Endosc* 2018;88:807-15.

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