

Continuing Medical Education Exam: June 2016

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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:

Krishnamoorthi R, Singh S, Ragunathan K, et al. Risk of recurrence of Barrett's esophagus after successful endoscopic therapy. *Gastrointest Endosc* 2016;83:1090-106.

Yoon SB, Park JM, Lim C-H, et al. Incidence of gastric cancer after endoscopic resection of gastric adenoma. *Gastrointest Endosc* 2016;83:1176-83.

Chaiterakij R, Barr Fritcher EG, Angsuwatcharakon P, et al. Fluorescence in situ hybridization compared with conventional cytology for the diagnosis of malignant biliary tract strictures in Asian patients. *Gastrointest Endosc* 2016;83:1228-35.

Bick BL, Vemulapalli KC, Rex DK. Regional center for complex colonoscopy: yield of neoplasia in patients with prior incomplete colonoscopy. *Gastrointest Endosc* 2016;83:1239-44.

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. Recognize the risk of recurrence of intestinal metaplasia after radiofrequency ablation.
2. Assess the need for endoscopic surveillance after endoscopic resection of gastric adenoma.
3. Demonstrate fluorescence in situ hybridization for the diagnosis of malignant biliary strictures.
4. Define the role of regional complex colonoscopy centers.

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: June 1, 2016

Activity Expiration Date: June 30, 2018

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)

Consulting/Advisory/Speaking: Olympus; Research Support: Takeda Pharma

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Disclosed no relevant financial relationships.

William Ross, MD (CME Editor):

Consulting/Advisory/Speaking: Boston Scientific, Olympus

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: June 2016

QUESTION 1 OBJECTIVE:

Recognize the risk of recurrence of intestinal metaplasia after radiofrequency ablation.

Risk of recurrence of Barrett's esophagus after successful endoscopic therapy: a systematic review and meta-analysis

Question 1:

A 75-year-old male with a 10-cm-long segment of untreated non-dysplastic Barrett's esophagus (BE) is in your office to discuss radiofrequency ablation (RFA). Based on the study by Krishnamoorthi et al, you can tell the patient which of the following:

Possible answers: (A-D)

- A. RFA will eliminate his BE permanently.
- B. RFA will eliminate his risk of esophageal adenocarcinoma.
- C. His age and length of BE segment are risk factors for recurrence of intestinal metaplasia.
- D. He will not require long-term surveillance after eradication of intestinal metaplasia.

Look-up: Krishnamoorthi R, Singh S, Ragunathan K, et al. Risk of recurrence of Barrett's esophagus after successful endoscopic therapy. *Gastrointest Endosc* 2016;83:1090-106.

QUESTION 2 OBJECTIVE:

Assess the need for endoscopic surveillance after endoscopic resection of gastric adenoma.

Incidence of gastric cancer after endoscopic resection of gastric adenoma

Question 2:

A 68-year-old Korean man who moved to the United States 1 year ago presents with dyspeptic complaints. An EGD is performed and reveals a 2-cm antral lesion, which is biopsied. Subsequent pathology is consistent with adenoma with low-grade dysplasia. Endoscopic mucosal resection (EMR) is performed with pathologic confirmation of adenoma with low-grade dysplasia. As you discuss the need for continued endoscopic surveillance with the patient, which of the following is correct?

Possible answers: (A-D)

- A. Because the incidence of metachronous gastric cancer is the same as in cases after endoscopic resection for early gastric cancer, similar careful surveillance is recommended.
- B. Because the risk of metachronous gastric adenoma but not gastric cancer is the same as in cases after endoscopic resection for early gastric cancer, continued but less frequent endoscopic surveillance is recommended.
- C. If metachronous gastric cancer occurs, over 90% are located at the site of the previously resected primary lesion.
- D. If metachronous gastric cancer occurs, it is less likely to invade the muscularis mucosa than in cases in which early gastric cancer undergoes endoscopic resection.

Look-up: Yoon SB, Park JM, Lim C-H, et al. Incidence of gastric cancer after endoscopic resection of gastric adenoma. *Gastrointest Endosc* 2016;83:1176-83.

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