Continuing Medical Education Exam: January 2017

James Buxbaum, MD, Karthik Ravi, MD, William Ross, 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: *Gastroinintestinal 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:

Ponugoti PL, Rex DK. Yield of a second screening colonoscopy 10 years after an initial negative examination in average-risk individuals. Gastrointest Endosc 2017;85:221-4.
Inamdar S, Han D, Passi M, et al. Rectal indomethacin is protective against post-ERCP pancreatitis in high-risk patients but not average-risk patients: a systematic review and meta-analysis. Gastrointest Endosc 2017;85:67-75.
Khashab MA, Ngamruengphong S, Carr-Locke D, et al. Gastric per-oral endoscopic myotomy for refractory gastroparesis: results from the first multicenter study on endoscopic pyloromyotomy (with video). Gastrointest Endosc 2017;85:123-8.
Vargo JJ, Niklewski PJ, WIlliams JL, et al. Patient safety during sedation by anesthesia professionals during routine upper endoscopy and colonoscopy: an analysis of 1.38 million procedures. Gastrointest Endosc 2017;85:101-8.

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. Determine the probability of adenomas in a second average-risk colonoscopy
2. Discuss rectal indomethacin for the prevention of post-ERCP pancreatitis.
3. Assess the safety and efficacy of gastric per-oral endoscopic myotomy for refractory gastroparesis.
4. Compare the differences in adverse events associated with anesthesia versus endoscopist-directed sedation for upper endoscopy and colonoscopy.

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: January 1, 2017
Activity Expiration Date: January 31, 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/conflictofinterest. 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
Amit Rastogi, MD (Associate Editor for Journal CME)
Consulting/Advisory/Speaking: Olympus
James Buxbaum (CME Editor):
Disclosed no relevant financial relationships.
Karthik Ravi, MD (CME Editor):
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.

Minimum Online System Requirements:
486 Pentium 1 level computer (PC or Macintosh)
Windows 95,98,2000, NT or Mac OS Netscape 4. × or Microsoft Internet Explorer 4. × and above 16 MB RAM 56.6K modem

Continuing Medical Education Questions: January 2017

QUESTION 1 OBJECTIVE:

Determine the probability of adenomas in a second average-risk colonoscopy

Adenoma prevalence on second average-risk screening examinations

Question 1:

A 65-year-old couple has been referred to you for their second average-risk colonoscopy, yet both are reluctant to go forward with the examination due to difficulties with their first exam 10 years ago. Both had normal examinations with good preps, and no lesions were identified. Their prior endoscopist had made known his adenoma detection rate (ADR) because it met the standards of the time. Both patients ask this question: if their colon was clear of polyps in the past, what is the likelihood of premalignant lesions being found with you as the examiner? Based on the study by Ponugoti et al in this month's issue of the journal, what do you respond?

Possible answers: (A-C)

A. The probability of adenoma is lower than their risk 10 years ago.
B. The probability of adenoma is comparable to their risk 10 years ago.
C. The probability of adenoma is higher than their risk 10 years ago.

Look-up: Ponugoti PL, Rex DK. Yield of a second screening colonoscopy 10 years after an initial negative examination in average-risk individuals. Gastrointest Endosc 2017;85:221-4.

QUESTION 2 OBJECTIVE:

Discuss rectal indomethacin for the prevention of post-ERCP pancreatitis.

Rectal indomethacin for the prevention of post ERCP pancreatitis

Question 2:

A 35-year-old female with no medical history undergoes ERCP for suspected choledocholithiasis. Cannulation proves difficult, and after multiple attempts, needle-knife (precut) sphincterotomy is performed. Which of the following is true regarding rectal indomethacin for the prevention of post-ERCP pancreatitis?

Possible answers: (A-D)

A. Evidence for benefit is superior in high-risk groups.
B. Evidence for benefit is equivalent in both high-risk and average-risk groups.
C. Combination of pancreatic duct stent and rectal indomethacin is superior to either approach alone.
D. Preprocedure timing of administration is critical.

Look-up: Inamdar S, Han D, Passi M, et al. Rectal indomethacin is protective against post-ERCP pancreatitis in high-risk patients but not average-risk patients: a systematic review and meta-analysis. Gastrointest Endosc 2017;85:67-75.