The ACG 2010 three-day Annual Scientific Meeting agenda has been slated and features top-notch faculty delivering the latest clinical updates. The Annual Meeting will be held Monday, October 18 through Wednesday, October 20, 2010. Many sessions are organized as debates or discuss controversies in treatment. In total, 10 plenary symposia have been developed and 16 optional breakfast sessions will be offered. The College is expanding the number of days for the breakfast sessions to Monday, Tuesday and Wednesday, with four offered on Monday, eight on Tuesday and four on Wednesday. This year’s plenary symposia include:

- Ins and Outs of Difficult Colonoscopy
- Controversial Pancreatic Cases: The Experts Debate
- Current Controversies in Crohn’s Management
- Out of the Heat, Into the Fire: Burning Issues in Barrett’s Esophagus
- Quality Improvement in Colorectal Cancer Screening
- Endoscopy: When to Get Out of Bed in the Middle of the Night

Rounding out the Annual Meeting agenda will be oral and poster presentations from colleagues who have submitted abstracts for ACG 2010. The Call for Abstracts submission process is open. Colleagues wishing to submit must do so no later than Monday, June 7, 2010 at 11:59 pm EDT in order to be considered for an oral or poster presentation at ACG 2010.
Medical Challenges Here and Abroad

By Philip O. Katz, MD, FACG

Colorectal Cancer Awareness Month just wrapped up and there was a flurry of activity around awareness of the importance of screening. In addition to the College’s public relations efforts to share the news on the lifesaving benefits of colon cancer screening, members have done a tremendous job in getting the word out in their communities. This year, members had the opportunity to go on ACG’s GI Circle and share with other members activities they implemented as part of Colorectal Cancer Awareness Month. On the ACG GI Circle, the College provided links to important information to share with patients regarding colon cancer screening, the various screening options, why an optical colonoscopy is the standard against which all other screening tests must be measured, and what to expect during a colonoscopy. I hope you had the opportunity to join the discussion on the ACG GI Circle regarding Colorectal Cancer Awareness Month. If not, you can review a number of the discussions that took place, and I encourage you to reach out to fellow members on the ACG GI Circle if you have information to share or have a question to ask. Highlighted on page 11 is an overview of what activities took place. A big thank you to all the members who reached out in their community to spread the word on colorectal cancer screening.

In our ongoing efforts to promote lifesaving colorectal cancer screening and to ensure quality in endoscopy, the College, along with the ASGE, has formed the GI Quality Improvement Consortium, Ltd. (GIQuIC). The pilot project started more than 18 months ago and will now be rolled out nationwide. Initially, outcome measures are being developed for colonoscopy with additional measures to follow. All major endowriters and electronic medical record companies were consulted during the pilot project. Members are encouraged to participate. You can learn more about the GIQuIC on page 12.

We’ve all seen the images of the devastation in Haiti and the public health crisis taking place due to a lack of infrastructure. One member was on hand to experience it and he shares his story in the Update. Fritz Francois, MD, with the New York University Langone Medical Center, led a team to his home country and offers advice on how others can help. The article can be found on page 6. Accompanying Dr. Francois’ story is an update on donations made by members, as well as the College, to support Haiti’s Hôpitale Albert Schweitzer.

Back at home, health care reform is moving forward. While reform has addressed many of the needs of patients and increasing access to insurance, it fails to address the issue of the looming physician payment cuts. At the time of this writing, the Senate has not passed the extender bill. CMS has announced it will hold claims for the first 10 days of April. We urge all members to write to their leaders in Congress and encourage them to address issues facing patients and providers. You can read more about current activities on page 3.

I’m pleased to announce that registration and housing for the ACG 2010 Annual Scientific Meeting and Postgraduate Course is now open. The agenda for the various programs may be found online. Highlighted on pages 1 and 4 is information about the Annual Meeting and the Postgraduate Course. New this year is the ACG Hands-on Workshop Center. Located in the Exhibit Hall, attendees will be able to see hands-on demos using devices and equipment from leading manufacturers. Continue to visit the ACG meeting website, See President’s Message, page 3
Health Reform Becomes Law

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (HR 3590) into law (PL 111-148), two days after the House of Representatives passed HR 3590 by a vote of 219-212. The Senate passed the bill in December 2009. The House also passed the “package of fixes” to the health bill, the Reconciliation Act of 2010, by a vote of 220-211. It was a big political win for House Democratic Leaders and President Obama, both of whom have gambled heavily on the bill’s passage. The House needed 216 votes to pass the bill. No Republicans and 34 Democrats voted against the measure. Stephen Lynch (D-MA) was the lone Democrat who voted against the health reform bill but for the “package of fixes.”

The Reconciliation Act of 2010 (4872) now heads to the Senate. Senate Democrats, however, have promised to use the momentum gained from the Sunday’s House vote to push this “package of fixes” through the Senate although the House may need to pass any minor revisions made in the Senate.

The health reform bill does not include Medicare physician payment or sustainable growth rate (SGR) formula reform—temporary or permanent—or meaningful medical malpractice reform. However, it requires private insurers to cover preventive services such as screening colonoscopy. It also waives Medicaid and Medicare beneficiary cost-sharing for colorectal cancer screenings regardless of screening or diagnostic code.

Please visit the ACG “National Affairs” website for more information on health reform and how it impacts GI services.

Congress passes legislation to prevent 2010 Medicare physician pay cut

On March 17, 2010, the House passed another delay in the -21% Medicare physician payment cut. The Continuing Extension Act of 2010 (HR 4851) extends the current Medicare physician fee schedule cut that was supposed to be in effect January 2010.

It is clear that Congress needs to address the obvious and pass permanent Medicare physician payment reform. While ACG applauds health reform efforts addressing the needs of patients and increasing access to insurance, health reform legislation must not ignore the needs of providers and threaten access to care. Congress must address the issues facing both the patients and providers, and only then, will there be true health care reform.

President’s Message

continued from page 2

www.acgmeetings.org, for updates. When you attend ACG 2010, invite your family to join you. The ACG Auxiliary is coordinating a number of activities for guests at the meeting. There is much to do and see in San Antonio. Learn more on page 5.

Coming up this summer, just weeks before ACG 2010, will be two additional regional courses. The St. Louis Course, which will be held August 27-29, will include a 1½ day educational agenda on Saturday and Sunday, August 28 and 29. Preceding the course will be a mini-course on EMRs, which will be offered on Friday afternoon, August 27th. Learn more about the program on page 14 and visit the ACG website, www.acg.gi.org, to register and view agenda and faculty.

In September, the ACG in conjunction with the VGS and the ODSGNA, will offer the perennial favorite, the ACG/VGS/ODSGNA Regional Postgraduate Course, September 10-12, at the Williamsburg Lodge in Williamsburg, Virginia. More information on this course will follow in an upcoming issue of the Update. In addition, our colleagues in Texas are also holding their Annual TSGE course, September 24-26, at Moody Gardens Resort in Galveston, Texas. You can learn more about these courses on ACG’s website.

Other College news includes members who have advanced to Fellows of the College (see list at right). Beginning with this issue, we will highlight members who advance to Fellows in the Update. Congratulations to the 15 members who have advanced to Fellowship.

ACG Members
Recently Advanced to Fellow Status

G. Anton Decker, MD, FACG
Bethany S. DeVito, MD, FACG
Lisa Ganjhu, DO, FACG
Claudia B. Gruss, MD, FACG
Joel J. Heidelbaugh, MD, FACG
Alan C. Moss, MD, FACG
Barry A. Ross, MD, FACG
Lawrence J. Saubermann, MD, FACG
Christopher E. Shih, MD, FACG
Shahid Sial, MD, FACG
Hidekazu Suzuki, MD, PhD, FACG
Bennie R. Upchurch, MD, FACG
Ian D. Wallace, MD, FACG
Jason M. Wilkes, MD, FACG
Steven S. Yang, MD, FACG
Expert Faculty to Cover the Foremost Topics in GI and Liver Disease at the ACG 2010 Annual Postgraduate Course

ACG’s Postgraduate Course Directors and Educational Affairs Committee have been working enthusiastically to develop a comprehensive educational program for the ACG 2010 Annual Scientific Meeting and Postgraduate Course. This year’s Postgraduate Course, entitled “Board Review and Challenges in Clinical Gastroenterology,” will focus on diagnostic modalities, therapeutic options, and emerging technologies in the treatment of common and not-so-common GI disorders that you now face, and what is on the horizon that may impact your practice in the future. The agenda promises to provide you with ideas that you can bring back and incorporate into your practice to enhance patient care during this challenging time in clinical gastroenterology.

The 2010 Postgraduate Course Directors are Francis A. Farraye, MD, MSc, FACP, and Atif Zaman, MD, FACP. The program kicks off with a session on The Upper Gut which will cover the latest in PPI Safety, the management of Barrett’s Esophagus, and the diagnosis and treatment of Eosinophilic Esophagitis and Celiac Disease. Following this session will be the annual David Sun Lecture, entitled “Detente in the Therapy of GERD,” which will be delivered by Tom R. DeMeester, MD, FACP. The next session of the morning, entitled “The President’s Corner – Challenges in Gastroenterology,” will be moderated by ACG President Philip O. Katz, MD, FACP, and feature talks by past presidents Eamonn M.M. Quigley, MD, FACP, David A. Johnson, MD, FACP, Jack A. Di Palma, MD, FACP, and Amy E. Foxx-Orenstein, DO, FACP. They will cover the topics of Nonulcer Dyspepsia, Nocturnal GERD, Refractory Constipation, and Obesity Issues for the Gastroenterologist, respectively.

The always popular Saturday Learning Luncheons will cover a range of topics, such as Complex Cases in Capsule Endoscopy, Sedation Issues/Office Administered Propofol in Your ASC, Management of Large Colon Polyps, and Implementing an EMR in Your Practice. On Saturday afternoon, a third session will cover Hot Topics in Liver Disease, including talks on Hepatitis B, Hepatitis C, and Non-Alcoholic Fatty Liver Disease. To conclude the day, afternoon simultaneous symposia will cover Clinical Dilemmas in IBD, Common Dilemmas in Liver Disease, and Barrett’s Esophagus – Still a Dilemma.

Sunday’s educational sessions begin with talks on Challenges in CRC Screening, including Colonoscopy Pearls, Identifying the Patient at Risk for an Inherited CRC Syndrome, Post Polypectomy and CRC Resection Intervals, and Non-endoscopic (CTC, Stool, Blood) Screening Technologies. Additional sessions for the day will cover IBD and Common Pancreaticobiliary Problems, followed by simultaneous sessions on Preventing Complications in IBD, State of the Art Management of GI Bleeding, and Controversies in Non-Viral Liver Disease. Sunday’s Learning Luncheons will also cover a range of topics, such as Difficult Cases in Acute and Chronic Pancreatitis, Coding Pearls: Common Errors in Coding that Are Costing You Income, How Will NOTES Impact Your GI Practice, and Four Functional Diagnoses Not to Be Missed.

Learn more about the Postgraduate Course educational agenda on the meeting website, www.acgmeetings.org, and continue to visit for updates on the entire slate of programs for ACG 2010.

Call for Abstracts Now Open

Share your research with colleagues by submitting an abstract for the ACG 2010 Annual Scientific Meeting. ACG invites abstracts from all physicians, including gastroenterologists, internists, surgeons, hepatologists, radiologists and pediatrics, and from fellows. Abstracts should relate to the field of gastroenterology. Abstracts will not be considered if they have been previously published or submitted for presentation elsewhere. Abstract categories include: Esophagus, Stomach, Pancreatic/Biliary, Small Intestine/Unclassified, Liver, Colon, Clinical Vignettes/Case Reports, Outcomes Research, Inflammatory Bowel Disease, Pediatrics, Functional Bowel Disorders, Endoscopy and Colorectal Cancer Prevention.

Information regarding the Call for Abstracts is available online at www.acgmeetings.org. The deadline for submission is Monday, June 7, 2010, at 11:59 pm EDT.
ACG Auxiliary has “Texas-Sized” Plans for the 2010 San Antonio Meeting

Plan your family visit to San Antonio early to ensure a spot in this year’s offerings because it’s muy caliente!

Every year, the ACG Auxiliary organizes activities that can be enjoyed by spouses, significant others and families with kids during the week long Annual Scientific Meeting and Postgraduate Course. Activities include tours that showcase and highlight the destination city, plenty of opportunities to make new friends or network with other ACG families, and the annual Auxiliary members’ luncheon.

Auxiliary 2010 Tours
Remember to sign up early for tours to guarantee a spot on the bus. Auxiliary members will receive direct notification of the early bird special.

TOUR #1 – Texas Hill Country Experience: Fredericksburg, TX
Saturday, October 16, departs 8:30 am, returns 4:00 pm. Cost: $40 early bird special, $45 regular price.
Board your deluxe motor coach and depart for a tour to Fredericksburg located in the beautiful Texas Hill Country about an hour north of San Antonio. While you sit back and relax with a drink and snack, your professional guide will relate stories of the German pioneers, Comanche Indians and all the delightful legends of the customs and traditions of the area.

Fredericksburg is a colorful and cultural blend of architecture, cuisine, art, music and friendly people. For over a century, local artisans, winemakers, craftsmen and shop owners have been mixing German heritage with Texan hospitality to create the kind of place you’ll want to return to time and time again. The city retains touches of its Old World heritage. The streets are broad and clean and the old sturdy buildings of native limestone are so typical of Texas German communities. Enjoy shopping and browsing among an endless variety of one of a kind stores and boutiques, visiting the National Museum of the Pacific War, or relaxing in German-style biergartens and schnitzelhausers. There is something for everyone!

Time permitting: On the way back, a stop at Wildseed Farms, the largest working wildflower farm in the United States, for beautiful scenery, walking trails, photo opportunities, and unique gifts.

TOUR #2 – Shop Until You Drop: San Marcos Outlet Mall
Sunday, October 17, departs 10:30 am, returns 4:00 pm. Cost: $20 early bird special, $25 regular price.
Enjoy a short and relaxing ride in a deluxe motor coach to one of the most visited outlet malls in the nation. Upon arriving, instructions and directions will be given concerning the shopping area, time to return to the bus, and best shops for bargains! Voted best outlet in Texas, it’s the third largest outlet mall in the United States. San Marcos is a shopper’s delight!

Auxiliary Members’ Luncheon at Los Barrios
Auxiliary Members will receive advance notification for sign up in the mail.
Monday, October 18, departs 9:30 am, returns 1:30 pm. Cost: FREE for members.
Los Barrios Restaurant features casero style cooking, which is family-style Mexican cooking. Los Barrios has received numerous awards and has become a San Antonio tradition. Diana Barrios Treviño, co-owner of Los Barrios, has been featured nationally with well-known chefs, Emeril Lagasse and Bobby Flay.

Ms. Barrios Treviño will present a cooking demonstration and will provide a history of the restaurant. In addition, she will teach Auxiliary members how to cook some of the Barrios family’s favorites, such as guacamole, enchilada verde with tomatillo sauce, Spanish rice and chocolate pecan pie. Members will then be served some of Los Barrios’ signature dishes. Additionally, Ms. Barrios Treviño has published a cookbook, Los Barrios: Family Cookbook, which she will gladly autograph.

See ACG Auxiliary, page 18
A CG member and colleagues from ASGE will contribute a generous gift of over $17,000 to support the mission and services of L’Hôpital Albert Schweitzer in Deschappelles, Haiti. As the earthquake struck on Haiti January 12th, the College was preparing for its Best Practices Course, and that gathering of physicians from ACG and ASGE created the opportunity to make an appeal for support of Haitian relief efforts. Donations of $10,000 were contributed at Best Practices by course attendees and faculty, as well as the ACG Board of Governors. The leadership of ACG approved a gift of $5,000 from the College, and invited the ASGE to participate as a partner in the Best Practices Course. ASGE will contribute $2,500.

“We identified Hôpital Albert Schweitzer through a connection by ACG member Edward Lilly, who has been on numerous medical missions to Haiti and had personal experience at Schweitzer,” explained ACG President Phil Katz. “It’s an ideal institution where our funds could make an immediate and much-needed difference to Haitians injured in the quake, and to the care of an impoverished population.”

Dr. Lilly, whose long experience with medical missions to Haiti is with Physicians for Peace, commented that the gift to Schweitzer is “focused and well-targeted.” He added, “That it’s American gastroenterologists who want to help makes me proud of my profession. Good work.”

Functional after the quake
Among the widespread devastation and damage throughout Port-au-Prince and elsewhere, vital infrastructure necessary to respond to the disaster was severely damaged or destroyed. This included all hospitals in the capital. According to news reports, the quake affected the three Médecins Sans Frontières (Doctors Without Borders) medical facilities around Port-au-Prince, causing one to collapse completely. A hospital in Petionville, a suburb of Port-au-Prince, also collapsed, as did the St. Michel District Hospital in the southern town of Jacmel, which was the largest referral hospital in southeast Haiti.

A five-hour drive from Port-au-Prince in the Artibone Valley of central Haiti, L’Hôpitaie Albert Schweitzer was largely unaffected by the devastation. The hospital provides medical care and community health and development programs for more than 300,000 impoverished people. Volunteer physicians work with a permanent Haitian staff of almost 550. According to blogs posted by Ian Rawson, Managing Director, the hospital used almost three month’s supply of medications and surgical materials in

A Somber Homecoming Saves Lives, Brings Relief to Haitian Earthquake Victims

When ACG member Fritz Francois, MD, arrived in Haiti a little more than a week after the January 12 earthquake, his initial shock quickly turned to focused action. Not only was he leading the first wave of New York University Langone Medical Center’s Haitian Effort and Relief Team (HEART), he was also returning to Port-Au-Prince for the first time since he left at age 10. Dr. Francois’ medical training had prepared him for the somber homecoming.

“This was the first time I’d been back to Haiti so it was deeply personal for me,” says Dr. Francois, who is Assistant Professor of Medicine and Assistant Dean for Academic Affairs and Diversity at NYU Langone Medical Center.

In his blog documenting his relief trip, Dr. Francois recalls the words of a departing physician affiliated with Partners In Health who greeted the NYU team at the airport and commented on conditions at the General Hospital: “It is hot; there is no running water and no bathrooms. If you need food, find the Army barracks and get some MREs (Meals Ready to Eat). Stay flexible. Good luck.”

Still, nothing could have accurately captured what he was about to experience.

From the moment he stepped off the plane, Dr. Francois says he was bombarded with sensory overload. Fresh island air was nonexistent, replaced instead with an atmosphere thick with disaster, desperation and the struggle to sustain life that came in the form of humming generators, the constant roar of airplanes taking off and landing, and a lingering heat that made everything worse.

“Every sense was stimulated at once. It’s not like watching the aftermath on TV when you just see images and hear bits and pieces of what’s happening. On the ground in Haiti I could feel the heat, I could hear the cries, and I could smell the decaying bodies. This was very difficult to
the first ten days after the quake. Supplies from the U.S., Canada and Switzerland arrived, but at one point about a week after the quake, they ran out of strong pain relief medications and antibiotics for a day.

**New challenges in the post-quake recovery**

Most of the illnesses treated at the hospital before the earthquake were illnesses that are the result of poverty — malnutrition and infectious diseases. During the earthquake, many people suffered crushing injuries to their extremities. Primary care for the injured often required amputation of injured or infected limbs. Rawson’s update reports that after the initial flood of patients directly from the quake zone, the hospital is receiving referrals of patients who have received primary care at tent hospitals in the capital, but who require more advanced surgical intervention.

The hospital has three operating rooms. Teams of orthopedic surgeons have arrived from the Peachtree Orthopedic Group in Atlanta and from a hospital in Canada to treat patients. Schweitzer was able to quickly develop a prosthetics laboratory with support from Hanger Corporation, a Bethesda, MD-based firm, and is meeting a desperate need because the two prosthetics labs in Port-au-Prince were destroyed.

The hospital anticipates even more challenges to their staff capacity and resources as they face a massive migration of displaced people. An estimated 162,000 people are moving to Artibonite Valley from areas destroyed in the earthquake, according to the United Nations’ Office for the Coordination of Humanitarian Affairs (OCHA).

**Inspired by Albert Schweitzer, Mellon heir founds hospital**

L’Hôpital Albert Schweitzer was founded in 1953 by William Larimer “Larry” Mellon and his wife Gwen. Mellon, an heir to the Pittsburgh banking fortune, was inspired by an article about Albert Schweitzer in *Life* magazine to start a hospital and care for the poor. He corresponded with Dr. Schweitzer, who would earn the Nobel Peace Prize for his work in Gabon, Africa. At age 38, without an undergraduate degree, Mellon left his work as a rancher in Arizona to attend Tulane’s School of Medicine. His wife Gwen trained as a laboratory technician at the same time. He graduated at age 44 in 1953.

Mellon had yet to choose a location for his own hospital when he sailed to Haiti to study tropical ulcers for his medical school research project in 1952. There, in the Artibonite Valley, Mellon found a spot where a hospital was desperately needed. Haitian President Paul Magloire granted the Mellons some land and buildings on the site of an abandoned Standard Fruit Co. banana plantation in the small town of Deschapelles, a barren area once home to lush mahogany forests. The Schweitzer Hospital, the only hospital the Nobel laureate ever allowed to use his name, provides essential services to the Artibonite Valley residents.

See *Hôpital Albert Schweitzer*, page 18
ACG Institute Tops $11 Million in Clinical Research Awards

2010 funding sets new records for career awards and overall support

For 2010, the ACG Institute for Clinical Research and Education is pleased to announce the award of $1,081,995 in support of outstanding clinical research in gastroenterology, a record for the College. Selected for funding were 18 Clinical Research Awards totaling $331,995. In addition, the Institute will support five Junior Faculty Development Grants, at an overall level of $750,000, the largest number of these career development awards given in a single year since their inception in 1997.

Founded in 1994, the Institute has provided funding to 479 investigators for research directly relating to the clinical gastrointestinal practice with funding of just over $11 million. Since its inception, ACG’s clinical research support has been funded under the auspices of the Institute in large part due to the success of the Capital Campaign. Thanks to generous support of ACG members and from industry, the Institute has a dedicated source of funds to support clinical research and education priorities.

ACG’s Junior Faculty Development Grant

Considered the “jewel in the crown” of the College’s research program, the ACG Junior Faculty Development Grant is a two-year award designed to support a junior faculty member or mid-career clinical investigator of outstanding promise to establish an independent, productive career in gastroenterology or hepatology. This award of $75,000 per year for each of two years provides salary support for protected time to young investigators at critical points in their career development.

Research Chair Bret A. Lashner, MD, FACG, guided the committee in its grant review. “We were very pleased with the caliber of applicants for the Junior Faculty award this year, and were able to recommend five candidates for funding, a record for the Committee,” said Dr. Lashner. “We are equally proud of our Clinical Research Award recipients, See ACG Research Awards, page 15

ACG 2010 Junior Faculty Development Grants

Katherine Garman, MD, Duke University – Insights into the Pathogenesis of Barrett’s Esophagus through MicroRNA

Jessica Lee, MD, Children’s Hospital Boston – Is Crohn’s Disease Marked by a Unique Molecular Signature?

Millie Long, MD, University of North Carolina-Chapel Hill – Skin Cancer in Patients with Inflammatory Bowel Disease

Alberto Rubio-Tapia, MD, Mayo Clinic – Clinical Staging and Survival in Refractory Celiac Disease: Validation and Refinement of a New Staging Model Using a Multinational Cohort

Harminder Singh, MD, University of Manitoba – Detection and Prevention of Colorectal Cancer

ACG 2010 Clinical Research Awards

Braden Kuo, MD, Massachusetts General Hospital – Non-Invasive Characterization of Gastric Motility Using MRI

Joseph Leung, MD, UC Davis Medical Center – RCT Comparing Effects of Continuous (Repeated) ERCP Mechanical Simulator (EMS) Practice on Trainees’ Clinical ERCP Performance

James Lord, MD, Benaroya Research Institute – CD4+ Regulatory and Effector T Cell Differentiation in Interferon Therapy for Hepatitis C

Heiko Pohl, MD, VA Medical Center, White River Junction, Vermont – Does Cap Assisted Colonoscopy Improve Adenoma Detection? A Randomized Trial

Ron Schey, MD, University of Iowa Hospitals and Clinics – The Effects of Cannabinoid on Patients with Non-GERD Related Non-Cardiac Chest Pain

Elizabeth Verna, MD, Columbia University College of Physicians and Surgeons – Serum Lipopolysaccharide Measurement to Predict Hepatic Fibrosis in Liver Transplant Recipients with Hepatitis C

Wahid Wassef, MD, University of Massachusetts Medical School – Pancreatitis Quality of Life Instrument (Panqoli): A Psychometric Evaluation

ACG 2010 Clinical Research Awards Pilot Projects

David Armstrong, MD, McMaster University – A Pilot Study to Develop and Evaluate a Multifaceted Educational Tool for Use in a Prospective, Cluster-Randomized Trial of Practice Audit and Targeted Education for Colonoscopy Quality Improvement

Kathleen Corey, MD, Massachusetts General Hospital – The Association of Serum Vitamin D Levels and Progression of Hepatitis Fibrosis

Linda Cummings, MD, University Hospitals Case Medical Center – Effect of Vitamin D Supplementation on 15-Prostaglandin Dehydrogenase Expression in Barrett’s Esophagus

Karen Kim, MD, Cleveland Clinic Foundation – Clinical Features and Outcomes in Patients with 15-PGDH-positive Colorectal Cancers

Montitha Maneerattanaporn, MD, University of Michigan – Pilot Study to Determine the Key Characteristics which Aid in the Diagnosis of Constipated Patients with Dyssynergic Defecation

Taran Narang, MD, Carolinas Medical Center – Intravenous Interferon During the Anhepatic Phase of Liver Transplantation and Prevention of Recurrence of Genotype 1 Hepatitis C Virus

Jenny Sauk, MD, Mount Sinai Medical Center – Developing a Confocal Microendoscope (CME)-Based Classification System of Histologic Inflammation in Ulcerative Colitis

Achuthan Sourianarayanan, MD, Cleveland Clinic – Foundation Mechanism of the Effect of Midodrine on Portal Pressures in Patients with Cirrhosis

Carlo Traverso, MD, Massachusetts General Hospital – Fecal DNA-based Ova and Parasite Detection

Miranda van Tilburg, MD, University of North Carolina – Dietary Restraint and Motility in Adolescents who Suffer from Irritable Bowel Syndrome

Yinghong Wang, MD, Cleveland Clinic Foundation – Investigation of Serotonin Pathway in the Pathogenesis of Irritable Pouch Syndrome
PROVEN SAFE AND EFFECTIVE
AND NO ORAL SODIUM PHOSPHATE

Lowest volume phosphate-free lavage
Less cramping, fullness, and overall discomfort

References:
1. IMS Health Inc, NPA Weekly Rx Audit, Jan 2008-Feb 2009.
2. In a clinical study of HalfLytely and Bisacodyl Tablets Bowel Prep Kits (10 mg vs 20 mg bisacodyl tablets) [See package insert; Table 2], Braintree, MA: Braintree Laboratories, Inc.

INDICATIONS AND USAGE:
A gastrointestinal lavage indicated for cleansing of the colon as a preparation for colonoscopy in adults.

CONTRAINDICATIONS:
Patients with the following conditions:
known allergies to polyethylene glycol or other components of the kit, gastrointestinal (GI) obstruction, bowel perforation, toxic colitis, toxic megacolon.

WARNINGS AND PRECAUTIONS:
Use with caution in patients using concomitant medications (such as diuretics) that increase the risk of electrolyte abnormality, patients with known or suspected hyponatremia, patients with severe ulcerative colitis, ileus or gastric retention.

There have been reports of ischemic colitis in patients with use of HalfLytely and 20 mg Bisacodyl Tablets Bowel Prep Kit. However, a causal relationship has not been established. If patients develop severe abdominal pain or rectal bleeding, patients should be evaluated as soon as possible. Patients with impaired water handling who experience severe vomiting should be closely monitored including measurement of electrolytes. Hives and skin rashes have been reported with PEG-based products which are suggestive of an allergic reaction.

Pediatric Use:
Safety and effectiveness in pediatric patients has not been established.

ADVERSE REACTIONS:
Most common adverse reactions (<3%) are abdominal pain/cramping, nausea, vomiting and headache.

Oral Administration:
Take two bisacodyl tablets with water (do NOT chew or crush). Wait for a bowel movement (or maximum of 6 hours) then drink the 2 liter solution at a rate of 8 ounces every 10 minutes. Drink all of the solution.

Storage:
Store at 20-25°C (59-86°F). When reconstituted you may keep the solution refrigerated. Discard within 48 hours.

Rx only. Distributed by Braintree Laboratories, Inc. Braintree, MA 02185.

For additional information, please call 1-800-874-6756 or visit us at www.halflytely.com
HalfLytely and Bisacodyl Tablets Bowel Prep Kit is a gastrointestinal lavage indicated for cleansing of the colon as a preparation for colonoscopy in adults. Most common adverse reactions (<3%) are abdominal pain/cramping, nausea, vomiting and headache. Use is contraindicated in the following conditions: known allergies to polyethylene glycol or other components of the kit, gastrointestinal (GI) obstruction, bowel perforation, toxic colitis, toxic megacolon. Use with caution in patients using concomitant medications (such as diuretics) that increase the risk of electrolyte abnormality, patients with known or suspected hyponatremia, patients with severe ulcerative colitis, ileus or gastric retention. There have been reports of ischemic colitis in patients with use of HalfLytely and 20 mg Bisacodyl Tablets Bowel Prep Kit. However, a causal relationship has not been established. If patients develop severe abdominal pain or rectal bleeding, patients should be evaluated as soon as possible. Patients with impaired water handling who experience severe vomiting should be closely monitored including measurement of electrolytes. Hives and skin rashes have been reported with PEG-based products which are suggestive of an allergic reaction.

Please see brief summary of prescribing information on adjacent page.
ACG Members Are Generating Major Buzz for Colorectal Cancer Awareness

The College unveils new CRC online resources, Q&A podcast series and GI Circle CRC page

This year’s March Colorectal Cancer Awareness Month is already making a huge impact. From partnering with an NBA basketball team, reaching out to the media and speaking with the community to promoting a song contest and performing colonoscopies live on local and national TV—your creative, fun and powerful efforts are reaching millions of Americans with a lifesaving message.

As of press time, some highlights of your CRC Awareness Month efforts include:

Local and National Television Coverage of Live Colonoscopies
ACG Trustee Mark Pochapin, MD, FACG scored a major win for CRC Awareness on March 10 when he performed an on-air colonoscopy on CBS “Early Show” co-anchor Harry Smith. This event is receiving ongoing media coverage all over the country and enjoying increased online attention via social media platforms such as Twitter, Facebook and YouTube.

Dan Pambianco, MD, FACG (ACG Governor for Virginia), secured a multimedia hit in his hometown of Charlottesville, Virginia. To raise awareness of the dangers of colon cancer, former Charlottesville city councilor Rev. Alvin Edwards allowed CBS19 cameras to roll during his colonoscopy at Martha Jefferson Hospital. Dr. Pambianco performed the exam and is quoted in the coverage.

National Radio Media Tour
During the month of March and lasting into April, members of the ACG’s Public Relations Committee and some of the Governors are participating in over 30 phone interviews with radio station news directors and talk show hosts across the U.S. Reaching more than 1 million listeners about the topic, “Saving Lives through Colorectal Screening,” these interviews are helping to raise the College’s profile as a source of public health information on colorectal cancer and to extend the College’s call-to-action: “Talk to your doctor about colon cancer screening.”

As of press time, the following ACG members have spoken or will speak to the radio media on behalf of the ACG: ACG Governor–Puerto Rico, Rafael A. Mosquera, MD, FACG; Patricia Raymond, MD, FACG; ACG Board of Governors Chair Samir A. Shah, MD, FACG; Beth Schorr-Lesnick, MD, FACG; John Bassett, MD; Michael Cox, MD; Jatinder Ahalwalla, MD; Howard Kroop, MD; ACG Governor–Idaho, Stephen M. Schutz, MD, FACG; and ACG Governor–Southern New York, David A. Greenwald, MD, FACG.

Partnership with NBA Team
ACG Trustee Carol Burke, MD, FACG, of the Cleveland Clinic is playing a key role in the month-long “Score Against Colon Cancer” campaign. The Cleveland Clinic and the Cleveland Cavaliers have teamed up to promote awareness and prevention of colorectal cancer with “Score Against Colon Cancer,” which kicked off March 8 with CRC Awareness night at the Cavs vs. San Antonio Spurs basketball game, and includes a Colon Cancer Web chat, a 24-hour risk assessment hotline as well as the Cleveland Clinic’s new CRC Risk Assessment tool, which Dr. Burke developed.

Hometown Letters to the Editor Initiative
The ACG Governors and members of the PR Committee have been reaching out to their local media, and several of them have already secured prime media placements: ACG Governor–Nevada, Craig Sande, MD, FACG, Reno Gazette; ACG Governor–Idaho, Stephen M. Schutz, MD, FACG, Idaho Statesman; and PR Committee veteran Patricia Raymond, MD, FACG, Dayton Daily News.

ACG Governor–Southern California A, Zelman G. Weingarten, MD, FACG, once again helped secure media placements for Cardinal Roger Mahony, the Catholic Archbishop of Los Angeles, who published a statement in English and Spanish newspapers, including La Opinion. The Cardinal credits colonoscopy with saving his life and has been a consistent supporter of the ACG’s CRC Awareness efforts.

Public Education Event
Seth A. Gross, MD, of Norwalk Hospital, Norwalk, CT, was the featured speaker March 16 for, “The Prevention and Treatment of Colon Cancer, a public education program sponsored by the hospital in observance of Colorectal Cancer Awareness Month.

Bottom Line Song Contest
Gerado Lanes, MD, was featured in a South Florida Sun Sentinel piece about

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ACG and ASGE Embark on Quality Improvement Registry Starting with Endoscopy

The GI Quality Improvement Consortium, Ltd. (GIQuIC) has formed a partnership with Outcome Sciences® to develop and operate a national GI data repository for storage and maintenance of quality measures. GIQuIC is a collaboration of the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE).

The national rollout of the new registry will occur in the second quarter of this year. The initial objective will be to develop measures for quality in colonoscopy, with additional measures added at a later date.

“We created GIQuIC based on a belief that the scientific measurement of the quality of endoscopic procedures will provide valid and reliable comparative information to participating physicians and facilities to support their quality improvement initiatives,” explained Irving M. Pike, MD, FACG, FASGE.

“These measures offer a practical, objective method to grade performance for individual endoscopists, and will help to prepare GI physicians and facilities for future reporting requirements from public and private insurers,” said Thomas M. Deas Jr., MD, FACG, FASGE.

The pilot study, which began in 2006, had more than 70 physicians participating. Supporting proof of concept for this new national GI endoscopy data repository has been completed, with the major endovision and electronic medical record (EMR) companies participating. An audit of the pilot data informed the development of the national registry which will allow participating physicians, ASCs and hospitals to better gauge performance. Ultimately, GIQuIC’s goal is to apply the lessons learned beyond endoscopic procedures to the range of GI consultative services either electronically or through a secure internet-based portal for those practices not using endovision or EMR systems.

Outcome Sciences® will bring its extensive experience and broad expertise in outcomes studies to power GIQuIC in its mission to establish recognized standards for high quality GI endoscopic procedures and other key GI conditions and provide benchmarking reports for gastroenterologists. Founded in 1998, Cambridge, Massachusetts-based Outcome Sciences® is a leader in developing registries and conducting post-approval research and quality improvement initiatives.

“With GIQuIC, GI endoscopists will have a mechanism to report their performance against measurable processes and practices at the national level. Ultimately, the goal of GIQuIC is to apply the lessons learned beyond endoscopic procedures to the broad range of GI consultative services,” commented ACG President Philip O. Katz, MD, FACC.

“Our expectation is that benchmarking will gradually improve the quality of endoscopies being performed throughout the United States as well as other physician/patient interactions while limiting the possibility of injury to the patient and improving patient outcomes,” said ASGE President Jacques Van Dam, MD, FACC, FASGE.

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would be suffering from surgical as well as non-surgical conditions—kids, pregnant women, people with infections would require acute as well as sub-acute care,” said Dr. Francois.

The NYU team was based at Port-Au-Prince’s General Hospital where Partners In Health, the International Medical Corps, the Association of Haitian Physicians Abroad, and other Non Governmental Organizations (NGOs) had helped to staff and organize a structure inside the hospital which included an emergency triage area, operating rooms, post-operative, pediatric, medical, as well as dialysis units.

Soon after the large aftershock, patients refused to stay indoors so tents were set up in sections outside the hospital for the various medical units, except for operating rooms which remained inside.

Dr. Francois took over an intensive care unit with 60 medical and surgical patients. He was the only doctor along with two nurses for the whole ICU, which he reports had no monitors, no equipment and very little medications, including antibiotics.

“Laboratory analyses were not readily available and we didn’t have basic things like glucometers, which were critical since some of the patients were diabetics presenting with ketoacidosis,” said Dr. Francois. “We had trouble monitoring sugars; we didn’t have enough insulin, 

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and no intravenous Lasix. Many people were suffering from congestive heart failure…but many of the conditions were bread and butter challenges that physicians are used to dealing with—the only difference was that we didn’t have all the equipment and the variety of medications that are usually at our disposal in the U.S.”

Dr. Francois relied instead on the foundations of good medicine.

“Besides my experience, the most important tools I had were the ability to take a good medical history and the ability to perform a physical exam—things I constantly explain the importance of to my students. I tell them that as medical doctors you really must actively think about what is going on, think about ways to solve the problem and come up with the best solution especially in situations like this where medical equipment and supplies are scarce.”

GI-related medical conditions were some of the most challenging as many patients presented with a variety of gastrointestinal conditions including gastroenteritis, gastritis, ascites, as well as upper and lower intestinal bleeding. Some of these GI issues were preexisting, such as chronic liver disease, while others, such as diarrheal illnesses, resulted from earthquake-related poor sanitary conditions. Many cases of UGI bleeding were probably related to untreated ulcers, according to Dr. Francois, who estimates that about 70% of Haitians likely have *Helicobacter pylori* infection compared with about 40% of people in the U.S.

“Patients with gastrointestinal bleeding had to be evacuated to the hospital ship U.S.N.S. Comfort for care since we could not perform endoscopies. Normally, such evaluations are routine but we didn’t have any endoscopes so we had to spend critical time arranging airlifts to the naval hospital ship after stabilizing the patients.”

With planes constantly flying in and out of Haiti, generators running and everyone living in the middle of the street, it was difficult for Dr. Francois and his team to get uninterrupted sleep each night.

But of all the challenges Dr. Francois faced, the lack of infrastructure was the most complex. “All of us were trying to do the best we could working within a structure that was less than ideal.”

Dr. Francois noticed that a coordinated system of night coverage had not been established.

“Generally, everyone began leaving the hospital at 5 or 6 p.m. and I realized that without a proper night coverage system, we were jeopardizing the hard work achieved during the day, and potentially endangering lives. After many discussions, a rudimentary coverage system began to take shape while we were there, so we did the best we could with what we had.”

The perfect storm for disaster—Lesson for rebuilding

When speaking about his experiences in Haiti, Dr. Francois is compelled to shed light on Haiti’s health care system in the days leading up to the earthquake—a situation he says created the “perfect storm” for disaster and should now frame the discussion for rebuilding Haiti.

“Very few people know that Haiti’s public healthcare system was crippled in the days before the earthquake due to a strike led by the medical students who were protesting a recent action to remove ten courses from the curriculum and the failure of the government to increase wages—in Haiti, minimum daily wage is $1.35.”

During this strike the only health care services sustained were offered by NGOs, such as Doctors Without Borders, Dr. Francois says, which “set up hospitals as alternatives to private ‘cash and carry’ clinics where it can cost $200 per visit.”

“The NGOs became overwhelmed after the quake—not only were they treating quake victims, but others who sought care after learning of these free health clinics, inundating them with people who had not been treated for months, coming for free medications, diabetes care and other medical treatment. Every day there were lines of people waiting to get in, stretched down blocks. Patients were everywhere with crush injuries—it was the most horrific picture—crushed eye sockets, amputation wounds and complications of these injuries, which included renal failure.”

Although he is back in the United States, Dr. Francois’ relief mission is ongoing. Armed with what he learned from his time in Haiti, he is educating the medical community and academic centers about ways they can help rebuild the country, which includes an awareness of Haiti’s situation before the earthquake. He recently participated in a U.S. Department of Health and Human Services sponsored international conference on rebuilding Haitian medical education and training.

Dr. Francois cautions that Haiti demands a careful approach that does not impose what we believe is right. He advises his colleagues to engage Haitian communities in the United States and abroad to understand Haiti’s needs, not what we think the country needs, but what it actually needs.

“You don’t have to go there if you have no experience in disaster relief—the situation in Haiti may be too jarring and too difficult for some—but you can certainly help to organize a system of engagement in your local community.”

He suggests targeting resources where there are Haitian leaders in the community and learning what is needed and what partnership may be formed to develop and deliver services.

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St. Louis Regional Course to Focus on Case-based Discussions

Mini-course added to address choosing and implementing an EMR in your practice

case-based discussions with the experts. Sessions will cover the Upper GI Tract, Pancreas/Biliary Tract, IBD, Colon and Liver. See the complete agenda below.

In addition, a course focusing on electronic medical records (EMR) will be offered as a separate mini-program on Friday afternoon, August 27th. Course Director James Leavitt, MD, FACG, experienced with incorporating EMR into practice, will lead the discussion. Joining Dr. Leavitt will be Lawrence Kosinski, MD, a gastroenterologist, also experienced in EMR implementation. Rounding out the mini-program will be presentations from a number of EMR vendors. This is a great opportunity to learn from the experience of physicians who have incorporated EMR into their practice plus meet the top EMR providers at one time. Invite your practice managers to join you at this invaluable session.

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Optional EMR Course
Friday, August 27, 2010
2:00 pm-5:15 pm

Regional Postgraduate Course
Saturday & Sunday, August 28-29, 2010

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Register for this and other ACG educational offerings at www.acg.gi.org
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his medical group’s (Digestive Care™) launch of the Bottom Line Song Contest where voters are asked to go online and vote for their favorite “bowel ballads.”

“Get Your Rear in Gear” 5k Run/Walk
ACG Governor—Southern Texas, Alejandro Pruitt, MD, FACG, and his practice, Gastroenterology Consultants of San Antonio, are spearheading the inaugural “Get Your Rear in Gear” 5k Run/Walk in San Antonio on March 28 in partnership with the Colon Cancer Coalition. On race day, the practice will also serve as official “Tweeters” and take photos for mysanantonio.com. The Colon Cancer Coalition currently produces more than 25 “Get Your Rear in Gear” events across the country for CRC awareness. Your practice can start its own CRC event. Visit the Get Your Rear in Gear Web site, www.getyourrearingear.com.

Colorectal Cancer Podcast Series
ACG is proud to introduce a new podcast series, “Audio Q&A on Colorectal Cancer Screening” featuring ACG experts answering common questions about colorectal cancer screening. Experts featured in the podcasts are: Douglas K. Rex, MD, FACG; A. Steven McIntosh, MD, FACG; David A. Johnson, MD, FACG; ACG President Philip O. Katz, MD, FACG; Jack A. Di Palma, MD, FACG; ACG Governor—Eastern Pennsylvania, Immanuel K.H. Ho, MD, FACG; ACG Trustee Carol A. Burke, MD, FACG; and Scott M. Tenner, MD, MPH, FACG. Listen to any or all of the over 30 podcasts at www.acg.gi.org/patients/crcpodcast.asp.

Ohio Legislative Activity
ACG Ohio Governors Costas H. Kefalas, MD, FACG, and Norman H. Gilinsky, MD, FACG, joined ACG Trustees Carol Burke, MD, FACG, and Bruce Cameron, MD, FACG, on March 10 in activities at the statehouse in Columbus aimed at passage of two colorectal cancer screening bills before the state Senate and House of Representatives. The Governors are reaching out to their Ohio colleagues asking them to contact their congressional representatives in support of these bills.

St. Colon’s Day Event
Green held new meaning for ACG’s Washington State Governor Harald Schoepnner, MD, FACG, of Providence St. Mary Medical Center in Walla Walla, Washington, who spearheaded a colorectal cancer awareness event on St. Patrick’s Day, March 17, which was renamed St. Colon’s Day. The event included new CRC education materials aimed at encouraging people to get screened.

Enhanced Support for Your CRC Awareness Efforts
In an effort to aid your Colorectal Cancer Awareness efforts for 2010, the College has enhanced its online offerings which include a new Colorectal Cancer page, a GI Circle CRC discussion area, and a CRC Education Toolkit. The new Colorectal Cancer Awareness page, now live on the ACG Web site, gives you the best of the College’s CRC resources with the click of your mouse. Featuring a wealth of information and multimedia tools for you and your patients, the CRC page is also a great place for you to direct the media as a source for background info. Visit www.acg.gi.org/coloncancer.

GI Circle Colorectal Cancer Awareness Discussion Area
Visit this new area of the ACG GI Circle to access information you need to impact colorectal cancer awareness—and collaborate with your colleagues. Whether you are answering a reporter’s questions, educating patients about colonoscopy or need inspiration or facts for an article you want to submit to your local media, the CRC Education Toolkit located in the right hand column of the page will help your efforts to make a difference.

We encourage you to share your continued success, exchange ideas for future CRC Awareness activities and engage with your colleagues in the GI Circle Colorectal Cancer Awareness discussion area, at https://acg-gi-circle.within3.com/public/sign_in.

CRC Education Toolkit
The GI Circle features a discussion area where you can share your success stories and access the CRC Education Toolkit with a wealth of resources, tips, examples, and background information including:
• 2010 Key Messages
• Colonoscopy Key Messages
• CRC Screening Fact Sheet
• 2009 Screening Guideline
• NIH CRC Conference Report 2010
• Sample Letters to the Editor
• Letter to the Editor Tips
• Template for Media Outreach
• Links to colonoscopy video, podcasts and more

You can access the CRC Education Toolkit on the ACG Web site at www.acg.gi.org/patients/crctoolkit.asp.

Whether you choose to write a letter to the editor of your local paper, talk to a reporter about colorectal cancer, participate in the 2010 CRC Awareness Radio Tour, or publicize the efforts your practice is making to educate the community about colorectal cancer prevention, your quotes, TV and radio spots, letters and bylined articles are collectively reaching hundreds of thousands of people all over the United States, and ultimately helping to increase CRC awareness and save lives.

ACG Research Awards
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particularly the large number of strong pilot projects. A $10,000 grant seems like a small amount, but we are always pleased to invest in proposals from young investigators.”

ACG Institute Director Edgar Achkar, MD, MACG, explained, “We have analyzed the careers and productivity of our Junior Faculty awardees since 1997, and we see a tremendous return on investment for this career development award in terms of the publications, presentations at the ACG Annual Meeting, notable success in securing NIH funding and careers in academics.”

The ACG Board of Trustees approved the five awards recommended by the ACG Research Committee from their review of an excellent field of applicants.
Timely Opportunities for Third Year Trainees

It is a time of anticipation for trainees across the country. If this is your final year, it is almost time to cross over into the promised land of a higher income tax bracket. For others, there is the hope that there will be at least a nominal pay increase in July.

This is a busy time, so the following is a quick list of potential timely opportunities.

**SEP IRA**
If you are in the process of doing your taxes and you just realized how much you owe in tax because of that moonlighting that you did last year, open a Simplified Employee Pension plan (SEP). This is a type of individual retirement plan that allows you to defer approximately 25% of any 1099 income that you may have had last year up to the federal maximum limit. If you are befuddled, call your CPA. He or she should be able to assist you in maximizing any opportunity.

**Disability Insurance**
Protect your current and future income! For many of you, everything that you currently have, plan to have or plan to pay off is based on your ability to earn an income. Make sure that it can’t go away!

- There are now five individual disability contracts with specialty specific (Own Occupation) language for a Gastroenterologist, in most states.
- You can often purchase up to $6,500 of benefit as a third year trainee with no financial qualification.
- Premium expenses have become increasingly more competitive in the past six months, further benefiting trainees.
- To view an informative video and obtain a personalized disability contract analysis, visit www.integratedwealthcare.com/education.

**Roth IRA**
Roth IRAs continue to provide significant tax leverage for trainees. Two thoughts:

- Funding – If you have been max funding your Roth IRA during residency/fellowship and will lose the ability soon due to your increased income, consider max funding a non-deductible traditional IRA. In the year 2010, you can convert those funds into your Roth IRA (paying taxes on any gains). Understand that there are some tricky guidelines to this and it is not advisable in every situation. Consult your tax advisor or financial planner for planning strategies.

- Roth Conversion – If you have money in former 403(b) or 401(k) accounts or in a traditional IRA, you can convert them to Roth IRA accounts this year, locking in a future tax free income. Again, consult your CPA first as there are tax ramifications.

**Evaluate Your Credit**
If you are planning to move this summer, and therefore purchase a new home, start to work on your credit score now. A few things that you can do are:

- If you have any incorrect information, late charges, or other negative influences, contact the reporting companies, solve the problem and have them adjust your report.
- Contact your credit card company and ask them to raise the limit on your card. If you keep less than 30% of your available limit outstanding, it has a positive impact on your credit score.

Following are the minimum FICO scores that you commonly need to get the best rates: Home Purchase – 620; Refinance – 680; Credit Card – 700.

If you are getting ready to purchase a home, get good advice. A mortgage broker or lender should be able to explain the different types of mortgages (Fixed, ARM, Interest Only). Be forewarned that the classic “Doctor Loan” programs with 100% financing are becoming more rare. The mortgage industry continues to try to shake the crisis that it has faced over the past 24 months. My suggestion is to interview several professionals and work with the person who has the greatest understanding of the culture of medicine. In particular, they must understand that just because you have a current salary of $55,000 and student loans of $150,000, you are not a poor risk!

**Develop a Plan**
To make this simple, take the next few moments to think about which of the above topics most interest or concern you. Next to each one, rank them in order of your priority and then write down where you can go to move each one forward. Start with number one and delegate each topic until you get to the end of the list. Now go back to the clinic.

Information on this page is courtesy of Shayne Ruffing, CLU, ChFC, AEP®, who is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne specializes in executive benefit planning for physicians and medical practices, and can be reached at 800.225.7174, or on the web at www.IntegratedWealthCare.com. Shayne is a Financial Advisor offering Securities and Advisory Services through NFP Securities, Inc., a Broker/Dealer, Member FINRA/SIPC and Federally Registered Investment Advisor. The Benefit Planning Group is not an affiliate of NFP Securities, Inc.
Learn the latest clinical updates, get the answers you seek and exchange ideas with colleagues at ACG 2010.

Join ACG, **October 15-20, 2010** in San Antonio for the ACG 2010 Annual Scientific Meeting and Postgraduate Course. Attend to learn the latest clinical updates and what is on the horizon that may impact your practice.

**Attend ACG 2010!**
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Dr. Lilly’s experience at Schweitzer

ACG’s Ed Lilly has volunteered for medical missions in Haiti for over twenty years with Physicians for Peace, a Norfolk, VA group. During Dr. Lilly’s long experience of 11 missions to Haiti over the years, his final mission was to Schweitzer Hospital.

Lilly describes Schweitzer Hospital as “an oasis” where Haitians can receive good medical care. His sense is that while the hospital started with Mellon family funding, it has faced hard times financially in recent years as it has been forced to spend down endowment capital. The hospital, like so many other charitable facilities, is dependent on contributions.

Volunteerism and opportunities to donate used scopes

Dr. Lilly has been an important inspiration for ACG’s Medical Missions International Volunteerism Reference Guide (www.acg.gi.org/physicians/medicalmissions.asp). Here, visitors can learn about humanitarian organizations, as well as practical issues facing physicians volunteering overseas.

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“So many in this country are dealing with loss of family and friends in Haiti and suffering with grief and PTSD. Furthermore, the Haitian community in the U.S. will grow as individuals affected by the quake arrive to stay with relatives. But right now we are not paying attention to these situations.”

Dr. Francois says he thinks about the road that he has traveled — and he is grateful for the opportunity he has had to leave Haiti and pursue his medical education in the United States — a road that brought him home again.

“If it wasn’t for my family deciding to emigrate, my life would have certainly been very different. I may not have become a physician. I could have been there during the quake… I could have died or my family could have died… or we could have been hurt. I think about what could have been and I am thankful that my experiences and training prepared me for my return.”

Read more about Dr. Francois’ experience in Haiti on the NYU team’s blog, http://heart.med.nyu.edu.


HalfLytely® & Bisacodyl tablets Bowel Prep Kit

PEG-3350, sodium chloride, sodium bicarbonate and potassium chloride for oral solution and bisacodyl delayed-release tablets

PROVEN SAFE AND EFFECTIVE AND NO ORAL SODIUM PHOSPHATE

- Lowest volume phosphate-free lavage
- Less cramping, fullness, and overall discomfort

References: 1. IMS Health Inc, NPA Weekly Rx Audit, Jan 2008-Feb 2009. 2. In a clinical study of HalfLytely and Bisacodyl Tablets Bowel Prep Kits (10 mg vs 20 mg bisacodyl tablets) [See package insert; Table 2], Braintree, MA: Braintree Laboratories, Inc. 3. See package insert: GoLYTELY® (PEG-3350 and Electrolytes for Oral Solution); 2001, NuLYTELY® (PEG-3350, Sodium Chloride, Sodium Bicarbonate and Potassium Chloride for Oral Solution); 2008, HalfLytely® and Bisacodyl Tablets Bowel Prep Kit; 2008. Braintree, MA: Braintree Laboratories Inc., MovPrep® (PEG-3350, Sodium Sulfate, Sodium Chloride, Potassium Chloride, Sodium Ascorbate and Ascorbic Acid for Oral Solution); 2006 Morrisville, NC: Salix Pharmaceuticals Inc.

Brief Summary: Before prescribing, please see full prescribing information for HalfLytely and Bisacodyl Tablets Bowel Prep Kit. INDICATIONS AND USAGE: A gastrointestinal lavage indicated for cleansing of the colon as a preparation for colonoscopy in adults. CONTRAINDICATIONS: Patients with the following conditions: known allergies to polyethylene glycol or other components of the kit, gastrointestinal (GI) obstruction, bowel perforation, toxic colitis, toxic megacolon. WARNINGS AND PRECAUTIONS: Use with caution in patients using concomitant medications (such as diuretics) that increase the risk of electrolyte abnormality, patients with known or suspected hyponatremia, patients with severe ulcerative colitis, ileus or gastric retention. There have been reports of ischemic colitis in patients with use of HalfLytely and 20 mg Bisacodyl Tablets Bowel Prep Kit. However, a causal relationship has not been established. If patients develop severe abdominal pain or rectal bleeding, patients should be evaluated as soon as possible. Patients with impaired water handling who experience severe vomiting should be closely monitored including measurement of electrolytes. Hives and skin rashes have been reported with PEG-based products which are suggestive of an allergic reaction. Pediatric Use: Safety and effectiveness in pediatric patients has not been established. ADVERSE REACTIONS: Most common adverse reactions (<3%) are abdominal pain/cramping, nausea, vomiting and headache. Oral Administration: Take two bisacodyl tablets with water (do NOT chew or crush). Wait for a bowel movement (or maximum of 6 hours) then drink the 2 liter solution at a rate of 8 ounces every 10 minutes. Drink all of the solution. STORAGE: Store at 20-25°C (59-86°F). When reconstituted you may keep the solution refrigerated. Discard within 48 hours. Rx only. Distributed by Braintree Laboratories, Inc. Braintree, MA 02185.

For additional information, please call 1-800-874-6756 or visit us at www.halflytely.com

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Please see brief summary of prescribing information on adjacent page.