ACG Grant Recipient Receives Advanced Training in Early GI Cancer Detection and Treatment in Japan

In this issue of the *ACG Update* we are highlighting the 2009 ACG North American International GI Training Grant recipient, Dr. Tonya R. Kaltenbach, MD, who works with the Veterans Affairs Palo Alto Health Care System, in Palo Alto, California, and who is also affiliated with Interventional Endoscopy Services at California Pacific Medical Center in San Francisco. This grant provides partial financial support to U.S. and Canadian GI fellows-in-training or GI physicians who have completed their training within the last five years, to receive clinical or clinical research training in Gastroenterology and Hepatology outside of North America.

As the winner of the 2009 grant, Dr. Kaltenbach traveled to Japan to train in the field of early gastrointestinal cancer detection and treatment. ACG is proud to have been able to play a positive role in her career development.

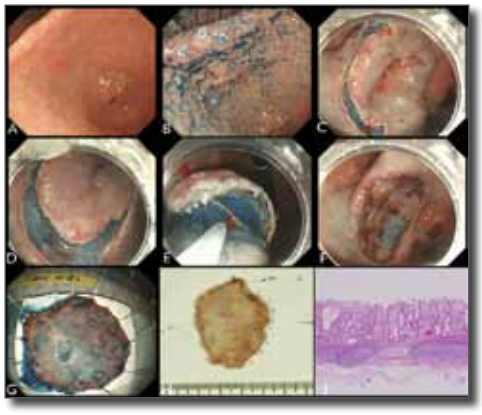
by Tonya R. Kaltenbach, MD

The American College of Gastroenterology 2009 North American International GI Training Grant facilitated an invaluable training opportunity for me at the National Cancer Center Hospital (NCCH) in Tokyo, Japan, in the field of early gastrointestinal cancer detection and treatment. During this two month focused training led by Dr. Takuji Gotoda, Chief of GI Endoscopy, I directly worked with renowned experts in the field to enhance my knowledge and technical skills in endoscopic mucosal resection (EMR) and submucosal dissection (ESD) of gastrointestinal neoplasia and early cancer.

I have been interested in gastrointestinal cancer prevention since medical internship. Directing my clinical and research interests to advanced endoscopic imaging and therapy of the GI Tract, I sought mentorship early in my training by Doctor Roy Soetikno. During GI fellowship, I matriculated in a clinical research masters program in epidemiology and biostatistics, and then pursued an additional year of training in advanced endoscopic mucosal imaging and therapy. In an effort to understand and master endoscopic resection techniques, over the years I have also closely collaborated with Japanese experts.

I have centered my clinical practice and research in advanced endoscopic imaging and therapy. I presented our long-term efficacy and cost data on EMR of large flat or sessile colorectal lesions at the ACG 2008 Annual Meeting in Orlando, Florida. Based on the hospital costs of our tertiary center experience, we found that the referral of large colorectal lesions for endoscopic evaluation and possible resection is a dominant strategy over surgery—the endoscopic procedure is safe, efficacious and has a lower cost compared to the published surgical literature cost. Equally important, the overall total hospital revenue was positive. Such data is important and timely in the current economic climate with limitations on resources and insurance. However, in the United States, there is a paucity of endoscopic resection practices. In fact, the majority of such lesions are typically referred for surgery due to a variety of reasons including insufficient technical skills, high complication risk, increased utilization of endoscopy resources and time, and inadequate reimbursement. Recent studies have corroborated this issue and the need to disseminate the training and practice of endoscopic resection for GI neoplasia and early cancer—particularly in Barrett's high grade dysplasia and non-lifting colorectal lesions.

Dr. Tonya Kaltenbach (left) assists Dr. Abby Conlin, visiting international scholar from the United Kingdom, during an ESD practice session using an explanted pig stomach model.



ESD of early gastric cancer. A. Located on lesser curvature of the antrum just distal to the incisura, B. Indigo carmine is applied for delineation of the lesion border, and the lesion is then marked using a needle knife. C,D. Two precuts are made using a needle knife, followed by cutting the periphery of the lesion using an insulated tip knife, E. followed by sequential submucosal injections and dissections. F. Post resection defect. G, H. Post resection specimen, and I. Histopathology.

The team of endoscopists at NCCH is focused and dedicated to advancing the field of early gastrointestinal cancer detection and treatment. Their rich knowledge and elegant technical skills are the aspirations of every endoscopist. During my stay, innumerable teaching points and experiences were presented on a daily basis during live cases, video reviews, impromptu lectures and formal journal clubs and clinical conferences. The endoscopy,

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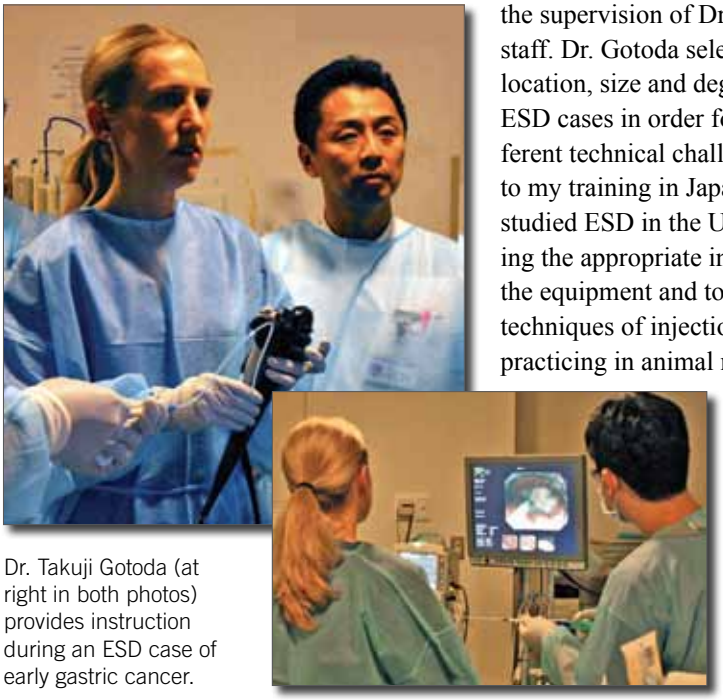
radiology and pathology digital images discussed at the joint endoscopy-surgery clinical conferences provided such a depth of information. These high quality image intensive conferences are a model to emulate for clinical collaboration.

At NCCH, in addition to didactics and observing, I was able to assist in the esophageal, gastric and colon diagnostic and therapeutic cases—gathering and sharing subtle technical points. I regularly practiced ESD using an explanted pig stomach, both performing and assisting with other Japanese and international visiting scholars. Moreover, I directly performed numerous ESD cases under the supervision of Dr. Gotoda and his staff. Dr. Gotoda selectively varied the location, size and degree of fibrosis in the ESD cases in order for me to face the different technical challenges of ESD. Prior to my training in Japan, I had thoroughly studied ESD in the U.S.—understanding the appropriate indications, learning the equipment and tools, mastering the techniques of injection and hemostasis, practicing in animal models, and actually assisting my mentor, Roy Soetikno, in live cases. Nonetheless, it was not until directly performing case after case that I acquired a confident feel for the ESD procedure—the endoscope and accessory maneuverability, the glide of the dissection and the prevention and control of bleeding at the various sites. The experience was a highlight and stepping stone of my young career.



Dr. Takuji Gotoda (at right in both photos) provides instruction during an ESD case of early gastric cancer.

I value the opportunity provided by the ACG to broaden my endoscopic resection skills through my advanced training at National Cancer Center Hospital, Tokyo; and look forward to bringing the Japanese endoscopic knowledge and techniques to the United States. Gambatte Ne! AICIG

Training Grant Applications Now Being Accepted

ACG is now accepting applications for the 2010 North American International GI Training Grant and 2010 International GI Training Grant. Applications are included in this mailing of the *ACG Update*. Visit www.acg.gi.org/physicians/research.asp#tragrants for aditional information.

New ACG Guideline Reviews UC in Adults

UC is 3rd practice guideline for 2010

Ulcerative Colitis in Adults will be the third guideline published in *The American Journal of Gastroenterology* this year. Spearheaded by leading experts, Asher Kornbluth, MD, and David B. Sachar, MD, MACG, along with the ACG Practice Parameters Committee, the Ulcerative Colitis in Adults Practice Guideline offers recommendations for diagnosis and assessment, approach to management, recommendations for management of mild-moderate distal colitis and recommendations for maintenance of remission in distal disease. In addition, the guideline also provides recommendations for management of mild-moderate extensive colitis: active disease, recommendations for mild-moderate extensive colitis: maintenance of remission, recommendations for management of severe colitis, recommendations for surgery, management of pouchitis, and recommendations for cancer surveillance.

Members may now access the practice guideline online or in print when the March issue of the *AJG* is published. All ACG practice guidelines may be found on ACG's website at www.acg.gi.org/physicians/clinicalupdates.asp#guidelines.

Coding

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par, not adjusted for locality).

Similarly, 99214 will pay $59 or 15% less than 2009's $70, CMS says.

Initial hospital care faces an 18% reduction; code 99222 for example will pay $100 next year, compared with $122 this year.

Congress may act—The House recently passed the Medicare Physician Payment Reform Act (H.R. 3961), which would permanently reform Medicare's physician payment formula. But a permanent fix is hardly a done deal. The Senate in October failed to advance a bill to halt the physician pay cut, with opponents arguing the bill would have added to the federal deficit.

Most likely, Congress will again pass a temporary measure to halt the pay cut for one or two years, physician societies predict. AICIG