Northern California Society for Clinical Gastroenterology

NEWSLETTER

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The Northern California Society for Clinical Gastroenterology (NCSCG) is pleased to announce the NCSCG GI Symposium being held October 17-18, 2020, in Monterey, CA. This year, the NCSCG is pleased to offer a two-day GI course, expanding on what has traditionally been a one-day meeting.

Please note that the date has changed from May 30-31, 2020. This difficult decision took into account not only the health risks associated with the rapidly evolving Coronavirus pandemic, but also the escalating state restrictions on gatherings of any kind. Though we are hopeful that this crisis will have passed by the end of May, we felt the safer and more prudent action was to move the conference to the fall.

MEET THE NCSCG 2020 PRESIDENT
RADHIKA KUMARI, MD

Associate Clinical Professor
Liver Transplantation
Stanford Medical Center

I am from a very small village in India. I respect my dad for allowing me to study when all my relatives in India wanted me to get married off at a young age. Love my job being part of a great Liver Transplant team at Stanford.

I have been with NCSCG for the last 5 yrs. It's been great to collaborate with different organizations in promoting educational activities in Northern California. I joined the NCSCG to help promote educational activities in Northern California. It's a great community where experts from various organizations meet, exchange and spread knowledge.

What excites me about GI/hepatology in 2020 is the research on Hepatitis B front and looking forward to help patients with curative treatments.

I love cooking, traveling and watching TV. Aim in the next 2 years to visit all the locations of Game of Thrones.

WOMEN IN GI: INTRODUCING GI JANES

This subgroup of the NCSCG was formed by Radhika Kumari, MD and Marina Roytman, MD, FACP, in 2020 in order to encourage membership, participation and networking of female gastroenterologists, hepatologists and health care providers in northern California

At the NCSCG GI Symposium, Women in GI are invited to attend a session ***Women in GI: Introducing GI JANES*** Meeting, held after the general session from 3:10pm-3:30pm on Saturday, October 17, 2020, featuring guest speaker Uma Mahadevan, MD, a lead female gastroenterologist in northern California.

MEET THE NCSCG 2020 VICE-PRESIDENT
WILL HOLT, MD

Born in upstate South Carolina, also have roots in Boston, Charleston, New Orleans, Honolulu and Oakland.
I was a high school teacher for 2 years through *Teach For America*; I have 3 kids in elementary school this year and I love running and camping. I'm also a 2nd grade basketball coach.

My clinical and/or research interests are nonalcoholic fatty liver, medical education, liver transplant, hepatitis B, and hepatocellular carcinoma.

Transplant Hepatologist at CPMC
Director of CPMC
Fatty Liver Clinic
Associate Program Director
CPMC GI Fellowship

This is my 4th year involved with the NCSCG– I have helped to plan the liver symposium most years. I joined the NCSCG as education is important to me and there's already a component of community outreach to my job at CPMC. This was a great opportunity to show my commitment to both.

What excites me about GI/hepatology in 2020 is that we will likely see the first drug approved for NASH this year, and we'll see a handful of other ones move into the final phase of development. I think the role of new pharmacologic agents in the treatment of NASH is yet to be fully defined, but we badly need more treatment options. It's been very exciting to witness the birth of a field of medicine firsthand.

NCSCG LEGISLATIVE CORNER
Neil Stollman, MD
East Bay Center for Digestive Health

To quote the dapper Scottish philosopher David Byrne "well, how did I get here?"

About 8 years ago, I was unexpectedly asked to take over as the American College of Gastroenterology (ACG) Governor for Northern California due to illness, and have spent that time, and now my final year as Chairman of the ACG Board of Governors representing you, our NorCal members. While an unexpected turn for this full-time clinician and part-time researcher, it has turned out to be rewarding in so many ways. In this column, I'd like to highlight the novel experience I've had as a political advocate, and also encourage all of you to get involved to the extent you're able or interested.

You've heard that 'all politics is local' and there's truth to that, but I've nonetheless spent the past eight Aprils flying to Washington, D.C. to advocate on the Hill. Given that I was the only Governor from NorCal, I would have 10+ 'visits' or 'calls' to make. If you've ever been to the Capital, you know how byzantine the buildings are, scattered far and wide, with trains and tunnels and security checkpoints (and invariably, rain!) and my best advice to newbies is to wear comfy walking shoes! Each visit was with either the Representative themselves, or more typically, one of their LAs (Legislative Assistants).

It is a bit disconcerting to find that these aides are often fresh-faced 20 somethings, barely out of college! And yet this is how the sausage is made!

They are, however, a very impressive bunch of youngsters, highly dedicated and clearly the best and the brightest.

NCSCG LEGISLATIVE CORNER Cont.

I'd typically have a 30 minute appointment, but it would often start late, and I'd have to leave 5-10 minutes to get to my next appointment (never be late!) so I would have to have my 'elevator pitch' down pat. I've refined my style over the years, but generally would start with an introduction to who GI docs are, and then I'd try and personalize our message (most of their parents are getting colonoscopies, many have personal or family histories, etc.) and then succinctly make the case for the legislation at hand.

Sometimes the Representative was already signed on and supporting the cause, in which case it was really more of a 'thank you' visit. Answer all of their questions (they're quite inquisitive, those LAs), repeat your 'ask' to wrap things up, and then it's on to the next one, as the Brooklyn philosopher Shawn Carter once said. After each encounter, I'd send a follow up email the next day, always including at least one personal tidbit that I'd jotted down (their grandma survived colon cancer, they moonlight as a mime, whatever) and finally, reemphasize my prior offer that both I, and the College's staff, are available to them down the road as needed.

That's the 'what' of advocacy, but of course there's the obvious 'how' and 'why'. The 'why' should be easy, nothing happens without legislation and legislators need to hear from their constituents, in this case, via you. Doctors are historically poor at advocacy, to our profession's detriment in my opinion, and among docs, gastroenterologists are relatively uninvolved.

We need to speak up for ourselves and our patients, period. The 'how' for you colleagues and readers who want to be part of our collective voice, is not to jet off to DC to meet legislators on your own but you can send letters and emails to your local Representatives, and in fact, I'd suggest you make an appointment with them one day, ideally with them directly when they're in the District, or with their LA if not.

It might seem awkward, but they really do WANT to hear from and connect with their constituents, and as a local physician, you're still a fairly 'important' constituent who's seen as a source of community wisdom.

NCSCG LEGISLATIVE CORNER Cont.

You can certainly express your personal local requests, but if and when appropriate, we (the ACG in my case, but certainly the AGA as well) can also help you to talk about GI issues of national importance and ask for their support. You'd be surprised as to how many of our docs have developed genuine connections to their local Representatives, to their and our collective benefit (particularly in smaller districts….a bit more of a challenge in, say, San Francisco).

Our ACG "Fly In" was to occur shortly, but has been deferred due to the current Covid issues. I did want to highlight an issue I've been talking about for nearly my whole tenure, that of legislation to fix the 'colonoscopy loophole' (when our patients get a surprise bill when their 100% covered diagnostic colonoscopy finds a polyp, it's intent, but then turns into a therapeutic colonoscopy with typically 20% coinsurance). The Removing Barriers to Colorectal Cancer Screening Act (HR 1570) is the most recent version of such legislation (previously, the SCREEN Act) and is finally getting some traction, as surprise billing (and out-of-network billing) have risen to many Rep's awareness. This was included in an early drug pricing bill, and while it's not likely to be taken up by the Senate, this is actually important momentum, and this will be the flagship issue that I and our 'army' of Governors will be talking up next month in DC. We'll likely also be working on legislation to curb the 'Prior Authorization' nightmare we're all living through now.

So, that's how a guy making poopshakes in Oakland turned into, in essence, an unpaid lobbyist leading 50+ GI docs into the fray in DC. But it's important work and I'm thrilled to be able to do it. I'm equally thrilled to see a hint of optimism with our high-priority legislation this spring. I would encourage you all to think about some of the simple things you can do to help these patient and provider-centric initiatives, from simply filling in an email form from the ACG or AGA to sign an email to your local Rep, or meeting them one-on-one locally or next time you're in DC

I intend to revisit this space sporadically with updates on (hopefully) good news, as well as to let you know where you might consider making your important voice heard.

P.S. Your new NorCal ACG governor, elected by you, is Ron Hsu at UC Davis. He's got more enthusiasm than anyone I know and is eager to hear from you with your concerns and issues.

Neil Stollman, MD, FACP, FACG, AGAF is a board member of the Northern California Society for Clinical Gastroenterology and current Chairman of the ACG Board of Governors. He is an Associate Clinical Professor of Medicine at UCSF, Chief of Gastroenterology at Alta Bates Summit Medical Center, and partner at East Bay Center for Digestive Health in Oakland, CA. Neil is a somewhat unique example of a practitioner who has managed to successfully incorporate the roles of clinical gastroenterologist, internationally accomplished GI academician, and political advocate into his daily practice. We look forward to hearing more of his GI adventures in future issues of the NCSCG newsletter.

MEET THE NCSCG EDUCATION AND TRAINEE COMMITTEE FELLOWS

Gavin Park, MD

Third Year GI Fellow
CPMC

I am originally from Oahu and attended undergraduate and medical school education at the University of Hawaii, so I am looking forward to returning to the islands to practice medicine and care for the people of Hawaii. After graduating fellowship, I will be working at Queens Medical Center on Oahu, Hawaii as a clinical gastroenterologist/hepatologist. I'm looking forward to surfing in warmer water once I move back!

What most excites me about GI/hepatology in 2020: For now, reaching the cecum in 3 minutes or less.

My clinical and/or research interests are: Colorectal cancer prevention and screening; Fatty liver disease and Medical education.

My first experience with NCSCG was in my first year of GI fellowship at their post-AASLD liver symposium. I was unable to attend AASLD so this was a great opportunity to be exposed to highlights of cutting edge topics I missed. It also gave me an opportunity to meet with other clinicians in the bay, specifically at nearby institutions including UCSF and Stanford. It continues to be challenging to attend all of the conferences one would like and this society helps to bring the knowledge presented at these conferences to our local community; moreover the discussion is tailored to our unique practice setting.

Jessica Rubin, MD, MPH

Third Year GI Fellow
UCSF

I'm originally from St. Louis and lived on the East Coast for 9 years prior to moving to SF for residency. After graduating fellowship I will be staying at UCSF for Advanced/Transplant Hepatology Fellowship.

In elementary school, I was asked to join the circus and my mom wouldn't let me…so now I'm a gastroenterologist!

What most excites me about GI/hepatology in 2020: Continual improvements in care for patients with GI and liver diseases – new medical, endoscopic, and surgical therapies that are saving lives and reducing morbidity.

My clinical and/or research interests are: Cirrhosis, liver transplant, care delivery, health services research, health policy, gender disparities.

I joined the NCSCG in 2019/2020 as I think it is a great way to meet other local gastroenterologists and provide education to providers and trainees in the area.

Vickie Aivaliotis, MD

Chief Fellow
Stanford GI Fellowship

I was born in Mountain View and raised in San Jose by my parents who are both Greek immigrants. I was fortunate to remain in the Bay area to attend Berkeley, UCSF, and Stanford for the various stages of my education and training. As a deeply rooted Bay Area native, I plan to dedicate my clinical practice to serving this community. I am thrilled to be joining the GI team at Kaiser Santa Clara upon graduation.

My clinical interests are in general gastroenterology and medical education. During my fellowship I also led several research studies on the characterization and management of chronic abdominal pain syndromes.

I recently joined the NCSCG in 2020 as a fellow representative on the Education and Trainee Committee. I joined the NCSCG to connect with the broader Bay Area GI community and to gain access to the various educational resources and conferences the society coordinates. I felt that the NCSCG would also provide opportunities for ongoing mentorship as I transition from a trainee to a new attending. I wanted to expand my skills in medical education by serving on the NCSCG's Trainee and Education Committee and developing larger-scale medical education programs that could benefit trainees across multiple institutions in Northern California.

Besides my love for the gastrointestinal tract, I also have a passion for the theater. I grew up performing in musical theater and minored in Theater and Performance Studies while at UC Berkeley. I have not been performing as much since starting my medical training, but I frequently play Broadway and Disney tunes in my endoscopy rooms!

How do I approach suspected drug induced liver injury (DILI)?

Marina Roytman, MD, FACP
UCSF Fresno

We have all been in this situation: evaluating a patient with hepatic dysfunction and thinking "could this be DILI"? If it is DILI, how do I prove and most importantly to which drug do I attribute it too? Manuscripts have been written on the subject of DILI diagnosis (I am guilty of writing one), but they are not tremendously helpful (I admit!) in the day-to-day clinical practice. My approach is to combine the logic of the DILI diagnostic algorithms with common sense.

To review: DILI is a diagnosis defined as hepatic dysfunction caused by prescription medications, over-the-counter medications and herbal dietary supplements (HDS) after alternative causes have been excluded. DILI itself can be further categorized as either intrinsic or idiosyncratic.

How do I approach suspected drug induced liver injury (DILI)? (Cont.)

- Intrinsic DILI refers to drugs that predictably cause hepatic injury if given in sufficiently high doses and often display stereotypic, well described phenotypes. The best-known cause of intrinsic DILI is acetaminophen.
- Idiosyncratic DILI is less common, although probably underdiagnosed, may more likely affect susceptible individuals, has no clear relationship to dose, and has a more varied latency, presentation and course. Certain host (e.g. age, malnutrition, obesity), environmental (e.g. alcohol consumption), and drug-related factors (e.g. dose, drug interactions, cross-sensitization) may predispose patients to idiosyncratic DILI. Most of the HDS DILI cases are idiosyncratic.

Clinically, DILI has a wide range of presentations and is known as the great mimicker. To an unsuspecting clinician it may look like acute viral hepatitis, biliary obstruction, acute fatty liver of pregnancy or chronic hepatitis leading to advanced liver disease. Since no specific biomarker for DILI has been identified, it remains a diagnosis of exclusion. The best-known scoring system is RUCAM/CIOMS (https://www.ncbi.nlm.nih.gov/books/NBK548049/) which uses several criteria that are more or less applicable to clinical practice. For practical purposes these criteria can be grouped into 4 major categories: clinical judgment (I), exclusion of alternative causes (II), knowledge of the potential of the agent to cause liver injury (III) and response to re-exposure (IV).

I. **Clinical judgment**: this is where I ask myself a question: does it make sense that this drug caused this type of injury? More specifically, does the timing of starting and stopping the drug correlate to the clinical course of the patient? In hepatocellular injury (predominantly abnormal AST and ALT), I expect to see a rapid rise of ALT (within 5-90 days) with starting the drug and a rapid fall (≥ 50% within 8 days) of ALT following the discontinuation of the offending agent. In cholestatic DILI the expected time frame for decrease in alkaline phosphatase or total bilirubin is significantly longer (≥ 50% within180 (!) days)

II. **Exclusion of alternative causes**: this is the easy part! I ask about alcohol misuse, risk factors for recent ischemic liver injury and test for common causes of hepatic dysfunction (acute hepatitis A, B and C) as well as (in the right clinical context) for less common causes such as hepatitis E, cytomegalovirus, herpes simplex virus and Epstein-Barr virus, acute exacerbation of chronic hepatitis (B, C, D), acute autoimmune hepatitis, primary biliary cholangitis, primary sclerosing cholangitis, Wilson's disease, acute worsening of nonalcoholic fatty liver disease, sinusoidal obstruction syndrome and graft-vs.-host disease. Imaging (US or CT) is used to rule out biliary obstruction, portal or hepatic vein thrombosis as well as to evaluate overall contour of the liver. Malignant infiltration of the liver should be considered in the right clinic context as it may be very subtle on imaging.

III. **Prior knowledge or suspicion for hepatotoxicity of the agent in question**: potentially one of the more challenging categories, especially in the setting of HDS DILI. While the hepatotoxicity of many prescribed drugs such as amoxicillin/clavulanic acid is well known and described, the hepatotoxicity potential of an HDS may be unknown. Moreover, HDS implicated in hepatotoxicity often contain multiple ingredients, obscure their ingredients with a "proprietary blend' label or may even be adulterated with unlisted drugs or chemicals, thus further complicating any assessment of causality. The lack of known toxicity of a compound does not preclude it from being hepatotoxic. The key to assessing this category is clinical suspicion and meticulous history. Patients often neglect to mention the use of HDS unless asked directly. www.livertox.nih.gov is an excellent database to explore potential hepatotoxicity of prescription medications, over the counter therapies, and HDS.

IV. **Response to re-exposure**: this should not be done intentionally! Certain drugs may cause liver injury through an immune-allergic mechanism, triggering a more vigorous, anamnestic type of response that can lead to worsening liver injury, potential liver failure and death. Re-exposure, however, may occur unintentionally. If re-exposure occurred with recurrent (and hopefully not life-threatening) DILI, you have nailed the diagnosis!

How do I approach suspected drug induced liver injury (DILI)? (Cont.)

An alternative and frequently used method of assessment of hepatotoxicity is "consensus" or "expert opinion". As the name implies, it relies on one or more experts with experience in evaluating DILI rendering an educated opinion on the validity of association of the suspect hepatotoxic agent with the liver injury. While it is theoretically a great option, we are not always in the position to easily reach out to a panel of DILI experts. My advice is to go through the logical steps of evaluating a potential DILI outlined above and have a low threshold to reach out to a colleague for a second opinion. If you are interested in more in-depth material regarding DILI, please see the NIH LiverTox Resource (https://www.ncbi.nlm.nih.gov/books/NBK547852/) or the 2019 European Association for the Study of the Liver 2019 DILI Guidelines (https://easl.eu/publication/cpg-drug-induced-liver-injury/)

Marina Roytman, MD, FACP is a board member of the Northern California Society for Clinical Gastroenterology, Health Sciences Clinical Professor at UCSF and Liver Program Director at UCSF Fresno. Her research interests include drug-induced liver injury, non-alcoholic fatty liver disease and viral hepatitis. She enjoys teaching hepatology, creative writing, hot yoga, and travelling.

NORTHERN CALIFORNIA GI PROGRAM HIGHLIGHTS

The Northern California GI Program Highlights section will be a regular section in our NCSCG newsletter that highlights different centers of excellence and expertise in our northern California GI community. On a rotating basis, each newsletter will highlight two programs from two institutions in northern California. In addition to highlighting the diverse wealth of expertise in our region, this will also provide helpful information for providers interested in referring their patients to these programs.

Inflammatory Bowel Disease Center at UC Davis

The Inflammatory Bowel Disease Center at University of California, Davis has experienced significant growth over the past two years. There had only been one inflammatory bowel disease (IBD) expert providing care to patients with ulcerative colitis and Crohn's disease in Sacramento and the surrounding region from 2014 to 2018. During the past two years, the IBD Center at UC Davis has expanded with the addition of IBD specialists Dr. Eric Mao and Dr. Maneesh Dave, joining Dr. Jesse Stondell and now provides care to more than 1,000 patients with IBD. The new additions bring clinical drug trials and translational research in regenerative stem cell therapy and microbiome to the IBD Center at UC Davis. Most recently, UC Davis has begun enrolling for a clinical drug trials in both ulcerative colitis and Crohn's disease. Through a collaborative partnership, the IBD specialists work closely with colorectal surgeons Dr. Wissam Halabi and Dr. Elizabeth Raskin who have expertise in minimally invasive robotic-assisted surgery. Furthermore, the IBD Center employs a multidisciplinary approach with a pharmacist and nutrition specialist integrated into the IBD center. With recent expansion, the IBD Center at UC Davis has increased its capacity to provide comprehensive and specialized care for IBD patients in the Sacramento Valley and surrounding regions.

In addition to patient care, the IBD Center at UC Davis is committed to the local IBD community including patients and providers. In partnership with the Crohn's and Colitis Foundation, the IBD Center organized the annual Sacramento Patient Education conference as a resource for IBD patients in the community.

Furthermore, the UC Davis IBD Center in collaboration with UC Davis-affiliated IBD provider Dr. Ronald Hsu, and CCF successfully organized the inaugural Sacramento Professional Symposium on Inflammatory Bowel Disease on February 8th 2020, featuring national IBD experts from Stanford, Kaiser, and UC Davis and international IBD expert Dr. David Rubin from University of Chicago. This event was attended by more than 90 local providers. The UC Davis IBD center will continue to provide valuable resources to its local IBD community.

For more information:
Midtown Ambulatory Care Center
UC Davis Inflammatory Bowel Disease Center
3160 Folsom Blvd, Suite 3500
Sacramento, CA 95816
New patient referrals: 1-800-482-3284 (option 3)
Existing patient scheduling (office visits and procedures): 916-734-1480
Existing patient line: 916-734-8616

Group photo of speakers and attendees of the inaugural Sacramento Professional Symposium on Inflammatory Bowel Disease.

Autoimmune Liver Disease Program at California Pacific Medical Center

The Autoimmune Liver Disease (AILD) Program was formed in 2014 when Dr. Kidist Yimam joined the division of hepatology at CPMC. Through Dr. Yimam's efforts, patients with primary sclerosing cholangitis (PSC), primary biliary cholangitis (PBC), autoimmune hepatitis (AIH) and other autoimmune liver and biliary diseases have gained a network of support and treatment not previously available in our area. Specifically, the AILD Program has brought clinical trials to the CPMC patient community and has established a robust support network for patients and their caregivers.

New research studies at CPMC have provided more treatment options for patients in the AILD Program. Since her arrival in 2014, Dr. Yimam has been the principle investigator for more than 10 clinical trials for PSC, PBC and AIH. Most recently, for example, CPMC has begun enrolling patients in a phase 2 study of the kappa opioid receptor agonist difelikefalin in patients with PBC and moderate to severe pruritis. Dr. Yimam also participates in a multicenter PSC registry through PSC Partners and contributes to important research in this disease.

The CPMC AILD Program hosts a conference entitled *Living with Autoimmune Liver Disease* that has drawn over 150 attendees at each of its first two events. The majority of participants are patients and caregivers from across Northern California and neighboring states. The November 2019 conference featured talks on nutrition, women's health, and developments in both medical imaging and the treatment of autoimmune liver disease. Sessions were led by social workers, patients, nutritionists and physicians across a wide range of specialties. Outside of this biennial conference, the AILD program hosts a monthly support group organized and led by a social worker and a patient advocate. In just a few years, the *Living with Autoimmune Liver Disease* has become a highlight not only of Dr. Yimam's AILD program but of the entire division of hepatology.

For more information:
Autoimmune Liver Disease Program
California Pacific Medical Center
1100 Van Ness Avenue, 3rd Floor
San Francisco, CA 94109

Scheduling: 415-600-3414 (option 1: appointments, option 2: procedures)
New patient referral fax: 415-369-1257
Existing patient line: 415-600-1020

Northern California Society for Clinical Gastroenterology

About the NCSCG

The Northern California Society for Clinical Gastroenterology ("NCSCG") is a 501(c)(3) non-profit organization devoted to the pursuit of clinical excellence in Gastroenterology and Hepatology, primarily through continuing medical education. By providing a forum for the exchange of ideas, the NCSCG aims to encourage professional growth, stimulate intellectual curiosity, and further patient outcomes by expanding access to up-to-date information of interest to practitioners.

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Membership

The NCSCG is comprised of gastroenterologists and hepatologists from private practices and academic institutions throughout Northern California. Members of NCSCG are offered complimentary registration to our spring and winter educational dinner meetings and discounted registration fees at the Post-DDW and Post-AASLD symposia. Complimentary membership is offered for fellows.

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Contact Us

For questions, comments or suggestions about this newsletter or becoming an NCSCG member please email ncscg@pacemedcom.com

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