Northern California Society for Clinical Gastroenterology

NEWSLETTER

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Dear Colleague,

The Northern California Society of Clinical Gastroenterology (NCSCG) Board and Meeting Planning Committee are pleased to announce that this year's hybrid meeting will be held live, in-person as a two-day event at the Intercontinental The Clement Monterey, CA and will also be offered as an interactive virtual platform that is accessible via the conference website on June 4 - 5, 2022.

We hope to see you in Monterey or online!

Sincerely,
The NCSCG Board and Meeting Planners

FELLOWS CORNER

David Leung, MD
Scripps Health
Fellow Representative, Southern California

Any personal background you would like to share

I am a first-year fellow at Scripps Green-Scripps Clinic. I'm originally from Long Island, NY and then went on to attend college and medical school in upstate New York before coming out to San Diego for residency and fellowship. As a first year, I am still trying to just take everything in and keep an open mind but currently am leaning towards advanced endoscopy.

Clinical and/or research interests

My current clinical interests are in in advanced endoscopy, particularly in endoscopic therapeutics and technology while my recent research interests are in bariatrics and the utility of cell-free DNA technology in the assessment for cancer risk.

Your involvement with SCSG/NCSCG and why did you decide to join SCSG/NCSCG?

I learned about SCSG/NCSCG through my co-fellows and recently joined both after attending a few of the monthly webinar/lectures. I think SCSG/NCSCG is an invaluable resource as a great way to meet other local gastroenterologists along with gaining access to educational resources.

What most excites you about GI/Hepatology in in the next 2-3 years

I think we are in such an exciting time with the development of new endoscopic therapies and I'm really looking forward to the advancements in AI-integration, endoscopic weight loss and metabolic therapies.

Other interesting facts you would like to share about yourself.

When I'm not in the hospital I enjoy surfing, golfing and training my new puppy. I am also looking forward to hopefully traveling abroad more often.

Faizi Hai, MD
Scripps Health
Fellow Representative, Southern California

Any personal background you would like to share

I am a native of and grew up in Buffalo, New York. I stayed there for my undergraduate education and medical school both of which were done at the University at Buffalo. I then moved to Scripps Clinic in San Diego, CA for my internal medicine residency and I stayed at Scripps Clinic for GI fellowship.

Clinical and/or research interests

My current clinical interests are in the field of GI motility, specifically SIBO and the use of endoflip.

Your involvement with SCSG/NCSCG and why did you decide to join SCSG?/NCSCG?

I am a relatively new member of SCSG and I am currently on the planning committee for the webinar series Advancing Career Development in GI and Hepatology Clinical Care for fellows. I wanted to be able to connect with local colleagues to hear about recent developments in the field of GI and have a space where we can discuss our shared experiences.

What most excites you about GI/Hepatology in in the next 2-3 years

I am most excited about the advancements being made in advanced endoscopy specifically procedures such as TIF which are attempting to provide a non-surgical approach to treating GI conditions.

Other interesting facts you would like to share about yourself.

I am a huge soccer fan and I enjoy playing recreational soccer, playing soccer video games, and watching professional soccer. My favorite team is Arsenal. Go Gunners!

The Power to Harm

By Marina Roytman

My patient died of COVID. As we breached 770,000 COVID-19 deaths in the US, my statement is hardly unique. In fact, we have become so used to it, we don't stop to acknowledge the tragedy of it.

But my patient was different: he did not have to die. Don't get me wrong: my patient had lots of opportunities to die in the 4 years that I have known him. He was an alcoholic who refused to acknowledge it. He had several bouts of alcoholic hepatitis from which he miraculously recovered and went back to drinking. I kept seeing him. After a particularly bad bout of alcoholic hepatitis, he acknowledged that alcohol was killing him and stopped. His family and I breathed a collective sigh of relief.

He stopped drinking, but never acknowledged that he was an alcoholic. He adamantly refused to engage in substance abuse treatment programs. He was fine, he argued, he stopped drinking on his own and he would stay stopped. I begged, pleaded and cajoled to no avail. I knew that with the amount of damage to his liver he was living on borrowed time. Eventually, even with the best care his liver will begin to fail and he will die. Unless he got a liver transplant, to qualify for which he needed to engage in substance abuse treatment such as Alcoholics Anonymous. Which he refused to do. I kept seeing him.

In time he developed ascites and we managed it. He developed hepatic encephalopathy and we handled it. We prevented a variceal bleed, which would have killed him by a series of endoscopic interventions. My patient and his family hung on to my every word and followed my instructions to a "t". Low salt diet? No problem: they researched tasty low salt recipes and he ate them. Enough lactulose to produce 3-4 bowel movements a day? No problem: done, with the chart documenting the endeavor. Repeated endoscopies? Done, done and done. He bragged about his amazing liver doctor all over town. He just did not go to AA.

His liver continued its slow but inexorable decline. Diuretics stopped working and he needed his abdomen drained with increasing frequency. He kept it up with a cheerful smile on his face. His encephalopathy was harder to control with first line medications and he and his family cheerily went along with 2nd, 3rd and 4th lines of treatment. He was losing muscle mass, his family tempted him with tasty protein-rich treats. He was declining, nevertheless. He would not go to AA. I continued to see him.

He eventually developed spontaneous bacterial peritonitis, a common complication of advanced cirrhosis. The hospital course was rocky, rockier than any of his previous hospitalizations. I was watching his liver tests worsen with dread. I made a few exploratory phone calls to the transplant centers and heard an expected reply: no substance abuse treatment, no transplant. I continued to see him.

This last hospitalization happened during the winter COVID surge. One of the very few positives that came of COVID-19 societal disruption was the availability of AA meetings on line. At the 11th hour of his life, my patient agreed to attend the virtual meetings opening the door to the possibility of liver transplant. I continued to see him and allowed myself to hope.

Given how sick he was and the fact that he was earnestly engaging in substance abuse treatment he was evaluated quickly and placed on a transplant waiting list within a few weeks. I continued to see him and allowed myself to hope a little more.

The vaccines came in late December of 2020. The winter surge decreased to a slow trickle. My patient was doing relatively well and managing to stay out of the hospital while keeping his (much needed) spot on the transplant list. I continued to see him, however less frequently, as I thought that the worst was behind us and that we had a backup plan.

The Power to Harm, Cont'd.

I saw him in the clinic in the late spring and told him to get vaccinated for COVID-19. As with all my previous recommendations, my patient and his family cheerfully agreed and left with the list of vaccination sites in town. It did not occur to me to give this interaction a second thought. I thought that I would continue to see him every few weeks to months and tinker with his medications until he got his transplant.

Alas, this is not how this story ends. Several weeks after his last visit with me, I received a call from his family telling me how fortunate they were to have avoided the COVID-19 vaccination. Thinking that I must have misunderstood, I pressed for details. They told me that they were on their way to get vaccinated, when their friend, a practicing medical professional, stopped by their house and talked them out of it. They felt very fortunate that she stopped them just in time...

The Delta variant was just starting to rear its ugly head. I threw everything I had into trying to convince him to get vaccinated: the best scientific arguments, the data on safety and effectiveness, the pictures of my teenage daughters getting the shots, all the work that we have done together to get to this point. To no avail: he was not getting vaccinated. I continued to see him.

The Delta surge was brutal in my hospital. ICUs overflowed, patients crowded in hallways, staff exhausted. Part way into it I got the dreaded phone call: my patient was in the ED and he had COVID. I went to see him. He did not look too bad and was his usual jokey self just with an addition of the high flow nasal cannula. I continued to see him.

His stability did not last long. His respiratory status deteriorated and along with it his liver function. He became more confused, swollen and stopped making urine. We started dialysis. After all, he was on the transplant list and was viable, right? He began oozing blood out IV sites. The ICU staff began giving me sidelong glances. He was in multi-organ failure and it was time to let him go. I continued to see him.

The next day I led the family meeting, COVID style. Me in full PPE, patient's family on the iPad and patient himself being kept alive with multiple machines. I went through the script and made him comfort care only. The family agreed as they agreed with my countless recommendations over the years. Except for the one for vaccination. He died within minutes of terminal extubation. I could no longer see him.

My PPE kept fogging up from the boiling volcano of anger inside of me. I cried tears of outrage and my tears temporarily cleared my field of vision only to fog up again. How could a member of my profession have caused this devastation by talking this fragile patient out of COVID-19 vaccination?

To quote Eleanor Roosevelt: "Freedom makes a huge requirement of every human being. With freedom comes responsibility." Freedom without responsibility is egoism. In the time of our county's great need, let us practice Eleanor Roosevelt brand of freedom.

GI WORD SEARCH

Answers to this word search can be found on page 12.

GI WORD SEARCH

Find all 12 GI terms below! They may be horizontal, vertical, or diagonal, including backwards.

A L S I S O L U C I T R E V I D R E O K D R
R L I T U R A E T S S I E W Y R O L L A M H
E E S G E E R O D I S E N T H R I A W T O F
O C A E Q R F E R D Y E N P S B T O C A S H
T H I F T S T O L P Y L O R U S S A R T M E
E T Y T E H S T A L I S R H K S N T A F T T
I E T N R N P L L H F R R I O T S P A A A U
U N I M I R I Z Z I S Y N D R O M E Y E O E
M A U I I B O B E T O T N E B T H A E L Y S
I P E T J B E U E R U S S I F L A N A G O A
S N S A C A P H E M N H S U T I E A V B O P
D I D I M L O P O I C P H C K H I T T I I I
I V E O G T C R E A L H A I U U I R Y T E L
I N P E E S A E S I D R E I R T E N E M W T
O I E S N R S E T E T R L R Y U B S E W R U
V H P O L A O E E E O T Y D S G U E O T L Y

Images in Clinical GI

Can you solve the case?

Welcome to Images in Clinical GI, where we present images from interesting cases submitted by some of our members! This quarter, we present a case from Dr. Aaron Yeoh, a GI fellow at Stanford. ***Answers and discussion on this case can be found on page 13****. We hope you enjoy!*

A 48-year-old man with a history of polysubstance use disorder presents with more than one year of diarrhea, abdominal pain and weight loss. The patient reports that approximately 18 months before presentation, he developed insidious onset of post-prandial non-bloody diarrhea which occurred shortly after meals and then progressed to more than 20 loose bowel movements daily. He subsequently developed diffuse cramping abdominal pain, a pruritic rash on his trunk, and a 65lb weight loss over 6 months.

At the time of admission, his exam was notable for a cachectic man with diffuse muscle wasting, distended abdomen with tenderness to palpation, 1+ lower extremity edema, and pruritic papules on his trunk and extremities. Initial laboratory studies showed a WBC of 9.2, Hgb 6.3, Plt 202, Na 131, K 3.2, CO2 17, Cr 1.0, Albumin 1.4 and otherwise normal liver enzymes and liver function tests. Soluble and insoluble vitamin levels were below normal levels. Fecal calprotectin was 17, CRP 4.8, ESR 40. Stool infectious studies were positive for yersinia enterocolitica, and he was treated with ciprofloxacin which did not improve his diarrheal symptoms. His 24 hour alpha-1 antitrypsin was markedly elevated at 204ml/24hr (normal < 50). CT Abdomen Pelvis showed enlarged mesenteric and pelvic lymph nodes and trace ascites. EGD and colonoscopy were performed with biopsies taken of small and large bowel (Figure 1) and special stains were performed.

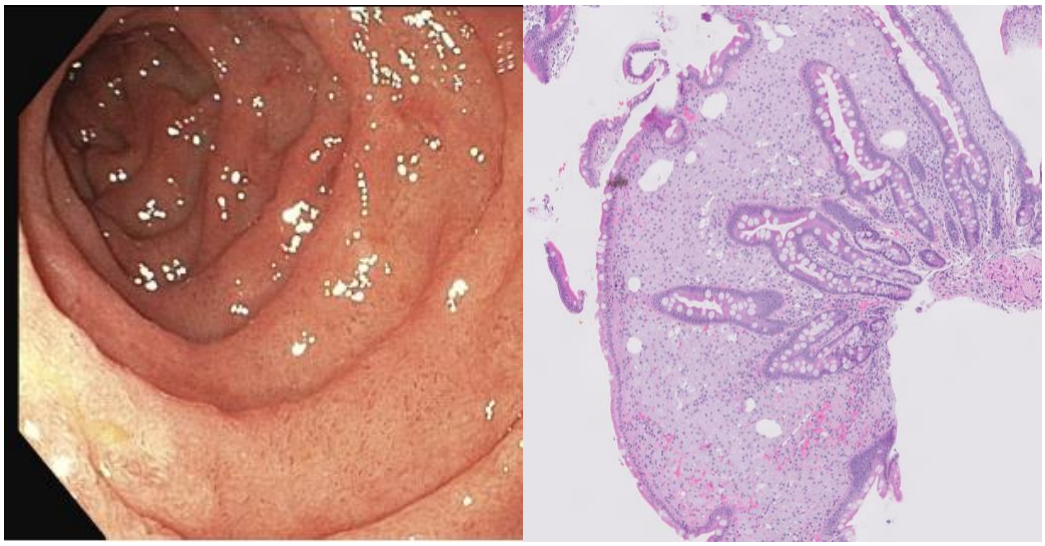


Figure 1: Endoscopic view of second portion of duodenum (left panel) showing mild congestion and erythema. H&E stain of duodenal biopsy (right panel) show villous blunting and expansion of the lamina propria.

What is your differential diagnosis? What additional stains might you perform?

If you have any interesting cases you would like to share or suggestions for this section, please contact us at: NCSCG@pacemedcom.com

Anastasia C (Ana) Waetcher, MD is a staff physician at UC Davis Medical Center. She practices general gastroenterology which involves caring for a wide variety of common GI illnesses, including gastroesophageal reflux disease (GERD), esophageal motility disorders, functional dyspepsia, irritable bowel syndrome (IBS), celiac disease, chronic constipation, functional abdominal pain and small intestinal bacterial overgrowth. She also participates in educational activities for medical students, residents, and GI fellows.

How to approach irritable bowel syndrome by Ana Waetcher, MD

Irritable bowel syndrome (IBS) is a common chronic disorder of the gastrointestinal (GI) tract characterized by chronic abdominal pain and altered bowel habits in the absence of an identifiable cause. The estimated global prevalence is approximately 11%, with a higher prevalence in younger individuals and in females. It accounts for significant health care costs and economic burden due to work absenteeism.

The pathophysiology of IBS remains to be elucidated but is believed to be multifactorial and related to abnormal GI motility, visceral hypersensitivity, intestinal inflammation, alterations in fecal microbiota, underlying food sensitivities, and/or a postinfectious phenomenon in a genetically susceptible individual. Psychosocial factors may influence the expression of IBS symptoms.

Abdominal pain in IBS is typically described as cramping sensation with variable intensity and periodic exacerbations and is frequently related to defecation. Altered bowel movements consist of diarrhea, constipation, alternating diarrhea and constipation, or normal bowel habits alternating with either diarrhea and/or constipation. IBS is diagnosed clinically, most commonly using the Rome IV criteria, as there is no lab test specific for IBS.

All patients with suspected IBS should undergo a history and physical exam and limited diagnostic testing to evaluate for presence of alarm symptoms concerning for organic disease. It is important to categorize IBS into subtypes based on the prevalent stool form (Bristol Stool Form Scale) as noted below.

Rome IV IBS Diagnostic Criteria

IBS is defined as recurrent abdominal pain, on average, at least 1 day per week in the last 3 months, associated with 2 or more of the following criteria:

- Related to defecation
- Associated with a change in stool frequency
- Associated with a change in stool form (appearance)

IBS-C (Constipation)	IBS-D (Diarrhea)	IBS-M (Mixed)
Type 1, Type 2	Type 5, Type 6	Type 1, Type 6

Type 1: Separate hard lumps • **Type 2:** Lumpy and sausage like

Type 5: Soft blobs with clear-cut edges • **Type 6:** Mushy consistency with ragged edges

Change in stool appearance must be >25% of stools to meet diagnostic criteria.

(Courtesy of Cabot Health, Bristol Stool Chart: https://commons.wikimedia.org/wiki/File:Bristol_stool_chart.svg.)

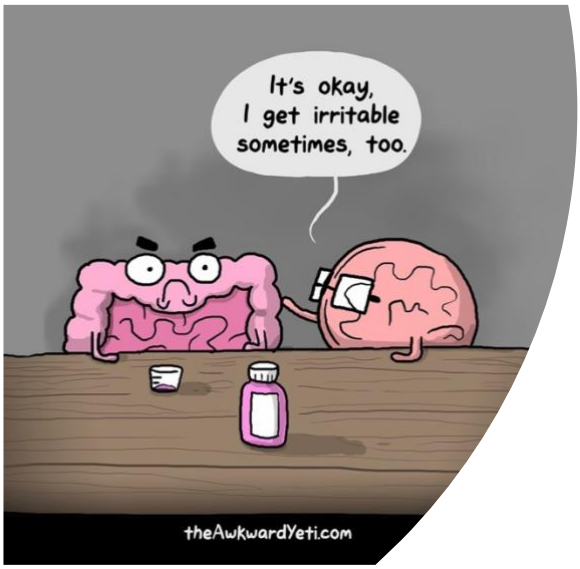
Diagnostic testing for suspected IBS with no alarm features can be divided into the subtype of IBS that the patient has. Alarm features include age of symptom onset > 50, blood in stools, nocturnal symptoms, unintentional weight loss, change in symptoms, recent antibiotic use, and family history of organic GI disease (colorectal cancer, inflammatory bowel disease). It is important that age-appropriate colorectal screening should be performed in ALL patients ≥ 45 years old.

IBS-D	IBS-M	IBS-C
CRP or fecal calprotectin TtG IgA + total serum IgA When colonoscopy is performed, obtain random biopsies to assess for microscopic colitis	CRP or fecal calprotectin TtG IgA + total serum IgA Stool diary Consider abdominal plain film to assess for colonic fecal loading	If severe or medically refractory constipation, recommend anorectal physiologic testing to assess for dyssynergic defecation

Make a positive diagnosis. Establishment of a therapeutic clinician-patient relationship and continuity of care is critical to management of patients with IBS. The first line therapy for mild to moderate disease include lifestyle and dietary modifications along with over-the-counter therapies targeting abnormal stool form and/or the most bothersome symptoms (abdominal pain, bloating). Recommend escalation to FDA-approved and validated therapies in patients refractory to first line therapies and in patients with moderate to severe disease that impacts quality of life.

Lifestyle modifications for IBS include dietary changes such as lactose-free diet in patients with lactose intolerance, low FODMAP diet, and gluten free diet. Activities such as exercise, sleep hygiene, minimize/eliminate alcohol also help. Medications options can be tailored to the subtype of IBS that the patient has. IBS-C medications include soluble fiber, PEG solution, lubiprostone, linaclotide, plecanatide, and tegaserod. You can consider loperamide, bile acid binders (eg cholestyramine), rifaximin, alosetron, and eluxadoline for IBS-D. For abdominal pain and discomfort, the options are antispasmodics, antidepressants (TCAs), lubiprostone, linaclotide, plecanatide, rifaximin, alonsetron, eluxadoline, and tegaserod. For bloating, the medication list includes rifaximin, lubiprostone, linaclotide, and plecanatide. Please note that soluble fiber, PEG solution, loperamide, bile acid binders, antispasmotics, and TCAs are not currently FDA-approved for IBS.

My approach to using antidepressants in IBS is dependent on the specific IBS symptoms that the patients have. TCAs can be used to treat abdominal pain in all subtypes of IBS and can help treat diarrhea in IBS-D. Anti-diarrheal effects are greater with tertiary amines (amitriptyline, imipramine) due to the greater anticholinergic side effects. Nortriptyline and desipramine (secondary amines) have fewer anticholinergic and antihistaminic side effects compared with amitriptyline and imipramine and are favored to allow higher doses to manage pain. The most common TCA side effects include: Dry mouth, drowsiness, blurry vision, urinary retention, dizziness, sexual dysfunction, weight gain, sweating, cardiac arrhythmias. I do check a baseline EKG prior to starting patients on TCAs. TCAs should not be used in patients with known bundle branch block or QT prolongation. TCAs should be started at low doses for 3-4 weeks initially due to delayed onset of action, then increased gradually based on tolerance and clinical response. Amitriptyline, nortriptyline, and imipramine can be started at 10 mg to 25 mg at bedtime. Desipramine should be started at 12.5 mg to 25 mg at bedtime. The standard dose that is required for symptomatic relief is anywhere from 25 mg to 100 mg daily. If the patient has anxiety, you can consider SSRI/SNRI therapy instead.



NCSCG 2021-2022 WEBINAR SERIES
ADVANCING CAREER DEVELOPMENT IN GI & HEPATOLOGY CLINICAL CARE

Dear Colleague,

The NCSCG Education and Trainee Committee is pleased to announce the CME Accredited NCSCG Education and Trainee Committee 2021-2022 Webinar Series. This year we are excited to collaborate with the Southern California Society of Gastroenterology (SCSG)!

About the NCSCG Webinar Series

The NCSCG Education and Trainee Committee Webinar Series aims to provide an education and career development focused resource for our GI community. Our series has been developed with gastroenterology and hepatology fellows from training programs in Northern California and incorporates sessions specifically focused on important aspects of career development and the job search process. In addition, our series will also include high yield and hot topics in clinical gastroenterology and hepatology. We offer these sessions as a free resource to anyone interested in participating.

To replicate a meal we would have together, the NCSCG would like to offer all NCSCG fellows who attend the webinars a meal up to the value of $30 to be eaten at the time of the webinar.

To receive your free meal during the webinar follow these easy steps:

1. Register for the event
2. Ensure that you are an NCSCG or SCSG fellow. You may register as a member or renew your membership by clicking here
3. Attend the webinar (attendance is monitored)
4. Order your meal for the time of the webinar up to the value of $30 and save the receipt!
5. Please turn on your webcam so that we can connect as we dine, converse, collaborate and learn together during this program
6. Fill in an expense reimbursement form sent after each webinar and submit this, along with your receipt to Dani Smith: dsmith@pacemedcom.com
7. Receive a check for the value of your meal, up to $30, mailed to you shortly after the event.

Sincerely,
The NCSCG Education and Trainee Committee

APRIL 21, 2022
6PM – 7PM PT
Updates on NASH Therapeutics - Anything on the Horizon?
Bilal Hameed, MD, UCSF

MAY 12, 2022
6PM – 7PM PT
C. difficile and FMT: The beginnings of microbiome management
Neil Stollman, MD, East Bay Center for Digestive Health

JUNE 9, 2022
6PM – 7PM PT
Research Seminar #3

TO REGISTER FOR THE ENTIRE SERIES AND FOR MORE INFORMATION, VISIT:
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Complimentary

View Past Recorded Webinars Now!
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ALAMEDA HEALTH SYSTEM

ADULT GASTROENTEROLOGIST PHYSICIAN: Oakland, California

The East Bay Medical Group (EBMG) is currently seeking a 6th full-time BC/BE adult Gastroenterologist to join the Division of Gastroenterology and Hepatology at Alameda Health System. This 1.0 FTE position is charged with serving the clinical and academic mission of the Division, the Department of Medicine, and Alameda Health System.

Alameda Health System (AHS) is a major public health system and medical training institution based in Oakland, CA (Alameda County). The system encompasses 3 hospitals – Highland Hospital (Level 1 Trauma Center), Alameda Hospital (Community Hospital), and San Leandro Hospital (Community Hospital) – and includes residency training programs in Surgery, Emergency Medicine, and Internal Medicine. East Bay Medical Group (EBMG) is a subsidiary of Alameda Health System and is the primary contracting entity for physicians.

The primary role of this position is to provide high-quality GI/Liver care to the underserved patients of Alameda County in both the hospital and ambulatory setting. Academic responsibilities are embedded within this role and include active participation in all teaching programs related to the Division and the Department. Teaching responsibilities include oversight of medical students, Highland Hospital Internal Medicine residents, and GI fellows who rotate from California Pacific Medical Center.

We are seeking candidates who:

- Are committed to AHS' safety-net mission of providing high quality care to the underserved.
- Are interested in being on a team that prioritizes a culture of continuous improvement, collegiality, respect, and support for one another.
- Are capable managing full spectrum GI and liver cases in both the ambulatory and hospital setting.
- Are proficient in both acute and outpatient endoscopy.
- Are capable and interested clinical educators and role models for trainees.

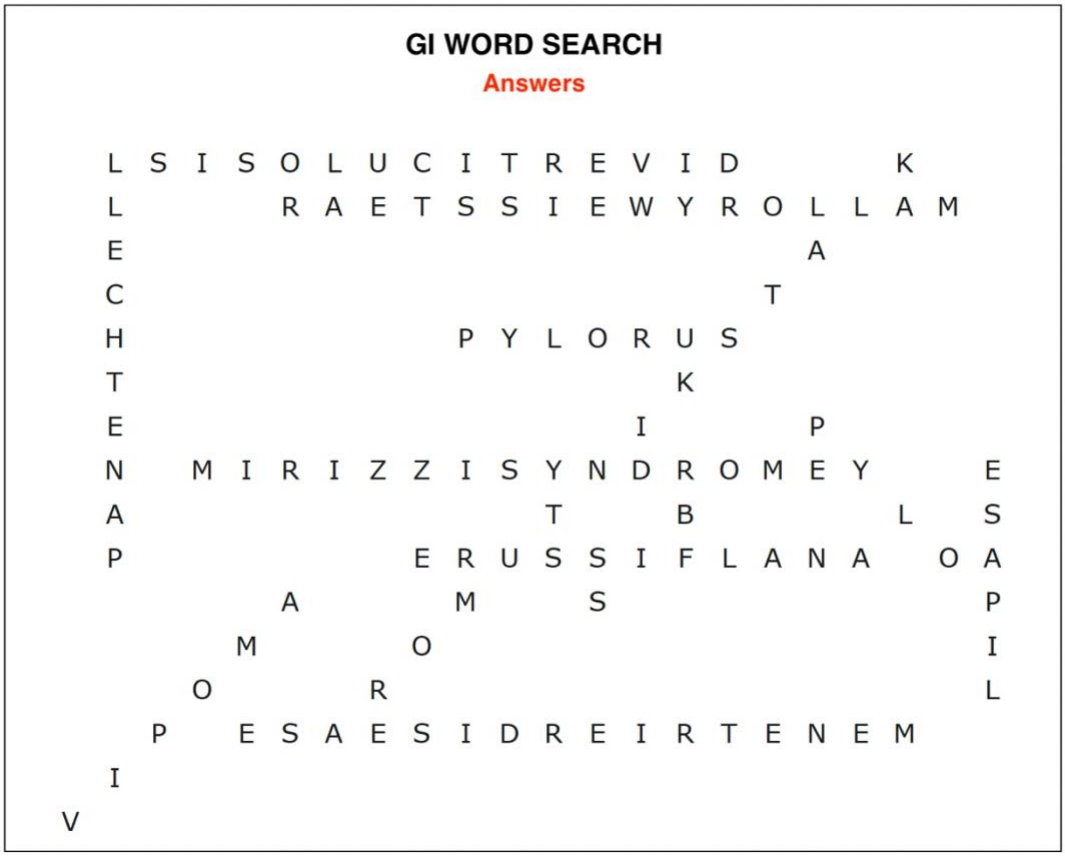
The ideal candidate would have proficiency in ERCP and EUS.

Compensation and benefits package is competitive for the San Francisco Bay Area.

For more information about the Division of Gastroenterology and Hepatology at Alameda Health System, please visit the Division website at: https://sites.google.com/view/highlandgi/about-us

If you are interested, please submit your CV and statement of interest to Dr. Taft Bhuket, Division Chief of Gastroenterology & Hepatology. tbhuket@alamedahealthsystem.org
Dr. Benny Liu, Associate Division Chief of Gastroenterology & Hepatology
beliu@alamedahealthsystem.org

GI WORD SEARCH SOLUTION



Images in Clinical GI

(Solution and Discussion)

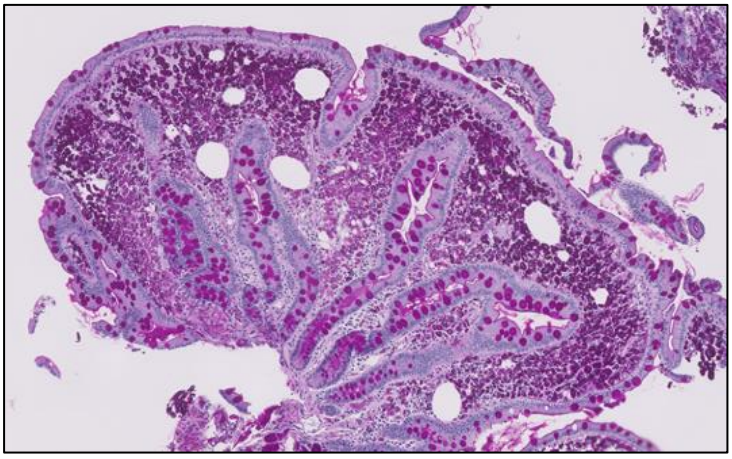


Figure 2: Periodic Acid–Schiff (PAS) stain of duodenal biopsies. Dark purple granules show PAS-positive macrophages.

Solution

Classic Whipple's Disease

Discussion

Whipple's Disease is a rare systemic illness caused by the organism *Tropheryma whipplei.* The clinical disease was first described by Dr. George Whipple in 1907, but it was not until 1992 that the organism was confirmed and named[1,2]. There have been fewer than 1000 cases of Whipple's Disease reported to date, with an expected incidence of 1-6 per 10 million individuals[3]. The typical patient is a middle-aged white male, consistent with the patient in this case. Site of infection is believed to occur in the gastrointestinal tract where organisms are engulfed by macrophages and then subsequently spread to other tissues. Diagnosis is made by biopsy (typically small bowel) with characteristic findings of gram positive, non acid-fast periodic acid-Schiff (PAS) stain positive bacillus within macrophages (Figure 2). DNA sequencing by PCR on fluid samples is another method for detection, but biopsy with staining is considered the gold standard[3].

Clinically, patients present with weight loss (80-99%), diarrhea (71-85%), and abdominal pain (23-60%)[3]. Other symptoms include arthralgias, rash, fever and neurologic involvement with CSF samples showing *T.whipplei* DNA on PCR. Labs often show a profound protein-losing enteropathy with hypoalbuminemia, as well as electrolyte and vitamin deficiencies.

Our patient was treated with the standard antibiotic regimen of Ceftriaxone IV for two weeks and then daily Bactrim double strength for one year. Within several months, the patient's symptoms had resolved, and he had regained 50 lbs. This case highlights a classic presentation of Whipple's Disease which is a can't-miss diagnosis in the workup of protein losing enteropathies with systemic symptoms including diarrhea, abdominal pain and weight loss.

References

1. Fenollar F, Puechal X, Raoult D. Whipple's disease. *N Engl J Med.* 2007;356(1):55-66.
2. Bentley SD, Maiwald M, Murphy LD, et al. Sequencing and analysis of the genome of the Whipple's disease bacterium Tropheryma whipplei. *Lancet.* 2003;361(9358):637-644.
3. Dolmans RA, Boel CH, Lacle MM, Kusters JG. Clinical Manifestations, Treatment, and Diagnosis of Tropheryma whipplei Infections. *Clin Microbiol Rev.* 2017;30(2):529-555.

Acknowledgements

Thanks to Drs. Gerald Berry and Emily Ryan from Stanford GI Pathology for providing the images used for Figures 1 and 2.

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 GI and Liver symposia. Complimentary membership is offered for fellows.

Click Here To Find Out More

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

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