

## 1: Program Book11 - [www.enganchecubano.com](http://www.enganchecubano.com)

*Stevens, P. D. and Eswaran, S. () Endoscopic Ultrasound for Biliary Disease, in Endoscopic Ultrasonography, Second Edition (eds F. G. Gress and T. J. Savides.*

Schedule at a Glance Disponibles en cantidad limitada. Carol Burke Dear Colleagues, We would like to invite you to join us for a groundbreaking, international educational event. For many years, the American College of Gastroenterology ACG and the World Gastroenterology Organisation WGO , have united on a number of activities and initiatives to advance the field of gastroenterology and hepatology, and ultimately, to improve patient care. This will be the first time in more than 0 years that the World Congress will be held in the U. The meeting will provide state-of-the-art education and science by a global faculty focusing on a world-view of GI and hepatology David Bjorkman diseases and treatments and will afford attendees an opportunity to present their research in an international forum. In addition, there will be hands-on endoscopy workshops, small group breakfast and lunch sessions with the experts, and sessions throughout the event that will offer simultaneous Spanish interpretation a first for a World Congress of Gastroenterology. Our goal is that the event will deliver a comprehensive clinical update on the latest in GI and hepatology, and build a sense of community as we all work to advance practice and patient care. Thrill-seekers will enjoy the numerous rides while movie fans can explore attractions based on their favorite characters. Orlando is a great vacation destination for adults as well as families with children of all ages. Getting to Orlando is easy. The Orlando International Airport has flights per day and is serviced by 40 airlines. It offers non-stop service from nearly 80 U. Make your plans now to attend. Registration and housing are open. We look forward to seeing you in Orlando! The app can be used to view faculty presentations on tablets, mobile devices, and laptops, and offers note-taking and highlighting capabilities. PDFs of the presentations can be printed or downloaded directly from the app. Pre-registrants will receive access to the app prior to the course, to view, download, or print the presentation slides. Internet access is required to download the app to a mobile device, and is required to access the slides on a laptop. Internet access is not required to use the app on a mobile device. A printed syllabus will not be provided. Wednesday, October 8 6: Limited quantities of headphones will be available. Pre-registration will remain open until Friday, October 6, After this date on-site registration will be required. Some sessions have limited space available. Pre-registration is strongly recommended. After this date, no refunds will be possible. Registration cancellations are not accepted by telephone. Refunds will be issued after the meeting. After this date, on-site registration will be required. Cancellation Written notice of cancellation and requests for refunds must be sent to by September 0, With the app, you will have full access to all available slide presentations for which you are registered. The app also contains a fully searchable schedule of events, list of program participants, oral and poster abstracts, maps, exhibit information, and more. The app can be used to view speaker slide presentations on tablets, mobile devices, and laptops, and provides note-taking and highlighting capabilities. Attendees can use the app to follow along with live presentations, take notes directly in the app, and review them after the event. Registrants will also be able to download and print PDFs of the slides directly from the app. No printed materials or USBs will be available. An Internet connection is required in order to view and use the laptop version of the meeting app, as this is a live website. The Convention Center will have complimentary WiFi in the meeting spaces. App for mobile devices: A WiFi or cellular data connection is required to download the app and download documents within the app PDF documents and presentations , but once documents have been downloaded inside the app, Internet is NOT required to use the app on an ongoing basis, access materials, and take notes. Information on how to access the meeting app will be ed to all registrants by early October. Exhibit Hall The science and technology of medicine is everchanging and advancing the practice of gastroenterology. Showcasing these latest advances in technology and therapeutics is the WCOG at ACG07 Exhibit Hall where more than 50 companies will display and demonstrate their products and services. Companies who exhibit include pharmaceutical manufacturers, medical instrument suppliers, research companies, technology companies, publishers, non-profit organizations, recruiters, and more. Employers have the opportunity to post jobs both in advance, and on-site in Orlando. Child care will take

place at the Hyatt Regency Orlando, the headquarters hotel. Food and drink are not included in the fee and are the responsibility of the parent s. About WGO Formed in and incorporated in , the World Gastroenterology Organisation WGO is a federation of over 00 member societies and 4 regional associations of gastroenterology, hepatology, and other related disciplines representing more than 50, individual members worldwide, focusing on the improvement of standards in gastroenterology training and education on a global scale. To learn more about the WGO, visit their website at [worldgastroenterology.org](http://worldgastroenterology.org). Child care service times are as follows: Saturday, October 4 7: Our mission is to advance world-class care for patients with gastrointestinal disorders through excellence, innovation, and advocacy in the areas of scientific investigation, education, prevention, and treatment. To learn more about ACG, visit our website at [gi.org](http://gi.org). About Orlando Plan your trip to Orlando, Florida. Book your room now through the official housing website. See page 8 for more information. We strongly recommend that you book your housing through this website. Orlando, FL Room rate: Department of State website. To apply, you will need the following: Embassy or with the U. Department of State on behalf of any conference registrant. The will outline the courses that you have registered for, as well as show proof of payment. If you do not receive this upon completion of your registration, please contact or call Letter of Invitation: Registrants applying for a visa to travel to the U. If booking through a travel professional or United Meetings at , please give them the following information: A service fee will apply when booking through United Meetings Reservations. There is no additional service fee when booking online. Please note that a Direct Ticketing Charge will apply for booking by phone. To reserve a rental car by phone, call , and provide the Avis Worldwide Code J All rentals are subject to a driver s license check and all drivers should be 5 or older with a major credit card. In addition to theme parks, visitors to Orlando will find a number of outdoor and sports attractions, as well as art museums and shopping. Highlighted on the following pages are just a few of the things to do and see in Orlando. Whether you are a Disney movie fan or not, you can t help but smile at seeing the many movie characters that have delighted millions of people for decades. New at Disney is Disney Springs, where you can enjoy shopping, dining and entertainment with your family. Here are just a few of the highlights of each of the Walt Disney World theme parks. Each park includes rides and attractions. You can when you visit Universal Orlando, the number one movie and TV-based theme park in the world. The Ride-3D, and more. In addition, there are more than 50 dining options, including character dining. Plus, learn about SeaWorld s efforts in animal care and rescue, as well as conservation. It s about an hour s drive from Orlando, so visit the Kennedy Space Center and take a tour to get an up-close view of the launch pad, the launch control center, the vehicle assembly building, and a history of Cape Canaveral, past and present. Orlando offers numerous art museums, shopping excursions, outdoor adventures, and of course, golf. There are more than 70 golf courses within an hour s distance from Orlando to choose from. Northwest Northeast If you are looking for attractions within driving distance of Orlando, you can also visit Central Florida locations such as Daytona Beach, home of the Daytona International Speedway, which is approximately one hour away. Augustine, Florida, is approximately hours away, and is one of the oldest and most historic cities of Florida. Founded in , St. If all you want to do is hit the beach, approximately one hour from Orlando are the beaches of Space Coast, home of the Kennedy Space Center. Also referred to as the Emerald Coast, Northwest Florida features numerous beaches and resorts. Jacksonville is the first major city as you enter Florida from the North. In addition to numerous beaches, Jacksonville also offers the Intercoastal Waterway, as well as a number of marshes and lakes to explore. Gainesville, Florida, is inland and about a 90 minute drive from Orlando or Jacksonville. It offers a variety of outdoor activities on one of the many lakes and rivers in the region. You can take a quick flight from Orlando to Miami to enjoy Miami s dynamic nightlife. If you want to explore the Everglades National Park, you ll find it south of Miami. In the Everglades, you can find camping, hiking and canoeing trails, ranger-guided programs and bird watching. From Miami, rent a car and drive down Highway to visit the Florida Keys.

**2: WORLD CONGRESS of GASTROENTEROLOGY in Orlando - PDF**

*Endoscopic ultrasound of the stomach and duodenum / Sarah Rodriguez, Douglas Faigel Gastrointestinal subepithelial masses / David Owens, Thomas Savides EUS for the diagnosis and staging of solid pancreatic neoplasms / Shawn Mallery, Kapil Gupta.*

Their leadership and inspiration have driven us to become advanced endoscopists. Edmund Bourke, Chair of Medicine for their unending support and to the GI faculty, trainees, Digestive Disease Center nurses, technicians and staff and to the administrative staff, especially Ms. Nancy Ruiz-Torchon for her tireless efforts in organizing this project. The first EUS prototype was designed and manufactured in the early s. Since that first prototype, endoscopic ultrasound has evolved into an accepted and valuable endoscopic modality and subsequently, a therapeutic modality for the management of many gastrointestinal disorders. EUS is now entering a new era in which the procedure is leaving the confines of specialized tertiary referral centers and academic institutions, and becoming disseminated in community based hospitals throughout the world. Additionally, the technology is now progressing from that of diagnosis and staging, to a more interventional therapeutic role. Our hope is that this 2nd Edition of Endoscopic Ultrasonography improves the training and dissemination of EUS by providing interested gastrointestinal endoscopists with an authoritative, yet practical, approach to the role of EUS in the management of specific digestive disorders. The primary purposes of this text are to first, allow a complete and thorough understanding of the current state of endoscopic ultrasonography and second, help guide the reader in learning both basic and advanced endoscopic ultrasound techniques. Both diagnostic and therapeutic applications of endoscopic ultrasonography are thoroughly reviewed. The target audience for this text includes all gastroenterologists and trainees wishing to know more about endoscopic ultrasound and its role in managing digestive disorders. This work will also be of interest to gastrointestinal surgeons, surgical residents, medical housestaff and internists, pulmonary physicians, and oncologists who deal with gastrointestinal malignancies. This 2nd edition brings many new and exciting changes and additions to the text including new chapters on the history of EUS, and several chapters on the emerging field of therapeutic EUS. Each chapter individually discusses a specific aspect of EUS as it relates to a particular gastrointestinal disorder or organ system. The experts who have graciously contributed to the book have identified up to date current references in their chapters and more importantly, have purposefully included their own particular styles, practices, and opinions as to how EUS should be performed. This individualized approach provides a diverse introduction to the role of EUS in gastroenterology today without obscuring key concepts in both the theory and performance of this procedure. They have contributed significantly to the field of gastrointestinal endosonography and have proven track records as clinicians, investigators, and educators. Their collective experience in applying endoscopic ultrasonography in the management of gastrointestinal diseases is unsurpassed. A tremendous amount of effort on the part of each individual author has led to this new 2nd edition. They are the true masters of gastrointestinal endoscopy. We are deeply grateful to them for their outstanding collaboration. The mass is nearly identical in echogenicity to the surrounding pancreas see Fig. Needle aspiration is performed using a gauge needle. A Cytology returns relatively bland, uniform cells DiffQuik stain which show characteristic positive staining for chromogranin B. The lesion is a complex collection of irregularly-shaped cystic components of variable size see Fig. The lesion is encapsulated. Surgical pathology demonstrates an encapsulated lesion filled with papillary excrescences. A complex mass is seen in the pancreatic tail with cystic see Fig. Needle aspiration shows evidence of squamous cell carcinoma x mag. The patient had a wellcircumscribed, hypodense pancreatic mass seen on CT interpreted as concerning for malignancy. There was a very remote history of acute pancreatitis managed at another institution. EUS demonstrated a 4. Diagnostic needle aspiration returned pasty material with cytology showing necrotic, acellular debris with crystalline structures. Diff-Quik stain at x mag. There is marked acinar atrophy, a mononuclear cell infiltrate with lymphocytes and plasma cells and marked fibrosis consistent with chronic pancreatitis. There are no ducts present. Plasma cells are stained positive by IgG4 brown pigment consistent with autoimmune pancreatitis. In their article, published in , these investigators described a prototype

echoendoscope assembled by attaching a transducer to a duodenoscope. Although images were obtained only in dogs, this work established the feasibility of EUS. As with nearly all seminal advances in endoscopy, EUS was basically an amalgamation of existing technologies. But in , the potential of this hybrid technology was scarcely apparent to anyone – probably including these first endosonographers, who did not expand on their demonstration of the feasibility of EUS. Neither of us can remember the exact date, but it was most likely Olympus was developing several new technologies, and Hiroshi offered me a choice between EUS and enteroscopy. The only other thing I recollect from that meeting is that, for some unknown reason, I did not ponder the choice very long before I selected EUS, largely because the idea of endosonography seemed especially intriguing; that it offered a greater challenge, but also a promise of a much wider range of prospective applications. I certainly gave little thought to, indeed did not appreciate, the formidable obstacles to the clinical realization of this potential, nor the investment of time and effort needed to reach this goal which was much more distant than I realized. Hiroshi did, in fact, lay emphasis on the obstacles, warning that the instrumentation was in the early stages of development a euphemism for crude, barely usable. Because of the scope and difficulty of the project, Hiroshi advised that Olympus proposed to work with two investigators in the United States actually the western hemisphere , the other being Dr Charles Lightdale in New York City, as well as a few individuals in other countries. I already knew Charlie, and thought him an excellent choice. As it turned out, this was the beginning of a long and rewarding professional association Endoscopic Ultrasonography, Second Edition Edited by F. Given the technical sophistication of present-day EUS systems, it is important to recognize that during the early years the viability of endosonography was far from certain. Until about , there was substantial skepticism concerning the future of EUS, even among those of us most closely involved with and committed to its development. The ample tribulations facing the very small cadre of nascent endosonographers became strikingly evident with the arrival of the first EUS system, a prototype in the truest sense. The protocol, essentially, had no hypothesis, other than the assertion that EUS was going to be a good thing. It listed almost every possible indication I could conceive, and minimized the risks, unknown in any case, to such a degree that I doubt it would be approved by any institutional research committee today. The major problems that had to be addressed in the beginning divided into four categories: More issues, some even more complicated, became evident over time. The prototype echoendoscope itself was, by modern standards, incredibly cumbersome. The electronic video endoscope had not been introduced into clinical practice, so that the prototype echoendoscope was a fiberoptic instrument; the optical endoscopic component consisted of an ocular lens and focusing ring coupled to a coherent fiberoptic bundle with another lens at the distal end of the insertion tube to focus an image on the bundle. The latter provided a limited, degree field of view, oriented obliquely at an angle of 70 degrees to the insertion tube. The ultrasound component of early echoendoscopes consisted of a transducer coupled to a rotating acoustic mirror at the distal tip of the insertion tube. In retrospect, this was the best choice because it seemed to simplify the problems of image interpretation. But this arrangement also had its limitations, mainly that it was unsuitable for guiding a needle to a target. Needle aspiration was, in fact, attempted with the sector scanning instrument, albeit unsuccessfully because the width of the tissue within the circular scan was much too narrow. Unfortunately, the ultrasound imaging sector provided by the first instruments was not a full degrees, but only degrees. To obtain a complete, circumferential sector scan of the surrounding tissue, a circumferential esophageal tumor for example, it was necessary to rotate the insertion tube degrees while maintaining the same scanning plane. This was a considerable feat, especially with the instrument deeply inserted, for example in the third part of the duodenum. In truth, it was largely impossible because any application of torque to the insertion tube invariably altered the scanning plane. This was but one among many difficulties. Owing to the mechanical components, principally the motor and its housing, the instrument was much heavier than a standard endoscope. Because EUS had no established clinical purpose, the first procedures can only be described as exploratory. Consequently, procedure length was determined largely by patient endurance, and with an especially tolerant patient, the weight of the instrument seemingly increased exponentially. After two or three examinations, often it was difficult and painful to straighten your left arm. The combination of optical and acoustical components at the distal end of the insertion tube conferred other penalties including some potential hazards.

The diameter of the insertion tube was 13 mm, i. To make matters worse, the distal end was rigid over a length of 4. Together with the limited field of view, this increased the difficulty of inserting the instrument through the mouth and pharynx and into the esophagus. Although we assumed that the risk of complications with EUS was no greater than that associated with upper endoscopy, and so informed our patients, in reality the risk of perforating the pyriform sinus was probably greater by comparison, a fact subsequently substantiated. Moreover, attempts at insertion of the large-diameter 2 echoendoscope through a constricting tumor in the esophagus were no doubt associated with an appreciable risk of perforation. In addition to developing technique for insertion of the echoendoscope safely, the learning curve for EUS imaging can only be described as long and steep, a line with a slope approaching straight up. The first quandary was the need to uncouple endoscopic imaging from ultrasonography. This related to the need for acoustic coupling; i. But this proved impractical for several reasons. However, it was not simply a matter of choosing between these two options. Depending on circumstances, including location within the gastrointestinal tract, one or the other was usually a better choice. With the balloon method in particular, the endoscopic view was lost as the balloon was brought into contact with the gut wall, meaning that ultrasound imaging could only proceed by abandoning the endoscopic view. For technical reasons, therefore, EUS imaging was, of necessity, endoscopically blind. Use of the balloon with early model echoendoscopes was so exasperating that it deserves a digressive paragraph of its own. The latex material that constituted the balloon was not of uniform quality, which made it nearly impossible to place the balloon on the echoendoscope without tearing it. When expanded, the balloon had an asymmetric bulge, and according to the instructions the bulge was to be placed over the transducer on the same side as the optical component; this was never accomplished. Assuming that the balloon could be maneuvered intact into correct position, it was next necessary to tie it in place with small sutures. The design of the instrument was such that the proximal end of the balloon sometimes occluded the opening of the channel for air insufflation and water irrigation, which would not be evident until it was securely tied in place and tested. Subsequent attempts to nudge the balloon into proper position usually resulted in tearing. Since the objective was to create a water-tissue interface, it was necessary to remove all the air from the balloon without breaking it. The balloon, if not placed exactly, could occlude the tiny diameter channel provided for this purpose. Once all of the delicate parameters were attained, and the balloon was in gloriously correct position and functioning properly, the most maddening occurrence was rupture of the ill-fated bag in the middle of an examination, usually at the most inopportune moment. I dealt with some of these frustrations by persuading a gentleman from the biomedical engineering department designated the balloon man to take on the task of balloon placement prior to each procedure. Chapter 1 Endoscopic Ultrasonography at the Beginning: Unfortunately, this design meant that the attached syringe protruded in perpendicular fashion. Accordingly, as the endosonographer moved his right hand from the control section to the insertion tube, he invariably broke the syringe.

**3: Endoscopic ultrasonography**

*In recent years, endoscopic ultrasonography (EUS) has emerged as an important tool for the diagnosis and management of pancreaticobiliary disease.*

By checking a box at the bottom of the page, you acknowledge that you have read and accept the TOS. Those crafted by the really expensive lawyers have two check boxes—the first indicating that you agree with and accept the TOS, the other that you indeed have read the words to which you assent. Does anyone without a certifiable DSM-5 [Diagnostic and Statistical Manual] I disorder go through the ponderous legalese before checking off the box that says he or she has done so? Furthermore, have there ever been negative consequences to such gross dishonesty? Naturally, obtaining consent and obtaining a consent form are different animals entirely. Although few if any anesthesia lawsuits hinge exclusively on the lack of a consent form, the absence of one may hurt a defendant accused of other misbehavior. Should a lawsuit arise for an unrelated cause, those smart, really expensive lawyers certainly will use a poorly written Now available! Kron is an anesthesiologist in Hartford, Conn. The anesthesia consent form has come a long way since my residency. Back then, it simply did not exist. Of course, we discussed anesthesia with patients during the preoperative visit. But because the surgical consent included a line that anesthesia would be administered, a separate written consent for the receipt of anesthesia was deemed unnecessary. The surgeon or anesthesiologist pretty much dictated the type of anesthesia, so the conversation tended to be one-sided. If my plan conflicted with their preconception, I would need to convince them of the benefits of my approach. Yet I did not need their signature. After a decade or so, in response to some outside review, we decided to add a line signed by the anesthesiologist testifying to the fact that he or she discussed anesthesia, possible complications and alternatives with the Conscious continued from page 5 Three ways to download: Read the 1 gastroenterology publication. No patient required atropine or ephedrine. There was still no requirement for the patient to sign. This was a bit of an adjustment for those of us who were not sure how to discuss complications. Conventional medicolegal wisdom says that you need to mention common but minor and rare but catastrophic ones. So, do you tell them that they may get a little sore throat, a bit of nausea and oh, by the way, you might die please sign at the X? Our most recent consent form is by far the most thorough I have ever seen and has been made the standard for all the members of the mega-hospital conglomerate to which we belong. It is similar to but even more complete than the form on the website of the American Society of Anesthesiologists and covers every possible issue that could arise. Of the hundreds of patients I have asked to sign this document, none—not one—has hesitated. Some of the reluctance is no doubt due to the same lack of interest I have for reading the TOS discussed above: In my dealings with genuinely sick patients having major procedures, I have found that they and their families generally do seem to appreciate the potential hazards of anesthesia and a signature at the bottom of the page is a true acknowledgment of that. Explaining to these folks that propofol is a great drug that will quickly sedate them and allow for a rapid and nausea-free emergence, but may cause apnea or an obstructed airway, can be tricky. It also violates the prime directive: GI to the Rescue: Surgical Considerations The Biliary System: A View from the Inside Infection Control: Is That Scope Really Clean? Check online at [www](http://www). My response is to agree, again offer to tell them the risks, and if and when they refuse, make a few lawyer jokes and off to sleep. Often, there is the complaint that the document is too long and wordy and written in an illegibly small font. Siegel has witnessed and participated in the meteoric advances in gastrointestinal GI endoscopy from the primary stages of examining most of the GI tract to treating most of the disease affecting that system as alternatives to surgery, and he is a leader in the field of endoscopic retrograde cholangiopancreatography ERCP for the management and treatment of pancreaticobiliary diseases. Siegel as he reflected on 40 years of changes in endoscopy, the global reach of the gastroenterology community and emerging therapeutic capabilities. Schindler Award mean to you? My residency in gastroenterology was at Columbia Presbyterian Medical Center [in New York City], where I had two mentors who influenced me tremendously: Charles Flood and Henry Colcher. Flood was part of the first group to be certified in gastroenterology in when it became a specialty, and he was one of the founding

members of the organization that became the ASGE. And Colcher, who was also very active within the group, invented the flexible endoscope, which was nothing more than a flexible fiberglass chain of tiny lenses in a hose. So it was very sentimental and symbolic to me that my former mentors were all recipients. It is exactly what Dr. He was always bringing new technology to the field, and he was one of the first to realize that a lot of what we were doing could be done endoscopically. He would even draw his own pictures after endoscopic procedures because there was no photography. Other surgeons and other jealous competitors criticized him, but eventually some of his advancements became the standard of care. Things are always evolving. How does teaching affect your understanding of the field? And when we were in London. You treatment, which is arguably one of the best Medical Schools in Vietnam, and really need to be extra cautious because of the more complex areas to treat the most important thing is always treatment within gastroenterology. What drew you to have spoken at countless international meetings. How about the patient. After my fellowship in outside of the United States? Then we In the beginning, the influence of other countries, so we know that they were confident applied what we learned to other areas—doctors—primarily Asians, Germans to spread the training that they had problems in the esophagus, mucosal and the Dutch—was very instrumental received from us.

**4: Endoscopic ultrasonography | Open Library**

*Find now Endoscopic ultrasonography edited by Frank G. Gress, EUS for biliary disease / Peter Stevens, Shanti Eswaran Digestive System Diseases.*

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**5: September by McMahon Group - Issue**

*Endoscopic retrograde cholangiopancreatography (ERCP) is the diagnostic procedure of choice in patients with biliary strictures and no culprit mass lesion on abdominal imaging, but it is limited.*

To ice qual dy on top of our endosel of serv alrea built wed the gaps mod believe we are: When we this we follo t would h Flexner gists who consider decades, Tha althoug ssary e matters, the past two scopy vendors. Cos ety, gove matters mus the consume ssment, foot units closa lack of all ing soci ist in solo Group, PC Nichola i. The current th care munity al prac ent, the vidual applyin of heal In cal com nal issues that At pres The tradition and indi le value. These chan , as they were physici valu as a bus pted pitals, been man corporate Am quality and the state ations for chan widely acce operate fare. Tha the Flex fit well with Whereas mos dem colpublic. Another ram combine U. Osle ate and sured. Flex ority of MD a pubr agreed: If thes, it is necessar g subjecte cafeteria of best emb business as they this: Hea ires requisite re to both the hospital for fear of bein care the ing. Physiades will become Dr. Am to the Era of savvy. When reading this interesting study published in The New England Journal of Medicine NEJM , one is left with the impression that there are more data in the study that were not put in that would have been very interesting and relevant, including: We can hire MBAs, but our role in life is to give empathetic and competent care, one patient at a time. The conjecture of the effect of polypectomy is therefore left as just that, and again it is surprising that NEJM M did not question the conjecture statement. Balance seems reasonable, but like a tuxedo, it is not quite natural. That is not because I find other things more interesting or challenging. Rather, it is because other arenas of human discourse have ways of influencing how I think about what is most important to me, namely medical care. Take, for instance, the history of the presidents. History is a funny thing. Rather than being a static appraisal of the past, it is quite like medicine in that it is constantly being revisited and corrected as new information percolates through parchment archives. The life of Thomas Jefferson is a telling example. The reaction of the academic history gaggle was swift and harshly critical. One might have thought that the religious affiliation of the pope had been challenged. Jefferson did not have a personal, private, intimate life with Sally. Thomas Jefferson and Sally Hemings had an intimate relationship and progeny. I enjoy history for itself and for how it informs medicine. Surgery sits on top. In truth, we spent an embarrassing two decades believing that mesalamine was a good treatment for the disease. Yet for more than a decade, mesalamine and its variations have remained at the base of the pyramid. It remains as the second pyramid tier. The AGA is softening the importance of short- and long-term risks, as well as the current reports that this class of drugs is no better than placebo in preventing relapses. All that remains for this group of medications is that they improve clinical effectiveness and reduce immunogenicity of the biologics and maybe, just maybe, reduce postoperative relapses. This point has not been investigated with rigor. As of this moment, the scientific data should require us to dismantle the holy pyramid. Surgery could be a pat of butter seated on top. The other drugs can receive their useful boutique mention. Regarding the October Gastroenterology publications, experts offer that the immunomodulators will remain in use because the biologics are too expensive. Astonishingly, such comments imply that practicing gastroenterologists should offer patients placebo and indeed dangerous care because effective treatments are too expensive. What would the genius, philosopher-politician Thomas Jefferson advise? The biologics are indeed expensive. However, it is not all the fault of the pharmaceutical industry. Big Pharma has recognized the problem to some extent. Programs exist to aid patients with limited incomes, high copays or no insurance. There are, of course, numerous reasons for this; but it has to be said that many gastroenterologists do not take the time or extend the required effort to provide successful enrollment for their patients. If they did, the cost issue would be blunted. The most vigorous tack is to work directly with i. Why would the companies do that? Consider that the biosimilar biologics will be here in probably a few years. In Europe, the first equi-effective biosimilar has been approved for the treatment of rheumatoid arthritis. If the prices were cut now for the originals, any merit of the marketed biosimilars would be dampened if not eliminated, and more patients could be given effective medications now. This would be a win-win situation for patients and for the current drug makers who would enjoy an even higher market share over the

biosimilars. These companies have made blockbuster profits over the past 15 years and have worked constructively with the gastroenterology community. Finally, the gastroenterology leadership can work with biosimilar drug companies and the FDA in order to ensure a fast-track program of approval. Actually, these drugs already are in fast-track mode. If we do nothing, I will be ashamed because it will reflect a lost opportunity for our specialty to very effectively honor a serious commitment to our patients. If the drug companies do nothing, I will have a good memory when the biosimilars come to the market. I am no genius, but I know the difference between placebos, pyramids and pancakes. Only the last has a taste of merit. Costrini can be reached via email at ncostrini@georgiagi.com. The Patient Component Lawrence B. The adequacy of bowel preparation should be assessed after efforts to clean the mucosa during examination have been completed. Colonic lesion detection rates according to preparation quality. Impact of colonoscopy preparation quality on detection of suspected colonic neoplasia. Factors Related to Poor Colonoscopy Preparation Identification of factors that could predict poor colonoscopy preparation would help target additional education or proactive interventions toward the appropriate population. Nguyen et al studied consecutive patients who underwent screening colonoscopy and who were instructed to use a standard preparation of 2, mL of polyethylene glycol bowel preparation. They determined that factors associated with inadequate bowel preparation included obesity odds ratio [OR], 1. What interventions might help improve the quality of bowel preparation in these patients? One important determinant of bowel preparation success is the type and degree of communication when instructing patients regarding a bowel preparation regimen. Furthermore, each aspect of the bowel preparation, including timing, dietary restrictions with specific examples, expected side effects, and office contacts in the event that the patient has questions, should be reviewed explicitly and in detail. All members of the clinical team and office staff, including nurses, medical assistants, and appointment schedulers, should be prepared to answer questions and guide patient efforts during clinical visits or when contacted by patients with questions or requests for guidance. Durable educational materials and instructions with simple checklists can be useful. The booklet also contains a Supported by.

### 6: The American Journal of Gastroenterology via [www.enganchecubano.com](http://www.enganchecubano.com)

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