Submission Date	Submission Time	Question
05/27/2022	09:09:56	IMPEDANCE TESTING?
		https://www.uofmhealth.org/conditions-treatments/digestive-and-liver-health/Esophageal-24-hour%20pH-impedance-reflux-monitoring
05/27/2022	09:22:39	Can you clarify which option is the best initial test to perform for achalasia (EGD vs manometry)?
		if achalasia is suspected, manometry is the test of choice
05/27/2022	09:29:34	What are the appropriate tests for eradication of H. pylori?
		Stool antigen or urea breath test
05/27/2022	09:31:27	if urea breath test and stool Antigen are given as choices, which do we pick?
		The boards will not ask you to choose between two options that would both work.
05/27/2022	09:32:39	would you ever do swallow test without doing the manometry?
		I think of a swallow test being done by SLP (speech and language pathology) for folks who I think may be aspirating etc to look for that. A manometry test is done to look for motility disorders like achalasia etc
05/27/2022	09:33:38	if person on PPI, does breath test work? or you must do stool antigen test?
		It does impact the sensitivity of the test-- and ideally you would ask a patient to discontinue for 1-2 weeks depending on your center prior to doing the test. This is nuance though beyond what the boards would ask about but important limitation to be aware of in clinical practice.
05/27/2022	09:36:20	I do believe that in the last ACP meeting they are no longer endorsing the use of clarithromycin based H pylori treatment because of resistance—- correct? Could you please confirm. Thanks
		Per reference we can find-- nationally response to clarithro based triple therapy is below 80% and can be limited by clarithro resistance-- has not been removed as an option but important to be mindful of clinically.

05/27/2022	09:37:51	if someone has PUD from NSAIDs or aspirin, does this mean must stop these meds indefinitely? or can they restart once treated (PPI) and asymptomatic?
		This depends on the clinical situation and informed conversation with the patient-- the preference from a GI standpoint might be to avoid these meds but if that results in pain and impaired QOL than may need to be considered in the greater context of the patient.
05/27/2022	09:37:54	Not long ago, PPI's were charged with causing memory loss. Is this a real concern?
		Although some studies have found a significant association between use of PPIs and incident dementia, others have not found an association between PPI use and cognitive function. The association between PPI use and dementia may reflect residual confounding by factors related to both use of PPIs and the development of dementia.
05/27/2022	09:39:26	can you see either microcytic or macrocytic anemia for chronic gastritis (depending on dutrition deficiency)?
		You could-- assuming you are thinking Fe def for micro and B12 or folate, liver disease etc for macro. Or normocytic because of the two populations with a high rdw. Again -- nuance that would be very hard to test in a high stakes setting like the boards.
05/27/2022	09:42:17	What's EMAG and CAAG stand for on slide 60?
		Environmental metaplasia atrophic gastritis (EMAG) and chronic autoimmune atrophic gastritis (CAAG)
05/27/2022	09:48:26	When do you recommend to pt taking ASA 81mg daily as primary prevention for cvd?
		The population this is recommended for has been shrinking over the years-- the current ACC/AHA recommendation is that the ASA should be used infrequently in the primary prevention of ASCVD.
05/27/2022	09:51:05	For Question 9, the reason we say this is an outlet obstruction is because of the vomiting itself? Couldn't this be a gastritis as well, rather than outlet obstruction?
		Agree the N/V is concerning-- as a constellation of symptoms paired with early satiety and postprandial bloating there are concerning features here which is what warrant endoscopic evaluation (which could also differentiate between obstruction and gastritis)
05/27/2022	10:16:10	please comment on chronic steroid use and risk for PUD

		Glucocorticoid use is associated with a nearly twofold increased risk of a Glucocorticoids increase the risk for adverse gastrointestinal effects, such as gastritis, ulcer formation, and gastrointestinal bleeding. NSAIDS and steroids together are especially problematic. The use of NSAIDs and glucocorticoids is associated with a fourfold increased risk of a gastrointestinal adverse effect compared with nonuse of either drug.
05/27/2022	10:30:07	what does "PSC" mean in these slides?
		primary sclerosing cholangitis
05/27/2022	10:46:28	Can you please comment on the role of calprotectin ?
		Fecal calprotectin or fecal lactoferrin – Fecal calprotectin levels are increased in intestinal inflammation and may be useful for distinguishing inflammatory from noninflammatory causes of chronic diarrhea. If fecal calprotectin and fecal lactoferrin are normal, a diagnosis of IBD is unlikely. If fecal calprotectin or fecal lactoferrin levels are above the reference range, then proceed with endoscopic eval with biopsy to confirm the diagnosis of IBD
05/27/2022	10:48:09	can you also give stool softener for anal fissure?
		treating underlying constipation and avoiding straining is important for fissures to heal. for anal fissues, initial therapy with a combination of supportive measures (fiber, stool softener, sitz bath, topical analgesic) and one of the topical vasodilators (nifedipine or nitroglycerin) for one month, rather than surgery, is recommended.
05/27/2022	10:53:10	What is currently the role of breath testing for FODMAP's intolerance?
		Educating folks about FODMAPs (there is an app that also can be helpful here for folks to use) makes sense and if this is helpful then we usually recommend a consult with a dietician who can help with further education. If folks do not improve with elimination of FODMAP foods, then further workup would be indicated.
05/27/2022	11:18:21	Do patients need to hold antiplatelet therapies before routine screening endoscopy?
		The decision of whether to stop antiplatelet agents or anticoagulants must take into account the procedure-related risk of bleeding and the risk of periprocedural thrombosis but in general, aspirin and nonsteroidal anti-inflammatory drugs can be continued safely in patients having an upper endoscopy

05/27/2022	11:21:13	for Upper GI bleeding, would you try to give reversal agents for anticoagulants?
		The approach to management of anticoagulants and antiplatelet agents depends on the medications being used and their indications, how severe the bleeding is, and how quickly reversal of anticoagulation is needed. For most patients, endoscopy should not be delayed because of anticoagulant or antiplatelet agent use. Provided the patient is hemodynamically stable, urgent endoscopy can usually proceed simultaneously with management of antithrombotic medications. When possible, anticoagulants and antiplatelet agents should be held in patients with acute upper GI bleeding. In patients with severe, ongoing bleeding who are taking an anticoagulant, administration of a reversal agent or intravenous prothrombin complex concentrate may be indicated. However, the thrombotic risk of reversing anticoagulation should be weighed against the risk of continued bleeding without reversal, and thus the decision to discontinue medications or administer reversal agents needs to be individualized.
05/27/2022	11:53:08	for US of acute cholecystitis, how sensitive is the sonographic murphy sign?
		numbers quoted are 50-60% -- a bit better than the flip of a coin.
05/27/2022	11:54:19	what is the abnormal CBD dilation size?
		Depends on age-- one rule of thumb out there would be dilated is above 4 mm at 40, 5mm at 50, 6mm at 60.....
05/27/2022	11:57:17	indications of when to use antibiotics during acute pancreatitis?
		if you have clinical suspicion of infection-- these patients can develop infection beyond the pancreatic bed as well (i.e., PNA, blood stream infections, etc). Infection of a the necrotic bed of the pancreas is generally not an acute event-- and more commonly happens 7-10 days out.
05/27/2022	11:58:40	If only biliary sludge was found on gallbladder ultrasound during an acute pancreatitis episode, would that be considered biliary pancreatitis, and would a cholecystectomy be indicated?
		this is likely a conversation that will require input from your surgical colleagues but a situation where asking them to evaluate the patient would likely be beneficial.
05/27/2022	12:00:40	Could you please explain what in the Q22 question stem pointed toward patient being high risk and requiring MRI/MRCP? Or is it appropriate to order MRI for all patients with diffuse thickening of GB wall?

		The asymptomatic nature of the diffuse gallbladder thickening-- none of the other answer choices provided would be helpful in the evaluation of why that thickening is present--- and delay to repeat the US to look at this may delay the diagnosis if due to malignancy.
05/27/2022	12:02:38	can you repeat again whey it is important to feed within 3 days of acute pancreatitis? something about stone/obstruction?
		Helps to maintain the intestinal barrier and prevents translocation of bacteria.
05/27/2022	12:05:00	do we need to memorize the HBV screening interpretation??
		This is generally considered a testable concept
05/27/2022	12:06:09	i believe the enzyme immunoassay for HCV antibody have false positives? if so, why?
		Most commonly talked about in those recovered from Hep C-- but unlikely to show up as a scenario on a high stakes exam like the boards.
05/27/2022	12:08:22	Which is high which is low FIB score ?
		the lower the number the lower the fibrosis stage
05/27/2022	12:09:13	Is DM contraindicated for prednisolone for acute alcoholic hepatitis? IF not, what is an example if a "predisposition for infections"?
		No-- usually clinically done in consultation with GI colleagues based on clinical suspicion but not driven by specific guideline criteria.
05/27/2022	13:02:20	since osteomyelitis can now be treated with oral antibiotics, is that the same with infected joint prosthetics? Must it be IV or can we give oral for 6 weeks?
		Often depends on organisms involved and resistance patterns.
05/27/2022	13:02:53	would you have systemic symptoms if you have an infectious arthritis but a negative blood culture?
		You could.
05/27/2022	13:07:02	Classically, allopurinol is usually the wrong answer in the setting of an acute gout flare. Would you expect them to be nuanced to have "low dose" allopurinol as a choice?
		Unlikely-- would expect something that is first line-- colchicine, NSAIDs, or maybe intraartricular steroids -- or ? anakinra in the right scenario
05/27/2022	13:09:01	When you have 100000 wbcs in synovial fluid with positve crystals, do u empirically treat for antibiotics? If so for how long?

		this is unlikely to be on the boards b/c would not have a single right answer--clinically yes, you probably would and then use gram stain/culture results as additional data to determine next steps.
05/27/2022	13:10:03	do you see more OA with connective tissue disease?
		You may if the CTD results in malalignment and therefore additional strain on the joint.
05/27/2022	13:21:56	What is the appropriate steroid dose and duration of the high dose for GCA with visual symptoms ?
		Often doses of 500 to 1000 mg are used for the first 3 days-- and then switch to oral pred 1 mg/kg/day
05/27/2022	13:23:15	What is the appropriate steroid dose and duration of the high dose for GCA with visual symptoms ?
		unlikely that you will be asked about how to taper b/c often the approach is slow after a few weeks and if symptoms return then you need to take the dose back up and get consultation if you have not yet.
05/27/2022	13:25:35	Is granulomatosis with polyangiitis what we used to call Wegener's granulomatosis?
		yes
05/27/2022	13:37:02	What are our typical ranges for WBC count from synovial fluid for the various acute arthritides? Infectious vs gout vs osteoarthritic vs autoimmune
		Noninflamatory-- in the 100s, inflammatory 1000-10s of thousands, septic think about 100,000 or higher.
05/27/2022	13:38:18	are there particular dosing recs for pregabalin or duloxetine when treating for fibromyalgia? or is it like depression, treat to symptom?
		Duloxetine 20-30 up to 60 but often not with greater benefit. in general the goal is to treat to symptoms while minimizing side effects.
05/27/2022	13:39:08	how do the osteophytes look different than the cortical overhanging of gout on xray?
		Osteophytes are bony prominances at the joint line-- gout is a punched out lesion either way from the joint line or under the joint line.
05/27/2022	13:39:22	does plaquenil decrease risk of glomerulonephritis?
		no
05/27/2022	13:40:23	RPGN p ANCA and WEgeners C ANCA??
		RPGN can be in multiple types of vasculitis so would not associated with p-anca alone.

05/27/2022	15:14:41	Why do you recommend iron replacement qod instead of qd?
		often is better tolerated this way
05/27/2022	15:39:57	what does TACO stand for?
		Transfusion associated circulatory overload
05/27/2022	15:52:28	I do believe that in the last ACP meeting they are no longer endorsing the use of clarithromycin based H pylori treatment because of resistance—- correct? Could you please confirm. Thanks
		Directly from the ACG guidelines "Clarithromycin in triple therapy consisting of a PPI, clarithro, and amox or metronidazole for 14 days remains a recommended treatment in regions where H. pylori clarithro resistance is known to be <15% and in patients with no previous. history of macrolide exposure for any reason."
		It is noted to be a conditional recommendation with low quality of evidence (with moderate quality of evidence for the duration).
05/27/2022	16:34:57	could you please review the slide about HIT treatment about what to do in positive vs negative immunologic assays?
		Yes, please review. ..The slide is confusing. Negative immuno assay : "Stop treatment" --> I guess it should say Unlikely HIT to avoid confusion;
05/27/2022	16:35:05	is this PERC score something we need to know for board exam
		May be a bit of a stretch to expect one to memorize-- but is something one could look up to apply to a question stem if you were unsure of next steps.
05/27/2022	16:38:24	the PERC score if sat > 94 % would be 1 so why does that need a d dimer and is sat < 94% wiyld be 0 so then no fruther eval
		This slide is a little tricky b/c the right column is does not meet criteria-- so if the O2 say was not >94% then they would get a point.