A Conversation with Richard Kozarek, MD
PAGE 3

Pancreatic Center of Excellence
PAGE 4

Inflammatory Bowel Disease Center of Excellence
PAGE 10

Visit Us at Digestive Disease Week 2014
PAGE 15

Pictured left to right: Michael Gluck, MD, Shayan Irani, MD, and Vincent Picozzi, MD, Pancreatic Center of Excellence
Digestive Disease Institute at Virginia Mason

Virginia Mason’s Digestive Disease Institute optimizes patient care through innovations in research, education, and a multidisciplinary approach to treatment of digestive and liver diseases.

Areas of Emphasis

Education | Headed by Ian Gan, MD, the Digestive Disease Institute is developing curricula for new fellowships and preparing to transmit its annual live endoscopy continuing medical education course in September 2014.

Research | Led by Kris Kowdley, MD, unique investigations focus on hepatology, inflammatory bowel disease (IBD), anal fissures, endoscopy and liver cancer.

Quality Improvement | Director Otto Lin, MD, is leading analysis of gastric pacemaker outcomes, rectal cancer outcomes and colonoscopy complication rate data.

Innovation | Under the direction of Lily Chang, MD, the team is trialing per oral endoscopic myotomy (POEM) and hosting intimate patient education forums on digestive disease topics.

Centers of Excellence

NEW **Bariatric Surgery Center of Excellence** | Joining the Digestive Disease Institute in 2014, director Jeff Hunter, MD, is reporting on bariatric outcomes and developing multidisciplinary care pathways for postoperative weight gain and hypoglycemia.

**Esophageal Center of Excellence** | Director Donald Low, MD, is developing an esophageal patient support network and pursuing unique international collaborations with centers interested in improving esophageal cancer care.

**Inflammatory Bowel Disease Center of Excellence** | Director Michael Chiorean, MD, is analyzing immunizations in immunosuppressed patients and expanding a cross-institutional IBD journal club.

**Liver Center of Excellence** | Led by Kris Kowdley, MD, the center is offering FibroScan® technology for the first time to patients in the Northwest and continuing research on complex liver disease.

**Liver, Pancreas and Biliary Surgical Center of Excellence** | Scott Helton, MD, and his team are studying hepatocreatobiliary (HPB) surgical outcomes and analyzing the total cost of HPB surgical care and quality of life for pancreatitis patients.

**NEW Nutrition Center of Excellence** | Joining the Digestive Disease Institute in 2013, director Jonathan Stoehr, MD, PhD, is focusing on nutrition in the context of obesity, including medical management and implementation of national guidelines.

**Pancreatic Center of Excellence** | Director Vincent Picozzi, MD, is analyzing long-term survival data for pancreas cancer patients, while associate director Shayan Irani, MD, is focusing on reducing readmission rates and length of stay for pancreatitis patients.

**Therapeutic Endoscopy Center of Excellence** | Director Andrew Ross, MD, is leading live transmissions of cases to audiences around the world and exploring improvements in the flow and quality of complex endoscopic procedures.
Q. As you travel and consult with colleagues around the world, what digestive disease trends do you see across international borders? What wisdom do you gain from your peers?

A. Although disease states still vary globally, emigration and developing world industrialization are homogenizing us as patients. In the developing world, IBD and diverticulosis are increasing dramatically, while H. pylori, chronic viral hepatitis, intestinal tuberculosis, and other infectious agents have significantly greater presence in certain immigrant populations.

Two things are clear. First, spending for treatment of all medical disorders in the United States is higher than any other country in the world. Second, few countries or practices come close to the multidisciplinary care model of the Digestive Disease Institute, where clinicians from so many disciplines team up to care for complex patients.

I’ve learned that innovation is not a uniquely American concept, and that in fact, we can perform excellent care with fewer resources. I’ve also been reminded that truly caring for patients may be more important than the latest and newest technology.

Q. How has the creation of an Inflammatory Bowel Disease Center of Excellence affected treatment for IBD patients at Virginia Mason?

A. Virginia Mason has taken care of a huge IBD population for the past 40 years. We were the first to describe methotrexate use in refractory IBD and were on the forefront of using tumor necrosis factor (TNF) inhibitors and anti-integrin drugs for IBD patients who remained ill.

Raising IBD to a Center of Excellence has allowed us to recruit a superb director, Dr. Michael Chiorean, and assure several active clinical research studies in patients who are unresponsive to conventional therapies. The new center has also prepared us to integrate groundbreaking basic science and translational work performed at Benaroya Research Institute at Virginia Mason, which is the National Institutes of Health-funded center for the Autoimmune Alliance.

Q. What do you most look forward to in the near future?

A. Our current Centers of Excellence are firing on all cylinders. I’m excited to integrate our Bariatric Surgery Center into the Digestive Disease Institute under the leadership of general surgeon Dr. Jeff Hunter, and establish a Nutrition Center of Excellence under Dr. Jonathan Stoehr from our endocrinology department. The nutrition center will focus on gastrointestinal disorders such as malabsorption, maldigestion, IBD, non-alcoholic steatohepatitis (NASH) and pancreatitis, and both centers will reinforce the 21st-century reality that obesity and its health consequences may be our number one health concern today. The future is bright as both centers intentionally blur training lines and model an integrated approach to care, all for the benefit of patients.
Pancreatic Cancer

Treatment at Virginia Mason first transformed in the 1980s, with the shared vision of oncologist Dr. Picozzi, gastroenterologist Richard Kozarek, MD, and surgeon William Traverso, MD. “We possessed a similar philosophy,” says Dr. Traverso, which led to the design of the Virginia Mason Protocol. Today, Virginia Mason diagnoses and treats 200 to 300 patients per year with pancreatic cancers, about 30 percent of all patients diagnosed in Washington state. Patients and their referring physicians receive timely access, consultation and care-plan development within 48 hours.

Surgery and Neoadjuvant Therapy

Surgeon Scott Helton, MD, and the HPB surgical team perform the highest number of Whipple procedures and distal pancreatectomies in Washington, with the lowest mortality and complication rates and shortest hospital stays. “For pancreas cancer in particular, surgery represents hope for a cure,” says Dr. Helton.

Surgical resident Bart Rose, MD, recently reported in the Annals of Surgical Oncology the effects of neoadjuvant therapy on patients with borderline resectable pancreas cancer. Therapy was well tolerated and extremely effective for a subset of patients with low perioperative morbidity. Dr. Rose and team found that this combined approach was associated with favorable survival.

Pancreatic Center of Excellence

The Pancreatic Center of Excellence, led by oncologist Vincent Picozzi, MD, and gastroenterologist Shayan Irani, MD, improves treatment across the spectrum of pancreas disease. “Our program has a long history of dedicated teamwork with a personal emphasis that’s unequivocally focused on the patient experience,” says Dr. Picozzi, director.

Concierge Access and Supportive Care

Pancreatic cancer care at Virginia Mason begins with a “concierge” approach. Anna Gfeller, RN, pancreatic cancer nurse navigator, offers personalized attention to patients and
Sixty-four patients with borderline resectable pancreatic cancer started neoadjuvant therapy, and 48 percent were resected. Of the resected patients, 58 percent had positive lymph nodes, 48 percent required en bloc venous resection, 87 percent had a complete resection, and 10 percent had a complete pathologic response. Median overall survival (OS) of all 64 patients was 23.6 months compared to 14.4 months for unresectable patients. Twenty-five of the resected patients (81 percent) were still alive at a median follow-up of 21.6 months.

Effects of Neoadjuvant Therapy on Patients with Borderline Resectable Pancreas Cancer

<table>
<thead>
<tr>
<th>A. All Patients</th>
<th>B. Attempted Resection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival Probability (%)</td>
<td>Survival Probability (%)</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Median OS 23.6 months</td>
<td>Median OS 75% alive, median follow-up 20.4 months</td>
</tr>
<tr>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Number at risk 64</td>
<td>Number at risk 40</td>
</tr>
<tr>
<td>50</td>
<td>36</td>
</tr>
<tr>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Resected</th>
<th>D. Unresectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival Probability (%)</td>
<td>Survival Probability (%)</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Median OS 81% alive, median follow-up 21.6 months</td>
<td>Median OS 15.4 months</td>
</tr>
<tr>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Number at risk 31</td>
<td>Number at risk 33</td>
</tr>
<tr>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

This graph compares Virginia Mason registry data to the national SEER (Surveillance, Epidemiology, and End Results) Program registry, including patients who were diagnosed or received some or all of initial treatment at Virginia Mason. Sample size variance (867 VM/47,580 SEER) precludes comparative survival analysis. Definitions of SEER's staging guidelines can be found at http://seer.cancer.gov/statfacts/html/pancreas.html.

Meg Mandelson, PhD, (right) research and quality director of the Floyd and Delores Jones Cancer Institute, and business analyst Alicia Edwards, have started to identify Virginia Mason’s survival outcomes in both American Joint Committee on Cancer and SEER terms. They are also helping to develop universally accepted national benchmarks for survival in pancreas cancer.
Benign Pancreatic Disorders

Virginia Mason is a high-volume pancreatitis referral center, treating more than 2,000 patients in the past decade with excellent outcomes. Standard algorithms for managing severe acute pancreatitis have contributed to high-quality care, including the use of enteral nutrition.

Expert Management of Walled-Off Pancreatic Necrosis

Dual modality drainage to manage infected and symptomatic walled-off pancreatic necrosis is the standard at Virginia Mason. This approach eliminates percutaneous fistulae, shortens hospital length of stay, and reduces both endoscopic and radiographic interventions. “A common endoscopic and percutaneous approach was novel four years ago, but because we’ve seen such vastly improved outcomes, it has become our normal treatment,” says Shayan Irani, MD, associate director.

Sharing Our Knowledge

Committed to education, Dr. Picozzi chairs the national Pancreatic Cancer Action Network medical advisory board and serves with Dr. Kozarek on the organizing committee of the bi-annual International Symposium on Pancreas Cancer. In July 2014, the center will welcome its first pancreatic cancer research fellow, Stephen Oh, MD.

Benign Pancreatic Disorders

A. CT scan demonstrating a large area of walled-off pancreatic necrosis (WON)
B. Percutaneous and transgastric stents in the area of WON; note gas bubbles
C. Complete resolution of WON; transgastric stents remain in place
Michael Gluck, MD, current chief of medicine at Virginia Mason, is the former associate director of the Pancreatic Center of Excellence who led the team in pioneering dual modality drainage. He now collects quality-of-life data from patients treated for walled-off pancreatic necrosis to better understand how symptoms touch patients, immediately and years after treatment.

Returning his quality-of-life survey, patient Travis Frandsen wrote, “I was very unsure of what to expect. It didn’t take me very long to realize the incredible level of care that is offered at Virginia Mason... I was introduced to the “Team” concept and felt that I was in the right place. During my stay and with my follow-up visits, I always felt safe and well cared for.”

**Promoting Consistent Care Across Settings**

Virginia Mason’s nurse leaders have developed a new nursing care model for pancreatitis patients across the health-illness continuum. The model emphasizes communication between inpatient and outpatient settings, timely engagement of the multidisciplinary team and elimination of defects. Preliminary data indicates 46 percent fewer readmissions and a 36.5 percent decrease in length of stay since the model was implemented.

A multidisciplinary pancreatitis work group meets regularly to spearhead quality improvement initiatives such as standardized care pathways for pancreatic cyst, pancreatic head mass, acute pancreatitis, pancreatitis pain management and pancreatitis nutrition. The pathways are available 24/7 via intranet to all team members. “Our goal is to ensure that everyone who treats pancreatitis patients is accessing our care pathways,” states Dr. Irani.

**Long-Term Follow-Up of Lithotripsy in Chronic Calcific Pancreatitis Patients**

With one of the largest experiences of lithotripsy in the United States, Institute providers studied the long-term effects of pancreatic extracorporeal shock wave lithotripsy (P-ESWL) for chronic calcific pancreatitis with intraductal stones. Surveying 120 patients with a mean follow-up of 7.5 years, the study found that 85 percent of patients achieved at least partial pain relief, 50 percent achieved complete pain relief with no narcotic use, and 84 percent avoided pancreas surgery. The study also revealed that cigarette smokers who quit smoking after P-ESWL required less narcotic medication after P-ESWL, and had less need for follow-up endoscopic retrograde cholangiopancreatography than patients who continued to smoke. In 2014, the team will delve further into pain management.
Honoring Staff and Patient Experiences

Experience-based design (EBD) is an emerging lean management method to capture the insight, wisdom and firsthand knowledge of patients, families and team members, as a foundation for improvement.

Nearly 200 people participated in Virginia Mason’s pancreatic cancer EBD pilot, which included observations, interviews, a focus group and three events to co-design new care processes. The group developed a “Know Me” tool for patients to express their preferences and needs at the start of and throughout treatment, plus resource books for patients and caregivers.

For patient Mary Cranny, the project has allowed her to help other patients and families. “My experience with having pancreatic cancer matters to the team and I am treated as an equal partner with a significant role to play. The team’s professionalism and commitment to improving patient care blows me away,” says Ms. Cranny.

Since her diagnosis, Ms. Cranny feels she’s gained a new support system with her gastroenterologist Dr. Irani, oncologist Dr. Picozzi and surgeon Dr. Helton. As treatment continues, she looks forward to contributing more to the EBD project. “I still have a voice, and they are listening to me,” says Ms. Cranny.

PANCREATIC CENTER OF EXCELLENCE: Clinical Research

To refer patients or learn more about these trials, please call the Cancer Clinical Research Unit at (206) 342-6954.

SEENA-1: Induction/Consolidation or Alternating Therapy Followed by a Maintenance Approach for Patients with Advanced Pancreatic Cancer
GOAL: Assess the role of alternating gemcitabine and fluoropyrimidine chemotherapy regimens along with individualized maintenance therapy in untreated metastatic pancreatic cancer.

A Phase 2b, Randomized, Controlled, Multicenter, Open-Label Study of the Efficacy and Immune Response of GVAX Pancreas Vaccine (With Cyclophosphamide) and CRS-207 Compared to Chemotherapy or to CRS-207 Alone in Adults with Previously Treated Metastatic Pancreatic Adenocarcinoma
GOAL: Determine the potential positive effects of above immunotherapy in second- and third-line treatment of metastatic pancreatic cancer.

An International, Multicenter, Double-Blind, Randomized Phase 3 Trial of 90Y-Clivatuzumab Tetraextan Plus Low-Dose Gemcitabine Versus Placebo Plus Low-Dose Gemcitabine in Patients with Metastatic (Stage IV) Pancreatic Adenocarcinoma Who Received at Least Two Prior Treatments (PANCRIT-1)
GOAL: Continue to assess the efficacy of drug radioantibody conjugate duo in third-line metastatic pancreas cancer.

Biomarker Discovery Program in Conjunction with University of Washington
GOAL: Discover new and improved biomarkers of tumor expression, progression and regression in pancreatic cancer.

Now Enrolling


Studying the Sources of Inflammation

The IBD center conducts clinical trials, translational research and laboratory research with the Benaroya Research Institute (BRI). Focus is on the processes that initiate and perpetuate inflammation, and on designing targeted immune therapies to block or reverse them. Clinical trials evaluate effectiveness and safety of immune modulation in patients with ongoing disease.

Dr. James Lord and Dr. Elisa Boden have dual roles as Virginia Mason clinicians and BRI researchers. Core to their research is an IBD bio-repository with more than 16,000 aliquots of blood and tissue samples from 700 patients, giving them a unique view into the immune systems of IBD patients.

Inflammatory Bowel Disease Center of Excellence

The Inflammatory Bowel Disease Center of Excellence treats more than 1,500 patients each year with a team of specialized gastroenterologists, surgeons, radiologists, nutritionists, pathologists and nurse educators.

“Our journey to improve care for patients with IBD never stops,” says director Michael Chiorean, MD.

IBD Team:
(left to right)
James Lord, MD, PhD
Richard Kozarek, MD
Amie Recker, RN
Richard Thirlby, MD
Elisa Boden, MD
Amy Zeigler, PA
Michael Chiorean, MD
The bio-repository was launched several years ago with surgeon Richard Thirlby, MD, when patients undergoing intestinal resection agreed to donate tissue.

More than 80 percent of Crohn’s disease (CD) patients develop serum antibodies against commensal bacteria. While these antibodies aren’t believed to be pathogenic, their presence reflects a loss of tolerance to intestinal microbiota. Dr. Lord and Dr. Boden are studying these inappropriate immune responses to intestinal microbiota, which are thought to play a role in prompting and prolonging intestinal inflammation in IBD.

The goal is to develop major histocompatibility complex class II tetramers to identify and characterize T cells that have lost tolerance to commensal bacterial antigens in patients with CD. “We are exploring whether there are differences in frequency or phenotype of commensal-specific T cells between subjects with CD and healthy controls. We’ll also determine whether the frequency of commensal-specific T cells is dynamic and correlates with clinical parameters. We expect to better understand the events that lead to loss of tolerance in CD and highlight novel therapeutic approaches for IBD,” says Dr. Boden.

**Improved Surveillance and Preventive Care**

Nationally, IBD physicians are focused more sharply on quality standards. Director Michael Chiorean, MD, has received “excellent” status in the American Gastroenterology Association’s Bridges to Excellence program, which recognizes clinicians who demonstrate outstanding patient care. Virginia Mason’s IBD Center of Excellence has also adopted quality measures based on guidelines published by the Crohn’s and Colitis Foundation of America (CCFA).

“Standardizing the care given by each provider to every patient is vitally important to ensuring quality,” says Dr. Chiorean. “We’ve developed several benchmarks and are using them in clinical practice through user-friendly instruments, such as IBD-management playbooks for health care providers and an IBD ‘Stoplight’ tool for patients.” See [VirginiaMason.org/IBDcenter](http://VirginiaMason.org/IBDcenter).

A large IBD registry with patient demographic and clinical information and disease activity scores is currently being analyzed by providers working with Digestive Disease Institute business analysts. This monitoring improves patient care and is an important quality indicator, preemptively conforming with Medicare’s expected Physician Quality Reporting System Quality-Data Codes for IBD. “Besides giving us a mechanism to track how the patient is faring from visit to visit, the system prompts us to address critical health maintenance and preventive care needs,” says Dr. Lord.

For diagnosis and surveillance, the IBD center uses chromoendoscopy, capsule endoscopy, deep enteroscopy and advanced radiological techniques to monitor disease status. Chromoendoscopy—or dye spraying—has improved detection of cancer precursors in patients with chronic colitis and proves more cost-effective than standard white-light endoscopy. Patients who otherwise would have undergone surgery to remove their colon for polyps may now keep their colon as long as the dysplastic area identified after applying the dye can be removed endoscopically.

The IBD center also tracks medication compliance and vaccinations. With immunosuppressants as the primary medical therapy making IBD patients susceptible to infection, vaccination is now an essential part of preventive care for high-quality IBD practice. Dr. Chiorean will present a poster on this crucial topic at Digestive Disease Week 2014. See page 15.
Teaching Peers and Patients

Providers within the IBD center teach patients and colleagues through patient lectures, continuing medical education (CME) courses and presentations throughout Washington and the Pacific Northwest. Physicians also facilitate a monthly IBD journal club with local providers to discuss the latest research and how it affects patient care.

The center enjoys strong ties with the Pacific Northwest chapter of Crohn’s and Colitis Foundation of America. Dr. Boden, Dr. Lord and Dr. Chiolean all serve on the chapter’s medical advisory committee, and Dr. Lord serves on the board and mission committee. “CCFA empowers us to support and teach our patients while funding essential cutting-edge research and advocating for the legal and financial rights of all IBD patients,” says Dr. Lord.

Virginia Mason hosted its second annual Update in Inflammatory Bowel Disease CME course in March 2014. Maria Abreu, MD, of the University of Miami presented, “IBD Adventures in Translation.” Faculty addressed standards and new approaches in IBD practice and explored the optimization of immunomodulator, biologic and combination therapies. They also reviewed the role of nutrition and recent developments in understanding the pathogenesis of IBD. To learn about other digestive disease CME courses, please visit VirginiaMason.org/CME.

Amie Recker, RN, James Lord, MD, PhD, and Diana McFarlane, PA, ran the Crohn’s and Colitis Foundation of America’s 2013 Napa to Sonoma Wine Country Half Marathon.
Persisting to Find the Right Treatment

When Caroline Kinghorn began experiencing rectal bleeding in December 2012, she was rightfully concerned. Although her symptoms continued, it wasn’t until she experienced incontinence that she visited her primary care physician at Virginia Mason. When tests found ulcers throughout her colon, Ms. Kinghorn was diagnosed with Crohn’s disease. As a nurse, she knew the pathology behind Crohn’s but didn’t fully grasp how much it would impact her quality of life.

“Once I was connected with the IBD team, I felt confident in their ability to effectively treat my Crohn’s disease.”
— CAROLINE KINGHORN

Over the next month, Ms. Kinghorn lost 30 pounds. In January 2013, she was admitted to Virginia Mason Hospital due to bleeding and excessive weight loss. Her gastroenterologist, Fred Drennan, MD, recommended that she see Elisa Boden, MD, of the Inflammatory Bowel Disease Center of Excellence.

During six months of regular appointments, Dr. Boden tracked Ms. Kinghorn’s health and meticulously adjusted treatment until the combinations and dosages of medications finally eliminated her symptoms. Although it took several months of adjusting her medications—which included Infliximab, Methotrexate and enemas—to achieve the target response, Ms. Kinghorn has been virtually symptom-free since July 2013.

“Dr. Boden was very thorough in finding the best course of action for my treatment. She never gave up on me,” says Ms. Kinghorn. “Once I was connected with the IBD team, I felt confident in their ability to effectively treat my Crohn’s disease.”

Ulcerative Colitis and its Effects on Mucosal Immune State and Microbiota

A Phase 2b, Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Dose-Response Study Evaluating the Efficacy and Safety of JNJ-54781532 in Subjects with Moderately to Severely Active Ulcerative Colitis

GOAL: Evaluate the dose response of JNJ-54781532 at week eight in subjects with moderately to severely active ulcerative colitis.

AMG 181 in Subjects with Moderate to Severe Crohn’s Disease

GOAL: Evaluate the efficacy of AMG 181 as measured by the proportion of patients with Crohn’s disease who are in remission.

Study of the Safety and Efficacy of Zoenasa® Versus Mesalamine Enema in Subjects with Left-Sided Ulcerative Colitis

GOAL: Assess the efficacy of Zoenasa rectal gel compared to mesalamine enema in patients with left-sided ulcerative colitis.

A Prospective, Randomized, Double-Blind, Placebo-Controlled Phase 2 Clinical Study of Trichuris suis Ova Treatment in Left-Sided Ulcerative Colitis and its Effects on Mucosal Immune State and Microbiota

GOAL: Evaluate the safety and effectiveness of trichuris suis ova (TSO) while learning how it affects the body’s immune response in ulcerative colitis patients.

The Digestive Disease Institute offers clinical trials for a variety of digestive conditions, including Inflammatory Bowel Disease. To refer patients or learn about trials, call the research hotline at (206) 341-1021 or visit Virginiamason.org/DDI-Research.

INFLAMMATORY BOWEL DISEASE CENTER OF EXCELLENCE:

Clinical Research Studies

Now Enrolling
Selected Recent Publications


• Chiorean MV. Oral versus intravenous steroids to define refractory ulcerative colitis. *Inflamm Bowel Dis* 2011; 17:2503-4.


• Lord JD, Boden EK. The role of endoscopy to define postoperative recurrence in IBD. In: Kozarek RA, Wallace MB, Chiorean M (eds.), *Endoscopy in Inflammatory Bowel Disease.* Springer, New York, 2014, in process.


IBD Center of Excellence Director Michael Chiorean, MD, performs an endoscopic procedure.
SUNDAY, MAY 4

• Endoscopic Treatment of Non-Stricture Related Benign Biliary Diseases Using Covered Self-Expandable Metal Stents (CSEMS)
  Shayan Irani, MD*, Andrew S. Ross, MD, Otto S. Lin, MD, Michael Gluck, MD, S. Ian Gan, MD, Richard A. Kozarek, MD

• Pilot Study of Oral Delivery of Monoclonal Anti-CD3 Antibody (OKT3) in Moderate to Severe Ulcerative Colitis
  Elisa Boden, MD*

• Small Bowel Tumors and Polyposis Syndromes: Diagnosis and Management | Michael Chiorean, MD*

• The Impact of Vaccinations on Infectious Disease Incidence Among IBD Patients | Michael Chiorean, MD*

• The Role of Confocal Laser Endomicroscopy in the Management of Patients with Biliary Strictures: A Consensus Report Based on Clinical Evidence | S. Ian Gan, MD

• Risk Factors for Rescue Therapy in Crohn’s Patients on Combination Therapy after Discontinuation of the Immunosuppressant
  Michael Chiorean, MD

• Definition of a Standardized Program of Training and Credentialing for the Use of Confocal Laser Endomicroscopy in Gastrointestinal Applications: A Consensus Report | S. Ian Gan, MD

MONDAY, MAY 5

• Acute Pancreatitis: Endoscopic Management of Complications
  Andrew S. Ross, MD*, Richard A. Kozarek, MD

• Moderator: Prevention and Treatment of Postsurgical Bile Leaks Secondary / Tertiary | Richard A. Kozarek, MD*

• Interventional Radiology Techniques for Identification and Rescue of Postsurgical Bile Leaks
  Mehran Fotoohi, MD*

• Incidence, Risk Factors and Consequences of Postsurgical Bile Leaks
  Scott Helton, MD*

• Sofosbuvir/Ledipasvir With and Without Ribavirin for Eight Weeks Compared to Sofosbuvir/Ledipasvir for 12 Weeks in Treatment-Naïve Non-Cirrhotic Genotype-1 HCV-Infected Patients: The Phase 3 ION-3 Study
  Kris Kowdley, MD

• Similar Outcomes of Sterile Versus Infected Walled-Off Pancreatic Necrosis Treated with Combined Endoscopic and Percutaneous Drainage
  Michael Gluck, MD*, Flavio G. Rocha, MD, Shayan Irani, MD, S. Ian Gan, MD, Michael C. Larsen, MD, Richard A. Kozarek, MD, Andrew S. Ross, MD

• SAPPHIRE I: Phase 3 Placebo-Controlled Study of Interferon-Free, 12-Week Regimen of ABT-450/rr/ABT-267, ABT-333, and Ribavirin in 631 Treatment-Naïve Adults with Hepatitis C Virus Genotype 1
  Kris Kowdley, MD*

• Accuracy of Optical Biopsy Using Probe-Based Confocal Laser Endomicroscopy (pCLE) in Patients with Indeterminate Biliary Strictures: Interim Results with Modified Criteria of a Large Multicentric Study
  S. Ian Gan, MD

• Hybrid Push-Pull Endoscopic and Laparoscopic Full-Thickness Resection for the Minimally Invasive Management of Gastric Gastrointestinal Stromal Tumors (GIST) | Andrew S. Ross, MD, Flavio G. Rocha, MD

TUESDAY, MAY 6

• Prevalence of Buried Metaplasia and Neoplasia in Patients Presenting for Management of Barrett’s Esophagus – A Cohort Study | Henner M. Schmidt, MD*, Artur M. Bodnar, MD, Andrew S. Ross, MD, Donald E. Low, MD

• Esophageal Shortening Ratio Provides a Simple Calculation to Predict Clinically Significant Esophageal Shortening in Patients with Giant Paraesophageal Hernias | Carol Murakami, MD, Henner M. Schmidt, MD, Donald E. Low, MD

• Role of UDCA in PSC-IBD
  Kris Kowdley, MD*

• Dead End Ducts. Rendezvous Techniques for Reconnecting the Obstructed Pancreas | Shayan Irani, MD*, Richard A. Kozarek, MD

• Validation of Automated Colonoscopic Findings From an Endoscopic Documentation Database (Provation) Against Manually Collected Data
  Otto S. Lin, MD*, Richard A. Kozarek, MD

• The Role of Confocal Laser Endomicroscopy in the Management of Patients with Barrett’s Esophagus: A Clinical Evidence-Based Consensus Report | S. Ian Gan, MD

• From Miami to Paris: Validation of Refined Probe-Based Confocal Microscopy Classification of Indeterminate Biliary Strictures | S. Ian Gan, MD*

* Presenters
The Digestive Disease Institute at Virginia Mason is a multidisciplinary coalition of providers from:

- Bariatric Surgery
- Endocrinology
- Gastroenterology and Hepatology
- General Thoracic Surgery
- Hematology/Oncology
- Hepatopancreatobiliary Surgery
- Interventional Radiology
- Pathology

CONDITIONS WE TREAT
Acute Pancreatitis
Anal Dysplasia
Ascites
Autoimmune Hepatitis
Bariatric Complications
Barrett’s Esophagus
Benign Hepatic Tumors
Bile Duct Strictures
Bile Duct Disorders
Biliary Duct Cancer
Celiac Disease
Chronic Pancreatitis
Cirrhosis
Colitis and Chronic Ulcerative Colitis
Colorectal Cancer
Colorectal Polyps
Constipation
Crohn’s Disease
Cystic Fibrosis
Esophageal and Gastric Varices
Esophageal Cancer
Fatty Liver Disease
Gallstones and Bile Duct Stones
Gastroesophageal Reflux Disease (GERD)
Gastroparesis (Delayed Gastric Emptying)
Hemochromatosis
Hepatitis B, Hepatitis C and Chronic Hepatitis
Hepatorenal Syndrome
Inflammatory Bowel Disease (IBD)
Irritable Bowel Syndrome (IBS)
Intraductal Papillary Mucosal Neoplasm (IPMNs)
Liver Cancer
Neuroendocrine Tumors
Nonalcoholic Steatohepatitis (NASH)
Obesity
Pancreatic Cancer
Pancreatic Cysts
Pancreatic Necrosis
Primary Sclerosing Cholangitis
Swallowing and Motility Disorders
Ulcerative Colitis

WHY REFER YOUR PATIENTS?
- We treat complex patients who may be untreatable in your area
- Multidisciplinary care in GI, hepatology, surgery, oncology, interventional radiology and nutrition
- GI Cancer Care Coordination Team will provide your patient with personalized attention
- Clinical trials may offer new hope to patients with no other treatment options

You may refer a patient to the Digestive Disease Institute by calling (206) 223-2319, or visit VirginiaMason.org/DDI.