**Anorectal Manometry: What is it?**

Anorectal Manometry consists of several studies that provide valuable information to determine if neurologic, muscular, or a combination of both is contributing to constipation or incontinence.

1. A pressure profile of resting and squeeze anal sphincter muscles that provide continence. Squeeze duration determines ability to maintain continence pressure.
2. The push study measures appropriate anal relaxation (decrease in anal sphincter pressures) when attempting defecation. This maneuver with the BET can determine dyssynergic defecation.
3. Rectal inhibitory reflex (FAIR) testing, which is helpful in excluding Hirschsprung’s disease.
4. Rectal sensation testing.
5. Compliance of the rectal wall.

**New Procedure Available: Anorectal Manometry**

**Anorectal Manometry**

**Diagnosing Esophageal Disorders**

- Most common example is constipation. The American Gastroenterology Association (AGA) clinical guidelines strongly recommend that if a therapeutic trial of laxatives and fiber supplements produces incomplete or no response to constipation, anorectal manometry (ARM) with balloon expulsion test (BET) should be the next step (Diagram 1).

**In This Issue**

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- New Procedure Available: Anorectal Manometry
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**Constipation: When to Refer for ARM**

1. Interview and physical examination
2. Consider metabolic and structural evaluation, baseline labs
3. Therapeutic trial - fiber +/- laxatives
4. Inadequate response
5. Anorectal manometry balloon expulsion test*

**Patient Experience**

Prior to testing, patients are instructed to do a very limited preparation with an enema. During the testing, the patient lies on his or her left side and an ARM-trained nurse performs a brief anal and digital rectal examination. A small, thin catheter with an inflatable balloon on the tip is then inserted into the anal canal and rectum. The nurse instructs the patient on maneuvers to gather pressures and sensation information. The entire testing typically takes about 30 minutes.

Exclusion criteria include patients who are unable to follow directions appropriately (i.e. patients with cognitive impairment or dementia) or patients who are unable to lie on their left side for 30 minutes.

**ARM at The Oregon Clinic**

At The Oregon Clinic Gastroenterology, ARM with BET has been available since 2015. We have two ARM-specialized nurses who perform the test with the patient. Dr. Swapna Reddy and Dr. Monina Pascua oversee the ARM program and review the high resolution impedance pressure tracings. They then provide a formal analysis and recommendations which are communicated back to the referring physicians.

**Multidisciplinary Approach**

Pelvic floor disorders are often managed with a multidisciplinary approach. Our gastroenterologists work closely with our colorectal, urogynecology, urology and physical therapy colleagues within our Pelvic Floor Collaborative to provide patient-centered care with a best-practice approach.

If you are interested in referring for anorectal manometry or evaluation of a pelvic floor disorder, you can refer by phone, online, or through your EHR.

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**Our Quality Assurance Data**

We strive to provide patient-centered care in a professional, comfortable environment. We have over 50 board certified gastroenterologists across four endoscopy centers and average over 36,000 procedures a year.

Accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), we meet the highest standards in patient quality care and use the latest technology and techniques, including high-definition scopes to get the clearest view.

We are proud to present our data on adenoma detection rate (view to the right), cecal intubation rate, withdrawal time, and other important endoscopy standards with providers and patients.

See how we compare to the National Benchmark and Mayo Clinic at oregonclinic.com/tocec.

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**Diagnosing Esophageal Disorders**

- Pelvic floor disorder is defined as any condition that involves the pelvic floor (muscles that provide continence).
- Inadequate response to treatment with antidiarrheals and laxatives with only modest results when the cause of the disorder is not clear due to incomplete work-up. Patients are often left frustrated or confused when these treatments are ineffective.

The most common example is constipation. The American Gastroenterology Association (AGA) clinical guidelines strongly recommend that if a therapeutic trial of laxatives and fiber supplements produces incomplete or no response to constipation, anorectal manometry (ARM) with balloon expulsion test (BET) should be the next step (Diagram 1).

Information gained from ARM can help determine if referral to a pelvic floor therapist for biofeedback is necessary.
Hepatitis C Treatment Options Continue to Expand

The Directly Acting Antiviral (DAA) therapy for hepatitis C began in late 2013 with the approval of Sofosbuvir, and has continued to rapidly expand with the addition of multiple additional DAA regimens. These regimens are interferon free and available for all genotypes of hepatitis C. Cure rates exceed 95% in many situations, which is a dramatic leap forward since the days of interferon. Patients with cirrhosis have lower sustained virologic response rates of 75-80% as their liver disease progresses.

The newest medications and optimized regimens also address the needs of previously difficult to treat populations, including those with advanced chronic kidney disease (such as dialysis dependent patients), those with decompensated cirrhosis, recurrent infection after transplantation, and those with HIV co-infection.

Insurance

Although the prices have dropped as more DAAs have become available, cost continues to be the main barrier to treatment for many patients. There continues to be wide variation between each insurance carrier’s requirements for treatment authorization.

Some carriers still only authorize patients with advanced fibrosis/cirrhosis or other significant extrahepatic HCV associated diseases, while many others authorize treatment for nearly all hepatitis C infected patients.

The overall trend has been toward approval of treating earlier disease, as many of the highest priority patients have been treated and cured since the arrival of DAAs.

Referring Your Patients

When referring patients for consideration for treatment, it is quite helpful for the referral to include:

- Labs including a CBC, CMP, PT/INR, hepatitis C quantitative PCR and a hepatitis C genotype.
- Patients should also be tested for Hepatitis A and Hepatitis B. Those who are not immune should receive the appropriate vaccine series.
- A recent abdominal ultrasound or other abdominal imaging.
- Liver biopsy has historically been the preferred method for assessing fibrosis, however, there are now multiple non-invasive tests for fibrosis. These tests do have some significant variability in accuracy (under-staging and over-staging fibrosis), but the best tests have operating characteristics similar to the accuracy of biopsy. As they are imaging/stiffness testing or blood tests, they are safer and generally much better accepted by patients than an invasive biopsy.

All of The Oregon Clinic’s gastroenterology locations offer expert consultation and guidance through the treatment process for patients with hepatitis C or advanced fibrosis. Liver disease

Hepatitis C Advancement

Acute Infection

Chronic Inflammation

Fibrosis

Cirrhosis

Cancer

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Many of the highest priority patients have been treated and cured since the arrival of DAAs.

Refer Your Patients - Your Way

Save time and refer your patients directly through your EMR system, online at oregonclinic.com/refer or by phone.

Help Us Improve

We are always looking to improve the way we connect with our referring providers and create a better referral process.

Please take our Satisfaction Survey: oregonclinic.com/physician-feedback

Diagnosing Esophageal Cancer

Esophageal cancer remains a challenge. Diagnosing esophageal cancer during an evaluation for symptoms usually leads to the diagnosis of an advanced cancer. Treatment of advanced esophageal cancer is associated with high morbidity and mortality, even in expert hands. Identifying a screening strategy for this cancer can make a significant impact, but remains a work in progress.

Having Barrett’s esophagus (BE) puts a patient at risk for progression to esophageal cancer. BE is a replacement of esophageal stratified squamous epithelium with metaplastic columnar epithelium (i.e. intestinal metaplasia).

Annual cancer incidence in BE patients ranges from 0.1 to 0.4% based on recent data. This risk, while low, is at least 30-fold higher than the general population. Of patients with BE, their risk increases with additional risk factors such as:

- Age > 50
- Male
- White
- Chronic GERD
- Elevated BMI
- Abdominal obesity
- Tobacco use

Screening

Screening for BE with upper endoscopy to prevent or screen for esophageal cancer remains controversial. Several societies including the American College of Physicians, American Gastroenterological Association, and the American College of Gastroenterology advocate for screening in highly selected patients.

In general, patients with multiple risk factors are recommended to be screened. This has allowed us to alter practice patterns and reserve BE screening only for those patients felt to be at the highest risk of this uncommon cancer.

Risk for Progression

Once BE is identified, the patient must be stratified further into risk for progression to cancer based on length of disease and histologic findings.

There has been emerging data to suggest that very short segment BE (<1cm) has a low risk of progression to cancer and may not require any surveillance. Short segment (<3cm) and long segment (>3cm) patients are recommended to undergo surveillance, assuming adequate overall health. The intervals for surveillance and treatment are guided by the presence or absence of dysplasia/cancer.

Treatment

Treating BE is generally reserved for patients with dysplasia or cancer. Over the last decade there have been significant improvements in therapeutic options.

Physicians at The Oregon Clinic have expertise in the advanced management of the full spectrum of BE and cancer including Endoscopic Ultrasound (EUS), Endoscopic Mucosal Resection (EMR), Radio Frequency Ablation (RFA), cryotherapy, esophagectomy, and esophageal stenting.

The Oregon Clinic is committed to remaining on the forefront of this challenging disease.

Would you like additional information on our new providers?
Visit oregonclinic.com/GI to see areas of interest, video interviews, and referral information.

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