UCHSC Gastroenterology
Ambulatory Care Curriculum

Course Director: Joel S. Levine, MD

Organization

Course director is responsible for ensuring the educational value of this rotation and will delegate certain activities to other faculty. For more information about rotation assignments at specific hospitals, you may contact the following faculty members:

University Hospital:	Joel Levine, M.D. Ph: (303) 315-2537 Email: joel.levine@uchsc.edu
Denver Health Medical Center:	Neil Toribara, D.O. Ph: (303) 436-6907 Email: neiltoribar@dhha.org
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Schedule

Based on a 5 days/week, no night-call schedule with Departmental and/or Divisional conferences and continuity medical clinics as scheduled. Core Hospital Saturday rounda are optional. It is assumed that 5 working days of the month will be vacation time for the resident/student. The Division strongly encourages vacation be taken in one block at either the beginning or the end of the rotation. The Division needs to know dates of vacation as far in advance as possible to allow for proper scheduling of patients.

Each resident/student will be assigned to a core hospital (UH, VAMC, or DHMC) where they will become a component of the in-patient consultation team that includes at least one Fellow and one Faculty member. Rounds are held daily. To assure adequate teaching material, no more than one resident will be assigned to each of the core hospitals.

Assuming no conflict with continuity clinic, each resident/student will be required to attend all of the GI clinics within our system. This will include 2 clinics at DHMC, 1 at UH, and 1 at VAMC.

Educational Content

At the beginning of the rotation, each resident/student will be asked to review the core syllabus and identify knowledge areas which they believe are strengths, and those that are weaknesses. This will be communicated to the attending on the in-patient service as well as the clinic faculty to allow teaching to be focused on perceived areas of need.

It is through the interactions during the clinics that the bulk of the ambulatory curriculum in gastroenterology will be taught.

Faculty on the in-patient services will be asked to stress the pre- and post-hospital phases of the patients seen within the confines of an urgent problem that has necessitated admission to the hospital. These faculty will also be responsible for communicating the core curriculum's content about the risks/benefits/costs of procedures; and teaching flexible sigmoidoscopy.

Many of the topics in the core curriculum are presented during Divisional and Departmental conferences. Each resident/student has the opportunity to learn from these didactic sessions.

Each resident/student will receive a syllabus of core references that they will be expected to read during the rotation.

Evaluations

A brief "outpatient" evaluation form will be completed by each of the faculty members in the clinics the student/resident attends, and will be incorporated into the standard evaluation form currently used.

Each resident/student will be expected, with the help and concurrence of their attending, to choose one focused area of ambulatory gastroenterology, research the topic beyond the confines of the syllabus, and present a 30 minute presentation to the consult team of which they are a member. The assessment of this presentation will be incorporated into the overall evaluation.

Course Evaluation

In addition to the standard Departmental evaluation of the in-patient attending, residents/students will also be asked to evaluate the educational content of each of the clinics as well as the faulty.

At the end of the rotation residents/students will be asked to score their understanding of each of the curriculum's focus areas. This will allow directed feedback to the faculty as well as the course Director to decide whether curriculum modification is required.

What should an internist know for their own outpatient practice?

A. Dysphagia
   1) Diagnostic decision making
   2) Evaluating the risks/benefits of medical and surgical treatment options
   3) When to consult a gastroenterologist.

B. Acid-peptic Diseases of the Esophagus, Stomach, and Duodenum
   1) When to just treat without being sure of diagnosis
   2) How helpful is an UGI series?
   3) H. Pylori - Importance, diagnosis, treatment
   4) Medical/surgical treatment options
   5) When to consult a gastroenterologist

C. Understand the benefits/risks/costs of routine endoscopic procedures; including:
   1) Upper endoscopy
   2) Esophageal dilation
   3) Variceal sclerosis
   4) Colonoscopy
   5) Polypectomy
   6) Mucosal biopsy

D. Chronic Pancreatitis
   1) Diagnostic decision-making; what should an internist do?
   2) Medical/surgical treatment options; the proper use of pancreatic enzyme therapy.
   3) When to consult a gastroenterologist.

E. Evaluation of Jaundice
   1) Diagnostic decision making
   2) When to consult a gastroenterologist

F. Evaluation of Abnormal Transaminases
   1) Diagnostic decision making
   2) Understanding acute hepatitis

G. Chronic Liver Disease
   1) Identifying the patient in your practice with potential risks of alcoholic liver disease
   2) Alcohol rehabilitation - value/resources
   3) When to consider a liver biopsy
   4) Identifying patients for interferon therapy
   5) Identifying patients for liver transplantation
   6) Outpatient management of the complications of chronic liver disease.
      a. Ascites
      b. Varices
      c. Encephalopathy
   1) When to consult the gastroenterologist/hepatologist

H. Gallstone Disease
1) When to get an ultrasound - Discriminating symptomatic cholelithiasis from dyspepsia
2) Therapeutic options for cholelithiasis. Risks vs. Benefits; when does a gastroenterologist have a role?

I. Inflammatory Bowel Disease (IBD)
1) Diagnostic process to separate diseases of known cause from idiopathic inflammatory bowel disease.
2) Understanding the difficulties involved with therapeutic decision making for patients with IBD
3) Management of IBD with the gastroenterologist

J. Idiopathic Chronic Abdominal Pain
1) The history/patient interaction
2) Clues to a successful/therapeutic relationship
3) What is the role of the gastroenterologist?

K. Irritable Bowel Syndrome
1) Defining IBS during initial interview
2) Structural illness that can mimic IBS
3) Therapeutic strategies
4) When to consult a gastroenterologist

L. Acute diarrhea
1) A cost efficient approach to diagnosis

M. Chronic Diarrhea
1) The initial diagnostic approach
2) Malabsorption - When to consider; diagnosis
3) Treatment options for idiopathic chronic diarrhea
4) When to consult a gastroenterologist

N. Constipation
1) How much diagnosis is needed? Helpful?
2) Management of idiopathic constipation in patients with and without neuromuscular disease
3) When to consult a gastroenterologist

O. Evaluation of Minor Hematochezia and Hemoccult Positive Stools
1) When to check the stool for occult blood and interpretation of the results
2) Bright red blood per rectum - How much diagnosis is enough?
3) Diagnostic approach to hemoccult positive stool

P. Flexible Sigmoidoscopy
1) Understanding the instrument, the indications, the risks, and the costs (one rotation)
2) Establish competency (two GI rotations) in performance