Bridge the GHAPP

Gastroenterology & Hepatology
Advanced Practice Providers

NEWSLETTER

VOLUME 12

LETTER FROM THE COMMUNICATIONS COMMITTEE

Dear Readers,

I would say “Spring has Sprung”, but this unpredictable weather has me questioning these climates. So I will say instead that the first conference season of the year is upon us: we are coming up on Digestive Diseases Week in San Diego and the European Association for the Study of the Liver Congress in Amsterdam.

We all work hard, all year long, for our patients, our colleagues and for the progression of medicine in general. Conference times are moments to stop and reflect on what we have accomplished and what we can still accomplish as APPs in clinical care and research. Our contributions are worthwhile and important. I hope that we will be able to grow in our work and continue to give to our fields more and more in times to come.

This volume has a great liver case study, guideline reviews, and the rumblings of the excitement about our own upcoming conference in September – this year we will be in Las Vegas! We had a fantastic turn out last year, and are looking forward to doing it again this year.

As always, we look for anyone who is interested in contributing to the newsletter, whether it’s an idea, an article or just general feedback, so don’t hesitate to let us know what you think!
Happy Spring to all our GHAPP members!

In Health,
Allysa Saggese, NP

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ACG Guideline: Focal Liver Lesions

Sarah Enslin, PA-C

The American College of Gastroenterology (ACG) has issued updated guidelines for the diagnosis and management of focal liver lesions (FLLs), which are increasingly detected on abdominal imaging, often incidentally. These guidelines focus on the most common types of FLLs, including hepatocellular adenoma, focal nodular hyperplasia, hemangioma, and hepatic cystic lesions such as polycystic liver disease, emphasizing the importance of distinguishing benign lesions from malignant ones. The document uses the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) framework to provide evidence-based recommendations for managing these lesions.

The guideline highlights that the management of FLLs often requires a multidisciplinary approach involving patient history, clinical symptoms, physical examination, laboratory tests, and advanced imaging techniques like contrast-enhanced ultrasound (CEUS), CT, and MRI. For benign lesions such as hemangiomas or uncomplicated hepatic cysts, imaging alone is usually sufficient for diagnosis and does not require biopsy or intervention unless symptomatic. Malignant lesions, including hepatocellular carcinoma (HCC), intrahepatic cholangiocarcinoma (iCCA), and metastatic disease, necessitate more aggressive management and may involve biopsy, surgical resection, or other interventions.

Key recommendations include:

1. **Initial Evaluation:** For incidental FLLs, a comprehensive evaluation that includes imaging (EUS, MRI or CT) and clinical history (weight loss, loss of appetite, fever, history of prior cancer, medication history including oral contraceptives and steroids, risk factors for liver disease, features of metabolic syndrome) is crucial to differentiate between benign and potentially malignant lesions.
2. **Use of Imaging:** Multiphasic contrast-enhanced imaging, especially MRI, is preferred for characterizing uncertain liver lesions due to its high diagnostic accuracy.
3. **Management of Specific Lesions:**
    - **Hepatocellular Adenoma:** Discontinuation of exogenous hormones and weight management are recommended for smaller lesions. Biopsy may be required for larger/atypical lesions. Larger or symptomatic adenomas, particularly those with potential for malignant transformation, may require surgical intervention.
    - **Focal Nodular Hyperplasia (FNH):** Biopsy is generally not needed. Usually managed conservatively with no need for surgical intervention unless symptomatic.
    - **Hemangiomas:** Biopsy should be avoided due to risk of bleeding. Typically do not require treatment unless symptomatic or causing complications.
    - **Hepatic Cysts:** Asymptomatic simple cysts do not require follow-up; however, complex or symptomatic cysts may need multidisciplinary evaluation and surveillance imaging.

These guidelines aim to standardize the approach to FLLs, ensuring high-quality care while avoiding unnecessary procedures, thereby optimizing patient outcomes through appropriate, evidence-based practices.

Frenette C, Mendiratta-Lala M, Salgia R, et al. ACG Clinical Guideline: Focal Liver Lesions. *The American Journal of Gastroenterology*. 2024; 119(7): 1235-1271

Liver Case Files - Can You Solve It?

Patrick Horne, MSN, ARNP

PATIENT: 43-year-old Caucasian female presents for elevated LFTs.

PERTINENT MEDICATIONS: Was on atorvastatin until just before 5/31/24.

INITIAL CONCERN: DILI from atorvastatin

TESTS COMPLETED:

- Ultrasound of Right Upper Quadrant 5/31/24: Increased liver echotexture suggesting hepatocellular disease.
- CT Abdomen and Pelvis with IV contrast 5/31/24: Normal liver, mild splenomegaly up to 14 cm.
- Liver related labs 5/31/24: AST 208, ALT 308, ALP 185, TB 0.9
- Fibroscan 6/5/24: CAP 330 dB/m, 15.0 kPa which equates to S3, F3-4 (depending on which guidelines are used).

INITIAL DIAGNOSIS: Metabolic Associated Steatotic Liver Disease (MASLD)

FURTHER TESTING AND WORKUP:

	2019
A/B	Negative
Hepatitis C Ab	Negative
Alpha-1 Antitrypsin	Normal
Ceruloplasmin	Normal

2024: Repeat ANA, AMA, ASMA, serum immunogobulins, iron panel, ferritin, Alpha-1 Antitrypsin and ceruloplasmin, results below:

	2024
ASMA	+ 64 (ULN 19)
AMA	+ 116.1 (ULN 24.9)
IgG	1509 (ULN 1616)
IgM	310 (ULN 281)
IgA	176 (ULN 433)

NEXT STEP: Due to abnormal Fibroscan and above results, EUS guided liver biopsy performed.

PATHOLOGY RESULTS:

Liver, left lobe, biopsy:

- *Hepatic parenchyma with chronic active hepatitis and bile duct injury with a focal "florid-duct lesion"*
- *Assessment of fibrosis on trichrome stain is pending and will be issued in an addendum*
- *See comment*

C. Liver, right lobe, biopsy:

- *Hepatic parenchyma with chronic active hepatitis and bile duct injury with multiple "florid-duct lesions"*
- *Assessment of fibrosis on trichrome stain is pending and will be issued in an addendum*
- *See comment*

Comment (B-C): *The liver biopsies are each composed of a single core of hepatic parenchyma, adequate for interpretation. The portal tracts show increased mixed inflammation, predominately lymphocytes, plasma, cells, and eosinophils. Prominent interface and lobular extension of the inflammatory infiltrate is noted. Many of the portal bile ducts show features of injury and multiple "florid duct lesions" are noted with damaged bile ducts and associated lymph histiocytic inflammation. There is minimal macro-vesicular steatosis (<5%), without diagnostic ballooned hepatocytes. No diagnostic alpha-1 antitrypsin globules are identified with PAS-D stain. Prussian Blue iron stain shows no significant iron deposition.*

Clinical concern for statin-induced liver injury is noted. Although a component of statin injury contributing to this process cannot be entirely excluded, the histologic features, elevated ALT, elevated alkaline phosphatase, and elevated ASMA and AMA is most consistent with an autoimmune hepatitis/primary biliary cholangitis overlap condition (AIH/PBC). Clinical correlation is recommended. Serum testing for IgG immunoglobulin levels could also be considered for further evaluation.

DIAGNOSIS: Given biopsy findings and elevations in AST, ALT, and ALP, diagnosis felt to be AIH/PBC overlap.

TREATMENT:

For PBC: start ursodiol 1750 mg daily (weight based, 13-15 mg/kg/day). Repeat labs every 2 weeks.

For AIH: Prednisone taper starting at 40 mg (8/7/24), decreasing to 30 mg (8/23/24), 20 mg (10/4/24), 10 mg (10/18/24), 7.5 mg (11/1/24), 5 mg (11/15/24), 2.5 mg (11/28/24), 2.5 mg every other day (12/12/24), stopped 12/19/24). Additionally, azathioprine started on 8/7/24 at 100 mg daily (weight based, 1 mg/kg/day), increased to 150 mg daily (9/20/24) due to increase in LFTs. Prior to initiating azathioprine therapy a TPMT level was checked as well.

OUTCOME: With increase in azathioprine and successful prednisone taper, transaminases and alkaline phosphatase all normalized and remain normal.

TAKE AWAY: What is important about this case is the old saying "you can't judge a book by its cover." The initial suspicion was valid for MASLD based on metabolic risk factors and CAP results from Fibroscan. However, upon further evaluation with liver biopsy, overlap syndrome with AIH and PBC was determined. This case demonstrates the importance of obtaining all pertinent information available to make the most accurate diagnosis possible.

	Latest Reference Range & Units	05/31/24 14:37	06/19/24 11:07	07/18/24 02:00	08/09/24 08:57	08/23/24 07:56	09/06/24 08:00
AST	0 - 37 IU/L	208 (H)	163 (H)	23	51 (H)	23	24
ALT (SGPT)	0 - 35 IU/L	308 (H)	270 (H)	36 (H)	63 (H)	31	41 (H)
Alkaline Phosphatase	33 - 133 IU/L	185 (H)	147 (H)	66	102	72	65

	Latest Reference Range & Units	09/20/24 08:15	10/04/24 08:11	10/18/24 07:53	11/01/24 11:18	11/26/24 15:46	12/30/24 07:44
AST	0 - 37 IU/L	32	23	32	29	31	27
ALT (SGPT)	0 - 35 IU/L	54 (H)	28	33	25	30	18
Alkaline Phosphatase	33 - 133 IU/L	69	71	79	87	71	69

AGA Clinical Practice Update: Diagnosis and Management of Cyclic Vomiting Syndrome

Sarah Enslin, PA-C

Cyclic vomiting syndrome (CVS) is a chronic disorder characterized by recurring episodes of severe nausea, vomiting, and retching, separated by symptom-free periods. Patients with CVS often recognize a consistent pattern of symptoms during both the prodromal (pre-vomiting) and emetic (vomiting) phases. Despite effective treatments, CVS is frequently underdiagnosed, leading to delays in diagnosis and inappropriate medical interventions, including unnecessary surgeries. The prevalence of CVS is about 2% in the U.S., with a higher incidence in women, yet many cases remain undiagnosed.

DIAGNOSIS AND PHASES:
CVS diagnosis relies on clinical criteria, particularly the Rome IV criteria, which include stereotypical episodes of vomiting lasting less than 7 days and occurring at least 3 times a year (2 episodes occurring in the past 6 months), with periods of normal health between episodes. A personal or family history of migraine headaches supports the diagnosis of CVS. Diagnostic evaluation to exclude other causes should include blood work (CBC, BMP, LFTs, lipase), urinalysis, and one-time EGD or upper GI imaging to exclude obstructive lesions.
CVS has four distinct phases:

1. **Inter-episodic phase** (normal health)
2. **Prodromal phase** (onset of nausea)
3. **Emetic phase** (vomiting and retching)
4. **Recovery phase** (gradual return to baseline health)

CLINICAL FEATURES AND TRIGGERS:
CVS episodes are often triggered by factors such as stress, sleep deprivation, hormonal changes, travel, motion sickness, and physiological stressors like infections or surgeries. Abdominal pain, anxiety, and other symptoms often accompany the vomiting episodes. Symptoms may occur at any time of day but often occur in the early morning hours. Hot water bathing/showering is common and provides temporary relief in the prodromal and emetic phases of an episode. Recognition of these symptoms and phases is crucial for timely intervention, particularly during the prodromal phase when abortive therapies are most effective.

Cannabis hyperemesis syndrome (CHS) has been recognized as a subset of CVS in patients with prolonged (> 1 year) and heavy (>4 times weekly) cannabis use. Cannabis should be discontinued for 6 months to effectively diagnosis CHS.

MANAGEMENT:
Management of CVS involves both lifestyle modifications and medical interventions:

- **Lifestyle Modifications:** Addressing comorbid conditions such as anxiety and depression, identifying and avoiding triggers, maintaining regular sleep, and managing stress.
- **Prophylactic Therapies:** Medications like tricyclic antidepressants, anticonvulsants, and antiemetics are recommended for preventing episodes, especially in patients with moderate to severe CVS (>4 episodes per year, each lasting > 2 days).
- **Abortive Therapies:** Medications like sumatriptan and ondansetron are used to abort an episode if administered early in the prodromal phase. Sedative agents may also be necessary to control symptoms during severe episodes.

COMORBID CONDITIONS AND COMPLICATIONS:
CVS is often associated with comorbid conditions, including migraines, mood disorders, and autonomic dysfunctions such as postural orthostatic tachycardia syndrome. Effective management of these comorbidities can improve overall outcomes and reduce the frequency and severity of CVS episodes.

FUTURE DIRECTIONS:
Further research is needed to understand CVS's pathophysiology, improve diagnostic criteria, and develop more targeted treatments. Additionally, addressing racial disparities and understanding the clinical predictors of response to treatments will help optimize patient care.

Levinthal D, Staller K, Venkatesan T. AGA Clinical Practice Update on Diagnosis and Management of Cyclic Vomiting Syndrome. *Gastroenterology*. 2024; 167(4):804-811

Membership Engagement Committee

Wow! We have been busy rounding out our subcommittees and expanding on subcommittee work. The interview process took longer than expected due to the numerous applicants with varied and excellent skill sets. The applicant pool reflects the depth of involvement and intellect of the APP's we have across the nation. We were impressed by so many of our peers' accomplishments, some in a very short time of being in the field, that it made it exceedingly difficult to choose. We had the hand-wringing job of choosing three candidates to fill the vacant positions.

It is with much excitement that we announce the following new members:

Patryk Madrid, NP
Anne Arundel Gastroenterology Associates
Annapolis, MD

Hana Nguyen, NP
Liver Specialist of Texas, Houston Methodist Hospital
Houston, TX

Nichole Sisserson, PA
Inova Health
Arlington, VA

In other exciting news:

- The Awards Subcommittee has finalized the criteria and scoring rubric for the GHAPP Advanced Practice Provider Excellence Award. You may have already seen the recent email calling for nominations—don't miss the opportunity to highlight a deserving colleague!
- The Mentorship Subcommittee is actively developing new and innovative ways to engage APPs—whether you're new to GI/Hepatology or a seasoned professional. Stay tuned for more details soon!
- And as always, our Newsletter Subcommittee continues to shine, consistently delivering high-quality content that keeps APPs informed of best practices and emerging updates in patient care and disease management.
- The Social Media Subcommittee will continue to share updates on committee initiatives, upcoming events, award nominations, mentorship opportunities, and newsletters across all platforms. The team aims to increase visibility and engagement by fostering a strong sense of community among APPs online.
- The Abstracts Subcommittee will focus on increasing awareness of abstract submission opportunities and deadlines. In addition, the subcommittee will be responsible for reviewing and judging submitted abstracts for the national conference.

Thank you for your continued support and engagement!

Education Committee

We're excited to invite you to the GHAPP National Conference this September!

More than just a place for top-tier education, the GHAPP conference is where professional growth meets a fun, rejuvenating getaway. With a wide range of sessions and breakout workshops, you can tailor the experience to fit your interests—and that's just the beginning.

What truly sets this conference apart is the vibrant, friendly GHAPP community. From casual dinner events to insightful conversations between sessions, many attendees say the connections they make here are the best part of the experience.

You'll leave feeling inspired by new ideas, shared challenges, and motivating discussions—all while enjoying a relaxed atmosphere where you'll be dined and welcomed.

Join us this year for a memorable, energizing trip that will strengthen your network and recharge your passion for what you do.

CALL FOR ABSTRACTS

The Course Directors of the 8th Annual GHAPP Conference invite the submission of abstracts on one of the categories in hepatology or gastroenterology listed below. Our goal is to provide a comprehensive update on the status of research and stimulate collaborations, recruitment of subjects, and ideas for developing other studies. Authors may submit abstracts of completed work, work in progress, or work presented elsewhere within the past 12 months.

ABSTRACT SUBMISSION DEADLINE:

Friday, August 1, 2025

VISIT
www.ghapp.org/call-for-abstracts
Click or scan the QR code

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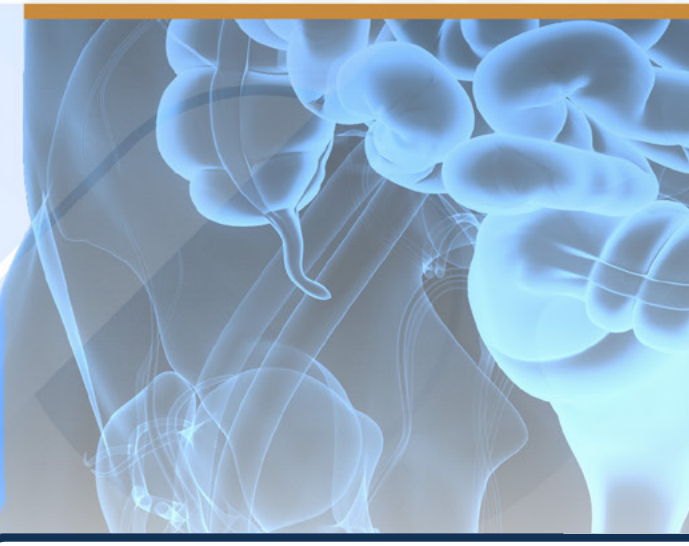

10 LOCATIONS

Los Angeles, CA – May 15, 2025

Denver, CO– May 29, 2025

Dallas, TX – June 12, 2025

Atlanta, GA – June 19, 2025

Chicago, IL – July 17, 2025

Boston, MA – July 31, 2025

Miami, FL - October 9, 2025

New York, NY - October 16, 2025

New Orleans, LA - November 13, 2025

Scottsdale, AZ - November 20, 2025

Earn 1.5 AAPA credit hours or 1.50 ANCC contact hours!

SCAN QR CODE FOR REGISTRATION AND DETAILS!

ACCREDITATION INFORMATION

https://www.ghapp.org/2025-regionals-accreditation

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APP Excellence Award

Nominate a deserving colleague or friend for the GHAPP Advanced Practice Provider Excellence Award! This award recognizes advanced practice providers (APPs) who have demonstrated exceptional leadership, clinical expertise, and dedication to improving patient care.

Click or scan the QR code for further details and nomination criteria.

NOMINATION FORMS DUE BY JUNE 30, 2025.

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