Continuing Medical Education Questions: August 2016

Steven L. Carpenter, MD

If you wish to receive credit for this activity, please refer to the Web site: http://acgjournalcme.gi.org/.

Article Title: Risks and Predictors of Gastric Adenocarcinoma in Patients with Gastric Intestinal Metaplasia and Dysplasia: A Population-Based Study

Am J Gastroenterol 2016; 111:1114; doi:10.1038/ajg.2016.284

QUESTIONS:

1. A 76-year-old white female presents with regurgitation, heartburn, and dyspepsia. She has no history of dysphagia, weight loss, or early satiety. There is no family history of gastrointestinal malignancy. On physical exam, she appears healthy with a BMI of 26 kg/m², and her vital signs are normal. Upper endoscopy is notable for chronic-appearing gastritis. No mass, ulceration, pyloric stricture, mucosal nodularity, or gastric fold thickening was identified. Antral biopsies demonstrate gastric intestinal metaplasia without evidence for dysplasia.

Based on this study, what is the annual risk for adenocarcinoma in this patient?

A. 0.07%
B. 0.11%
C. 0.25%
D. 0.77%

2. A 48-year-old Hispanic female presented with a history of epigastric pain. There was no history of weight loss, nausea, vomiting, dysphagia, or early satiety. Vital signs were stable and her physical examination was unremarkable. Upper endoscopy was notable for mild erythema of the gastric antrum. Biopsies revealed gastric intestinal metaplasia without evidence for dysplasia. Atrophic gastritis was also noted. There was the notable absence of ulceration, mass presence, gastric fold thickening, or nodularity on the endoscopy.

Based on this study, which one of the following factors places this patient at the highest risk for the future development of gastric adenocarcinoma?

A. Presence of coexisting Barrett’s esophagus
B. Location of the gastric intestinal metaplasia
C. Presence of low- or high-grade dysplasia
D. Presence of Helicobacter pylori

3. Based on this study, which one of the following factors was associated with the highest risk for progression of gastric intestinal metaplasia to gastric adenocarcinoma?

A. Presence of coexisting Barrett’s esophagus
B. Presence of low- or high-grade dysplasia
C. Presence of Helicobacter pylori
D. Presence of atrophy on pathology