



### Five Things Physicians and Patients Should Question

1

**For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine<sub>2</sub> receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals.**

The main identifiable risk associated with reducing or discontinuing acid suppression therapy is an increased symptom burden. It follows that the decision regarding the need for (and dosage of) maintenance therapy is driven by the impact of those residual symptoms on the patient's quality of life rather than as a disease control measure.

2

**Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.**

A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this population. Therefore, following a high-quality colonoscopy with normal results the next interval for any colorectal screening should be 10 years following that normal colonoscopy.

3

**Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.**

The timing of a follow-up surveillance colonoscopy should be determined based on the results of a previous high-quality colonoscopy. Evidence-based (published) guidelines provide recommendations that patients with one or two small tubular adenomas with low grade dysplasia have surveillance colonoscopy five to 10 years after initial polypectomy. "The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician)."

4

**For a patient who is diagnosed with Barrett's esophagus, who has undergone a second endoscopy that confirms the absence of dysplasia on biopsy, a follow-up surveillance examination should not be performed in less than three years as per published guidelines.**

In patients with Barrett's esophagus without dysplasia (cellular changes) the risk of cancer is very low. In these patients, it is appropriate and safe to exam the esophagus and check for dysplasia no more often than every three years because if these cellular changes occur, they do so very slowly.

5

**For a patient with functional abdominal pain syndrome (as per ROME III criteria) computed tomography (CT) scans should not be repeated unless there is a major change in clinical findings or symptoms.**

There is a small, but measurable increase in one's cancer risk from x-ray exposure. An abdominal CT scan is one of the higher radiation exposure x-rays — equivalent to three years of natural background radiation. Due to this risk and the high costs of this procedure, CT scans should be performed only when they are likely to provide useful information that changes patient management.

## How This List Was Created

The American Gastroenterological Association (AGA) convened a work group that included members from the Clinical Practice and Quality Management Committee (CPQMC), chair of the Practice Management and Economics Committee (PMEC), the chief medical officer for the AGA Digestive Health Outcomes Registry® and members of the AGA Institute Governing Board. Ideas for the “five things” were solicited from the workgroup for review by the CPQMC, which developed additional topics, resulting in six draft items. The workgroup continued to pare down and refine the list, before submitting a final draft to both the CPQMC and the PMEC for approval. After final refinements were made to simplify language and avoid complex clinical terminology, the final list was submitted to and approved by the AGA Institute Governing Board. AGA’s disclosure and conflict of interest policy can be found at [www.gastro.org](http://www.gastro.org).

## Sources

- 1 American Gastroenterological Association Medical Position Statement on the Management of Gastroesophageal Reflux Disease. *Gastroenterology*, 2008.
- 2 Winawer S et. al. and US Multisociety Task Force on Colorectal Cancer. Colorectal Cancer Screening and Surveillance, Clinical Guidelines and Rationale—Update Based on New Evidence. *Gastroenterology*, 2003.  
Rex et. al. Quality indicators for colonoscopy. *Gastrointestinal Endoscopy*, 2006.
- 3 Levin B et. al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline From the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. *Gastroenterology*, 2008.  
Rex et. al. Quality indicators for colonoscopy. *Gastrointestinal Endoscopy*, 2006.
- 4 American Gastroenterological Association Medical Position Statement on the Management of Barrett’s Esophagus Gastroenterology.  
Wang KK, Sampliner RE and The Practice Parameters Committee of the American College of Gastroenterology. Updated Guidelines 2008 for the Diagnosis, Surveillance and Therapy of Barrett’s Esophagus, *Journal of Gastroenterology*, 2008.
- 5 Drossman DA, Corazziari E, Delvaux M, Spiller RC, Talley NJ, Thompson WG, et al. , eds. Rome III. *The Functional Gastrointestinal Disorders*, 2nd edn., 2006.  
Clouse, RE et al. Functional Abdominal Pain Syndrome. *Gastroenterology*, 2006.  
U.S. Food and Drug Administration. Reducing Radiation from Medical X-rays This article appears on FDA’s Consumer Updates page, which features the latest on all FDA-regulated products. Date Posted: February 19, 2009. Accessed at <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm095505.htm>.  
Image Wisely and US Food and Drug Administration. My Medical Imaging History. Access at [http://www.radiologyinfo.org/en/safety/ImageWisely/7678\\_Medical%20Imaging%20History.pdf](http://www.radiologyinfo.org/en/safety/ImageWisely/7678_Medical%20Imaging%20History.pdf).

### About the ABIM Foundation:

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.



To learn more about the ABIM Foundation, visit [www.abimfoundation.org](http://www.abimfoundation.org).

### About the American Gastroenterological Association:

The American Gastroenterological Association (AGA) is the trusted voice of the GI community. Founded in 1897, AGA has grown to include 16,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. The AGA Institute administers the practice, research and educational programs of the organization. Become an [AGA fan on Facebook](#). [Join our LinkedIn group](#). Follow us on Twitter [@AmerGastroAssn](#).



For more information or questions, please visit [www.gastro.org](http://www.gastro.org).

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit [www.choosingwisely.org](http://www.choosingwisely.org).