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Dear Colleagues,

Our cover story for this issue of Digest This focuses on reoperative surgery – an extremely relevant topic given the high percentage of patients referred to both Cleveland Clinic’s main campus and Cleveland Clinic Florida for such surgery. These procedures are among the most common reasons for patient referral to both campuses, either due to the need for repeat or revisional surgery following complications or failure after prior procedures and/or recurrence of disease.

Our surgeons use a multidisciplinary approach to provide these patients with complex problems with the most effective surgical options, including both the latest open surgical techniques and advanced minimally invasive approaches. We continue to play a leading role in surgical innovations and constantly strive for new ways to make procedures safer and more effective for our patients. To learn more about some of our advances in the area of reoperative surgery, please see our detailed report on p. 6.

In this issue of Digest This, we also provide updates on other services within our Digestive Disease Institute (DDI). On p. 1, we preview our brand new state-of-the-art endoscopy unit, which is scheduled to open this January. We highlight DDI’s pediatric capabilities through our service spotlight on p. 2. Also on p. 4, you can learn about our use of probe-based confocal laser endomicroscopy (pCLE) for detecting choloangiocarcinoma as well as a study to find out if the technology may improve treatments for small bowel transplantation patients.

Finally, we invite you to attend our 22nd Annual International Colorectal Disease Symposium from Feb. 17 to 19, 2011 in Fort Lauderdale, Fla. We again expect more than 800 attendees from over 50 countries to participate. This year’s course will provide the most current detailed and in-depth analysis of the current status of colon and rectal surgery, including topics such as NOTES, robotics, TEM, TME and advanced laparoscopy. Our focus will be upon optimizing patient outcomes through the clinical applications of the current best practices in the field demonstrated by world renowned experts with extensive use of video and audience interactive discussion. We look very much forward to seeing you there.

We hope you will find much new information to engage you in this issue of Digest This. If you have any comments, questions or suggestions about this publication or the Digestive Disease Institute, please contact us.

Sincerely,

Steven D. Wexner, MD
Chairman, Department of Colorectal Surgery; Chief Academic Officer; and Emeritus Chief of Staff, Cleveland Clinic Florida
DDI’s advanced endoscopy team is preparing to open a brand-new 15,000-square-foot facility in January 2011 built to improve both access and patient experience.

Located in the Glickman Tower on Cleveland Clinic’s main campus, the state-of-the-art facility emphasizes both safety and quality. This expansion will double the number of therapeutic endoscopy suites for performing endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasound (EUS) and deep enteroscopy. Specialized fluoroscopic equipment will allow for the next generation of 3-D cholangiography, which is available at only a handful of units nationally.

The unit was designed to improve patient satisfaction and features private recovery rooms with TVs and seating for family members. It will help maximize communication between patients and caregivers and enable close interaction with staff from other specialties, including anesthesiology, hepatobiliary surgery, colorectal surgery, thoracic surgery, oncology and radiation oncology, during treatment. New Provations software will provide improved reporting for patients, allowing referring physicians to access images and recommendations from their patients’ visit.

“This much-anticipated expansion will increase our ability to handle additional volume to speed up diagnosis and treatment of patients.”
- John Vargo, MD, MPH
DDI Spotlight: Treating Pediatric Gastrointestinal Diseases

Cleveland Clinic offers a full range of digestive disease services – including gastroenterology & hepatology, colorectal surgery, general surgery, hepato-pancreato-biliary and transplant surgery and human nutrition – for pediatric patients through a close collaboration between DDI and experts from Cleveland Clinic Children’s Hospital.

GASTROENTEROLOGY & HEPATOLOGY
• The Pediatric Gastroenterology Department’s highly specialized medical staff provides expertise in pediatric liver disease, inflammatory bowel disease (IBD - ulcerative colitis and Crohn's disease), biliary atresia, celiac disease, pediatric endoscopy, motility disorders and intestinal rehabilitation, including intestinal transplantation, as well as the full spectrum of pediatric gastrointestinal disease.
• Advanced motility studies in children are directed by Rita Steffen, MD, Section Head, Pediatric Motility Disorders. Sophisticated colonic motility studies are performed over a two-day period for children with complex motility issues in addition to rectal motility. Esophageal motility and antroduodenal motility studies are performed for upper gastrointestinal issues, such as gastroparesis or intestinal pseudo-obstruction.
• Cleveland Clinic Children's Hospital specialists can offer parents the peace of mind of advanced, less invasive endoscopic procedures for children experiencing digestive disease issues, led by Marsha Kay, MD, Head, Pediatric Endoscopy. These include procedures to prevent and stop gastrointestinal bleeding, remove accidentally ingested foreign bodies, catheter and tube placement and dilation of gastrointestinal strictures and wireless capsule imaging of the small intestine.

PEDIATRIC SURGERY
A magnet for complex digestive disease cases, Cleveland Clinic Children’s Hospital’s Pediatric General Surgery Department, chaired by David Magnuson, MD, offers advanced options for digestive disease issues, including:
• irritable bowel disease
• the Kasai procedure for biliary atresia
• advanced laparoscopic procedures
• Hirschsprung's disease
• imperforate anus

PEDIATRIC PREVENTATIVE CARDIOLOGY & METABOLIC CLINIC
The Pediatric Preventative Cardiology & Metabolic Clinic uses a multidisciplinary approach to combat the effects of obesity and other issues in children showing evidence of a metabolic complication. Increasingly seeing teens and young adults with evidence of non-alcoholic fatty liver disease and rising obesity in children, pediatric gastroenterologist Christine Carter-Kent, MD, and a team of pediatric cardiologists, behavioral specialists, exercise physiologists, dietitians and preventative cardiologists, work together to address these issues.
Created in 2009, the pediatric clinic has worked with more than 100 patients, globally addressing their medical problems to help prevent future complications. In addition, Cleveland Clinic pediatric gastroenterologist Ariel Feldstein, MD, an award-winning researcher in the Pediatric Institute, is currently working on two NIH-funded studies examining the identification and treatment of non-alcoholic fatty liver disease, associated with obesity in children.
HEPATO-PANCREATO-BILIARY & TRANSPLANT SURGERY

The DDI’s pediatric surgical transplant team leaders – John Fung, MD, Chairman of Hepato-pancreato-biliary and Transplant Surgery, Director of the Cleveland Clinic Transplant Center and Chairman of General Surgery, Bijan Eghtesad, MD, and Charles Miller, MD, Director of Liver Transplantation – together have performed more than 3,000 transplants with 75 years of combined experience. The one-year survival rate for their pediatric liver transplant patients: 100 percent. The surgeons collaborate with the pediatric GI staff, including Vera Hupertz, MD, Medical Director, pediatric liver transplantation.

NUTRITION

Certified pediatric registered dietitians from Cleveland Clinic Children’s Hospital see nearly 10,000 children annually, providing:

- inpatient consultation and ambulatory clinics with nutrition counseling for patients who have undergone heart, liver and kidney transplantation
- total parental nutrition programs, and recommendations regarding enteral feeding regimens for children who require gastrostomy or jejunostomy feedings, for both inpatients and outpatients
- nutrition support feeding strategies for improved health and restoration of oral feeding skills, as well as dietary strategies for improved quality of life for children dealing with neurological, genetic, and metabolic disorders

FEEDING DISORDERS PROGRAM

A team of specialists from psychology, developmental pediatrics, occupational therapy and clinical nutrition help infants and children with the following feeding difficulties: poor/faltering growth, tube feeding dependence, aversive feeding behavior, problems eating textured food and significant food selectivity. Parental guidance and support are key program components.
New Probe-Based Technology
Confocal Laser Endomicroscopy Detects Early-Stage Pathology, Intestinal Rejection

Probe-based confocal laser endomicroscopy (pCLE) enables in vivo observation of the mucosal tissue at the microscopic level and cellular visualization in real time. Although this technology is new and is being used for certain clinical applications in only 25 U.S. medical centers, including Cleveland Clinic, pCLE is demonstrating its capability to accurately detect the early stages of pathology that cannot be detected via current endoscopic imaging modalities, including magnification endoscopy.

Several small research studies have shown pCLE’s utility in detecting cholangiocarcinoma, Barrett’s esophagus and colorectal cancers. In addition, researchers have demonstrated pCLE’s capability in depicting recognizable features of malignant and benign tissues in bile and pancreatic ducts.

At Cleveland Clinic, physicians have found pCLE to be effective in detecting cholangiocarcinoma in some patients. In addition to this clinical application, Cleveland Clinic researchers are investigating another application of pCLE that may improve treatments for small bowel transplantation patients.

The study’s primary aim is to evaluate whether pCLE can accurately classify small bowel transplantation patients as negative or positive for rejection by comparing pCLE to conventional surveillance endoscopy with biopsy. The study’s second objective is to determine whether pCLE can improve the efficiency of surveillance endoscopy by decreasing the number of biopsies while increasing the ability to target lesions at greatest risk of harboring mucosal changes consistent with rejection.

“Monitoring for intestinal rejection is vital after small bowel transplantation since graft rejection is the main complication of the procedure, and early diagnosis and treatment of graft rejection is an absolute necessity,” explains Dr. Parsi. “Clinical symptoms of graft rejection usually appear much later than the first signs of histological damage. Therefore, repeated endoscopy with mucosal biopsies for conventional histology and immunohistochemistry is routinely used to monitor patients for rejection after intestinal transplantation. Development of new techniques for earlier diagnosis of rejection is an important aspect of improving the outcomes of small bowel transplantation.”

Paris-based Mauna Kea Technologies developed the first pCLE system, Cellvizio. In 2005, the U.S. Food and Drug Administration approved Cellvizio for clinical applications. Compatible with any endoscopy environment, the portable Cellvizio system has four confocal miniprobes for esogastroduodenoscopy (EGD), cholangioscopy during endoscopic retrograde cholangiopancreatography (ERCP), colonoscopy and bronchoscopy.

MONITORING POST-OPEVATIVE REJECTION
Cleveland Clinic gastroenterologist Mansour Parsi, MD, in cooperation with hepato-pancreato-biliary and transplant surgeon Cristiano Quintini, MD, and gastroenterologist Milan Dodig, MD, have launched a research study examining confocal laser endomicroscopy in small bowel transplantation.

The incidence of rejection is high in small bowel transplantation compared to other organs, though there has been some degree of improvement in recent years. For example, from 1990 to 1994 the incidence of rejection was 85 percent. From 1995 to 2001, the incidence
of rejection was 67 percent. Unfortunately, mortality associated with severe rejection is about 25 percent to 45 percent at six months. Graft loss occurs in virtually all patients with severe rejection despite aggressive immunosuppressive therapy.

Typical symptoms of patients with acute rejection are increased stoma output, fever, abdominal pain, distension and ileus. Patients also are susceptible to sepsis from bacterial translocation and fungal infections.

**BENEFITS OF EARLY DIAGNOSIS**

It is therefore beneficial to the patient to diagnose rejection in its earliest stages to enable intervention before irreversible complications develop. In the early postoperative period, protocol serial endoscopies with intestinal biopsies are performed for graft surveillance because the highest number of rejections occurs within the first month following transplant.

At Cleveland Clinic, rejection monitoring is accomplished by performing endoscopy and intestinal biopsies through the temporary ileostomy. The endoscopy with biopsy is performed twice a week in the first month, once every week in the second month, once every two weeks in the third month, once a month in the fourth to ninth month, and then once every three months. However, if rejection is suspected or diagnosed, endoscopy and biopsy will be performed every other day until the rejection is resolved.

Another approach that has been suggested for earlier detection of rejection is magnification endoscopy, which may reveal early mucosal changes that may not be visible with standard endoscopy. These include erythema, villous congestion and blunted and shortened villi. In one series, Dr. Parsi notes, the sensitivity and specificity of these findings compared with histology were 45 and 98 percent, respectively, in adults with clinical features suggestive of acute rejections. Similar test characteristics were described in children.

“Although confocal endomicroscopy has not been previously evaluated for detection of mucosal changes associated with small bowel rejection, the ability of this technology to magnify the image to the cellular level may allow better diagnostic capability than magnification endoscopy,” says Dr. Parsi.

Ten small bowel transplantations are anticipated to be performed at Cleveland Clinic annually. All patients undergoing small bowel transplantation within two years will be asked to participate in this case series.

For more information or to make a referral, please call 1.888.410.1775 or email parsim@ccf.org.

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**2008**

Cleveland Clinic surgeons perform our first adult intestinal transplant.
“Repetition is the mother of all skill.” This principle, says Feza H. Remzi, MD, Colorectal Surgery Chairman at Cleveland Clinic, is no doubt critical to the care of many patients requiring colorectal surgery, such as those with complex inflammatory bowel disease (IBD).

The experience and expertise that come from such repetition is essential for patients with inflammatory bowel disease because reoperations can be complex procedures,” explains Dr. Remzi.

It also may account for the fact that reoperative surgery is one of the most common reasons for patient referrals to colorectal surgeons – for not only IBD, but also colorectal cancer and pelvic floor disorders – at both Cleveland Clinic main campus and Cleveland Clinic Florida.

“Our Institute surgeons see one of the highest volumes of complex reoperative cases in the country,” says David Dietz, MD, Vice-Chairman of the DDI. “Both patients and referring physicians see us as the last stop on the line for many of these problems. It is not uncommon for patients to say they’ve been told nothing else can be done. Our tremendous experience in these situations not only allows us to offer them another option, but generally leads to a very good outcome. There is nothing that is more gratifying than restoring a patient’s quality of life.”

SURGICAL EXPERIENCE AND EXPERTISE
Reoperative cases may be either repeat, due to the recurrence of disease, or revisional, to fix complications related to prior surgical procedures, Dr. Remzi explains.

“For example, because of the recurrent and complex pathologies of Crohn’s disease (CD), approximately 35 to 40 percent of CD patients may require a reoperation every five years,” he says.

In these cases, the long-term medical care establishes a close surgeon-patient relationship that fosters communication and confidence. It also enables surgeons to
urgery
develop a thorough knowledge of each patient’s medical history. This in turn allows surgeons to optimally manage the element of unpredictability that may occur during reoperations.

“It is to the patient’s advantage to develop a long-term relationship with a surgeon who will know their particular anatomy and structure, as well as get to understand their individual thresholds for both surgery and step-up use of medications,” Dr. Remzi notes.

In addition to reoperations and revisional procedures, Cleveland Clinic colorectal surgeons are increasingly sought out by patients with complex and/or challenging problems to try to use their expertise and technical skills to preemt surgical complications, says Steven Wexner, MD, Chairman of Colorectal Surgery at Cleveland Clinic Florida.

“Many times, a primary surgeon may recognize a patient’s high risk level, for instance, a patient with UC who needs a J-pouch, and make the referral to either of our campuses because of our expertise and very high volume of these operations,” Dr. Wexner says. “They may feel more comfortable making the referral knowing the vast experience we have in managing surgical complications and recurrences.”

In such cases, Dr. Wexner says, it is Cleveland Clinic’s reputation for innovation and pioneering new therapies that is the differentiator.

“In both Cleveland and Florida, we have long pushed the envelope – doing things differently. For instance, in 1998 we were the first center in the United States to implement and champion double stapling rather than mucosectomy to improve the outcomes of the procedure and in 1991 we were the first center in the nation, if not the world, to introduce laparoscopic J-pouch surgery with Dr. David Jagelman.”

For certain procedures, like the J-pouch, Dr. Remzi adds, doing the procedure from the first go-around is an important reason for patients to be referred to a high-volume center, such as Cleveland Clinic’s DDI.

“This is because the first time around has the best outcome,” he notes.

REOPERATIVE PELVIC POUCHES

In addition to performing one of the world’s highest published volumes of J-pouch surgeries, Cleveland Clinic has become the largest referral center for addressing issues and pathologies with failing pouches. The DDI also established the nation’s first Pouchitis/Pouch Disorders Clinic to provide patients with multidisciplinary and comprehensive follow-up care.

There are several risk factors associated with pouch failure: pathologic diagnosis (CD versus non-CD) patient’s comorbidities, prior anal disease, diminished anal sphincter function, anastomotic complications such as separation, leak, abscess, stricture and also development of perianal fistula.

“In order to preclude the necessity of an ileostomy, in certain cases we may consider doing a redo pelvic pouch procedure,” Dr. Remzi says. “This may include performing a major laparotomy, abdominal pelvic pouch mobilization with disconnection and creating a new hand-sewn anastomosis.

“Under these circumstances, we may either salvage the old pouch or create a new pouch. The critical reason we do this is to eliminate the septic focus related to the failed anastomosis and its related complications.”

DDI’s colorectal surgeons are expert in dealing with anastomotic conditions relating to prior surgery. Overall, the reoperative pouch success rate at Cleveland Clinic is 85 percent. This includes a 96 percent success rate in UC patients and a 60 percent success rate in CD patients.

One of the other areas that the colorectal surgeons at the DDI have expertise is the surgical management related to prior surgeries, Dr. Remzi says. This can be classified as issues related to enterocutaneous fistulas or patients with anastomotic leak and chronic infection related to prior low anterior resection and colorectal anastomosis or colo-anal anastomosis.

Especially in the latter conditions, reestablishing the anastomosis is challenging because of the close proximity of the pathology to vital

Figure 1: Redo of an ileal pouch surgery for a septic complication related to a prior osteo leak.

![Redo of an ileal pouch surgery for a septic complication related to a prior osteo leak.](image)
anatomical structures. Colorectal surgeons at DDI developed a unique pull-through technique to avoid permanent colostomy and establish a functioning anastomosis for these morbid pathologies, says Dr. Remzi.

**LAPAROSCOPIC ADVANCES**

Although reoperations are usually open procedures, advanced minimally invasive procedures are becoming more common for colorectal operations.

Daniel Geisler, MD, Cleveland Clinic colorectal surgeon who performed the world’s first single-incision proctocolectomy last year, says reoperations can be performed laparoscopically at Cleveland Clinic.

“We not only are using cutting-edge technology on a daily basis, but we also are using it to train the next generation of colorectal surgeons, as together with Cleveland, we train more residents than any other program in North America.”

- Steven Wexner, MD

We can still do minimally invasive surgery for patients who are having elective surgery for a disorder that involves previous abdominal operations,” Dr. Geisler says. “This offers patients the benefits of quicker healing and less pain with less visible scarring.”

A large percentage of pelvic floor reoperations for fecal incontinence also are done at both Cleveland Clinic main campus and Florida, adds Dr. Wexner. “We not only are using cutting-edge technology on a daily basis, but we also are using it to train the next generation of colorectal surgeons, as together with Cleveland, we train more residents than any other program in North America.”

For more information or to make a referral for reoperative surgery, please call 1.888.410.1775. Contact Dr. Remzi at remzif@ccf.org and Dr. Wexner at wexners@ccf.org.

**ON-CALL SWAT SUPPORT**

About six years ago, John Fung, MD, PhD, Chairman of Hepato-pancreato-biliary and Transplant Surgery, Director of the Cleveland Clinic Transplant Center and Chairman of General Surgery, established Surgical Work-up, Alternatives and Treatment (SWAT), an on-call service to support Cleveland Clinic’s regional hospital surgeons who may occasionally require specialized surgical expertise to correct a complication during a cholecystectomy procedure.

Although complications during a cholecystectomy are rare – only one percent of 750,000 procedures – the first attempt to repair the biliary tract complication is important in order to prevent infection or prolonged stricture formations that may lead to liver damage and other chronic conditions.

“I’m on call because it is more conducive to perform these procedures at a patient’s point of care center, and preferably during the cholecystectomy when the surgeon detects a complication,” says Dr. Fung. “The SWAT process facilitates the expediency of the surgical repair, prevents post-operative complications and improves the patient’s overall quality of care and recovery.”

For biliary tract complications, Dr. Fung typically performs a Roux-en-Y hepatojejunostomy, which involves an 8-inch to 10-inch loop from the small intestine bowel. Following the suturing to close one end of the bowel, the top portion of the loop is sutured to the bile duct. The low end of the bowel is sutured to the intestine, which serves as a conduit to remove bile so that it flows into the intestinal tract.

Contact Dr. Fung at 216.444.3776 or fungj@ccf.org.

**AREAS OF REOPERATIVE EXPERTISE:**

- complex IBD, such as medically refractory ulcerative colitis (UC), UC with cancerous or dysplasia conditions, familial adenomatous polyposis (FAP) and Crohn’s disease
- colorectal cancer
- pelvic floor disorders, including sacral nerve stimulation for fecal incontinence
- biliary tract complications
Wound Ostomy Continence

Nursing School Expands its Program Online

When it was founded in 1961, Cleveland Clinic’s R.B. Turnbull, Jr., MD, School of WOC Nursing was the first of its kind in the world. Since then, it has graduated more than 1,500 of about 6,000 WOC nurse specialists practicing throughout the world.

In June 2010, Cleveland Clinic began offering its wound, ostomy, continence (WOC) educational program online with its first class of students. The program was the vision of Paula Erwin-Toth, MSN, RN, CWOCN, CNS, WOC Nursing Education Program Director, and made possible through a generous grant from Mrs. Ann Goldstein to support WOC Nursing Education. The Ann Goldstein Online WOC Nursing Education Program offers students the same range of curriculum and access to expert faculty as the live school program.

Online WOC Nursing Education allows students to complete the program and become eligible for certification right from the comfort of their own homes with many opportunities to interact with classmates and faculty along the way. Each course includes a clinical component that may be completed with an approved local WOC nursing preceptor.

“The training prepares students to play a vital role in pre- and post-operative management of the person with an ostomy; to be instrumental in the prevention and treatment of pressure ulcers, fistula, and other skin disorders; and to be a specialist in the care of patients with urinary and fecal incontinence. Students will acquire the necessary skills to provide patients with effective psychological support, discharge planning, rehabilitation counseling and follow-up care,” says Linda Stricker, MSN/ED, RN, CWOCN, Assistant Director, WOC Nursing Education.

To enroll in the upcoming Fall 2010 class, applicants must be registered nurses and have earned a BSN and have at least one year of medical-surgical nursing experience.

Visit clevelandclinic.org/OnlineWOC for further details on this program and registration information.
Capsule Endoscopy Sheds Light into the Small Intestine of Pediatric Patients

To date, approximately 200,000 patients have undergone video capsule endoscopy (CE) throughout the world. The primary indications for CE include the evaluation of obscure small intestinal bleeding, small bowel Crohn’s disease, celiac disease, polyposis syndromes and other small bowel mucosal abnormalities. Capsule endoscopy has been increasingly used in pediatric patients since its approval by the U.S. Food and Drug Administration in 2003. Numerous studies have documented that CE is safe, well tolerated, and more sensitive than radiological and standard endoscopic modalities in the detection of small bowel mucosal abnormalities in children.

This technology is readily available in the Department of Pediatric Gastroenterology at the Cleveland Clinic Children’s Hospital. A team of physicians trained in capsule endoscopy perform and interpret these studies. A recent study in our department by Uko et al (Endoscopy 2009;41:380-382) demonstrated the safety of a capsule endoscopy delivery device for capsule delivery beyond the pylorus in children as young as 3 years of age.

Capsule endoscopy does not require sedation and it is generally well tolerated by the majority of patients. Children and adolescents who undergo the procedure are fitted with an external recording device, which is worn on a belt around their waist. The patient will be asked to swallow the capsule with a glass of water. Once the data record light is blinking, verifying that the test is in progress, the patient is encouraged to walk and move around so that capsule will move effectively through the digestive tract. Most tests take from six to eight hours, and the patient can take fluids and any medication two hours after the test has been in progress. After four hours, he or she may progress to a light snack. Once the recording time is complete, the patient returns the waist belt, and is asked to watch bowel movements for the capsule to pass.

The capsule is not reusable and is excreted in stool within a couple of days. If the patient does not see the capsule pass in a bowel movement, an abdominal X-ray is subsequently performed to ensure capsule passage from the patient’s body. The ability to swallow the capsule which measures 11mm x 26mm is a challenge for some patients, especially those in the pediatric population. Future generations of video capsules that are smaller, safer and capable of sampling tissue and being manually steered are under development.

Should you have questions regarding this technology or wish to refer a patient for evaluation, please contact Lori Mahajan, MD, at 216.445.1572.

New Hernia Center Established

Cleveland Clinic recently established a Hernia Center, which formally combines the expertise of its surgeons who see patients at 16 convenient locations in Northeast Ohio. Its more than 30 surgeons perform more than 1,700 hernia repairs each year, from the routine to the most complex cases.

The new center is designed so that patients have easy access to individualized care: comprehensive evaluations with a board-certified surgeon determine the best surgical procedure for their specific type of hernia, which helps avoid repeat hernias and complications.
### Actively Enrolling Clinical Trials

**THE TRIALS BELOW ARE HIGHLIGHTS OF THE NEARLY 200 TRIALS OPEN AT THE DIGESTIVE DISEASE INSTITUTE:**

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<td>A Randomized, Triple-Blinded Study of Endoscopic Ultrasound (EUS) Guided Celiac Plexus Blockade (CPB) with Bupivacaine and Triamcinolone vs. Bupivacaine Alone For Treatment of Pain in Chronic Pancreatitis</td>
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<td>An Investigation of the Treatment of Fecal Incontinence using the TOPAS Sling System for Women (TRANSFORM WC 0807)</td>
<td>Massarat Zutshi, MD, Dana Sands, MD</td>
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<td>A Randomized, Controlled Trial to Compare the Functional Outcome and Quality of Life of Patients with Low Rectal Cancer who Undergo a J-Pouch or a Side-to-end Colo-anal Anastomosis</td>
<td>Massarat Zutshi, MD, Steven Wexner, MD</td>
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For more information or to refer a patient to any of the above listed trials, please call 216.636.5340 or visit clevelandclinic.org/ddiresearch.
Medical professionals are invited to attend the following continuing education programs:

**AASLD/Liver Update**  
Dec. 04, 2010  
Cleveland, Ohio

**Endorectal Ultrasonography Course**  
Feb. 16, 2011  
Cleveland Clinic Florida Jagelman Conference Center  
Weston, Fla.

**22nd Annual International Colorectal Disease Symposium**  
Feb. 17-19, 2011  
Harbor Beach Marriott  
Fort Lauderdale, Fla.

**Transanal Endoscopic Microsurgery (TEM) Hands-on Workshop**  
Feb. 20, 2011  
Harbor Beach Marriott  
Fort Lauderdale, Fla.

**Endoscopic Natural Orifice Surgery Workshop**  
Feb. 20, 2011  
Biltmore Hotel  
Fort Lauderdale, Fla.

**Surgery of the Foregut Symposium**  
Feb. 21-23, 2011  
Biltmore Hotel  
Coral Gables, Fla.

For more information about the above events, call the Cleveland Clinic Department of Continuing Education at 216.444.5696 or 800.762.8173, or visit ccfcme.org.

**Featured Upcoming CME**

*The 22nd Annual International Colorectal Disease Symposium* will be Feb. 17 to 19, 2011 at the Marriott Harbor Beach in Fort Lauderdale, Fla. Directed by Steven D. Wexner, MD, Chairman, Cleveland Clinic Florida Colorectal Surgery, this year’s course will provide the most current detailed and in-depth analysis of the current status of colon and rectal surgery, covering topics such as NOTES, robotics, TEM, TME and advanced laparoscopy. It will focus on optimizing patient outcomes through the clinical applications of the current best practices in the field demonstrated by world renowned experts with extensive use of video and audience interactive discussion.

For more information or to register, visit clevelandclinicmeded.com.
Digestive Disease Institute Access Guide

SERVICES FOR PHYSICIANS

DDI Referrals

clevelandclinic.org/digestive

Colorectal Surgery | Gastroenterology & Hepatology | General Surgery
Hepato-pancreato-biliary & Transplant Surgery | Human Nutrition

888.410.1775 or 216.444.5405

Critical Care Transport Worldwide

Cleveland Clinic’s critical care transport team, whose fleet comprises mobile ICU vehicles, helicopters and fixed-wing aircraft, serves critically ill and highly complex patients across the globe. Call 216.444.8302 or 800.553.5056 or visit clevelandclinic.org/criticalcaretransport.

Clinical Trials

Visit clevelandclinic.org/ddiresearch for a complete listing of all active clinical trials.

SERVICES FOR PATIENTS

Same-day Visits Available

Same-day appointments often are available for urgent cases. All same-day visits will be coordinated through the DDI patient navigator, a registered nurse who will triage all requests for same-day visits to ensure patients receive immediate attention. To arrange a same-day visit, call 216.444.5405.

Medical Concierge

Complimentary assistance for out-of-state patients and families 800.223.2273, ext. 55580, or email medicalconcierge@ccf.org

Global Patient Services

Complimentary assistance for national and international patients and families 001.216.444.8184 or visit clevelandclinic.org/ic