General GI Knowledge Assessment
Name: _____
Date: _____

1. A 40-year-old man undergoes an upper endoscopy for the evaluation of dyspepsia. He has antral erythema and biopsies confirm the presence of *Helicobacter pylori*. He is given a 10-day course of amoxicillin, clarithromycin, and omeprazole twice daily. His dyspeptic symptoms improved significantly. A stool test performed 4 weeks later is positive for *H. pylori*. What would you recommend next?

a. No further treatment since his symptoms improve
b. Repeat treatment with amoxicillin, clarithromycin, and omeprazole, but for 14 days
c. Treatment with bismuth, metronidazole, tetracycline, and omeprazole for 14 days
d. Treatment with clarithromycin, tetracycline, and omeprazole for 14 days

2. A 70-year-old woman was admitted to the hospital for melena. She underwent an EGD which showed a gastric ulcer. Gastric biopsy of the ulcer revealed no *Helicobacter pylori* or neoplastic cells. Both serum *H. pylori* IgG testing and urea breath tests were negative. She denied any NSAIDs use. After discharge, the patient began to take a twice-daily PPI, half an hour before her meals. She underwent an EGD 2 months later, which showed resolution of her gastric ulcer. She is asymptomatic and now presents to your office for follow-up. What is your treatment recommendation for this patient?

a. Discontinue PPI.
b. Add sucralfate.
c. Reduce the dose to once-daily PPI and take it indefinitely.
d. Annual endoscopic surveillance.

3. A 40-year-old otherwise healthy man has a chronic dry cough worked up extensively by his pulmonologist, allergist, and otorhinolaryngologist who all suspect reflux-related cough. He rarely experiences heartburn or regurgitation. He undergoes an EGD which shows a normal-appearing esophagus with laxity in the LES valve on retroflexion (Hill grade 2). Treatment with a daily high-dose PPI twice a day for 8 weeks taken consistently alleviates only some of his symptoms. What is the best next step in management?

a. Addition of sucralfate
b. Add an H2 blocker at bedtime.
c. Trial of alginate with meals
d. Trial of gabapentin or baclofen

4. A 58-year-old man who had a normal colonoscopy 8 years prior to presentation is seen in your office with 6 months of constipation. His baseline bowel habits included 1 formed stool daily, but 6 months ago, he started to have the sensation of incomplete evacuation and increased straining to move his bowels. He denies anal pain or rectal bleeding. Over the prior 8 weeks, he has had on average 4 bowel movements per week. He takes no prescription medications. The patient initially tried fiber supplements, bisacodyl, and a polyethylene glycol laxative, but has only had temporary relief with each treatment. What is the next most appropriate step in his evaluation?

A. Digital rectal examination

B. Anoscopy and colonoscopy

C. Anorectal manometry with assessment of recto-anal inhibitory reflex

D. Defecography

E. Sitz marker study

5. Which of the following patients is the most likely to develop tardive dyskinesia from metoclopramide?

A. An 80-year-old woman on 10 mg 3 times daily for 8 weeks for nausea

B. A 32-year-old man on 10 mg 4 times daily for 4 weeks for migraines

C. An 18-year-old woman on 15 mg 4 times daily for 14 weeks for gastroparesis due to diabetes

D. A 74-year-old man on 15 mg 3 times daily for 10 weeks for refractory reflux

6. A 35-year-old man presents with bloating that starts 45 minutes after eating meals. He is able to consume his usual amount of food within 20 minutes without discomfort, nausea, vomiting, or excessive belching. The sensation of bloating begins 45 minutes after most meals and peaks 20 minutes later. His abdomen feels "full" at that time and his pants feel "tight," but symptoms subside over the next 30 minutes. He has no excessive flatus, has normal consistency bowel movements daily, and has not lost any weight. Physical examination done while he was symptomatic showed no abdominal distention and no tympany. The symptoms occur multiple days per week and have been present several years. Dairy avoidance and dietary review have not revealed a source of his bloating. Other work-up has been negative. What is the diagnosis?

A. Aerophagia

B. Gastroparesis

C. Functional dyspepsia

D. Functional bloating

E. Constipation

7. A 25-year-old white woman comes in with several years of bloating symptoms. She has 2-3 bowel movements (BMs) starting in the morning initially formed then soft, without blood and usually with left lower quadrant (LLQ) discomfort reduced after the BMs. This all began shortly after returning from a trip abroad 5 years

ago. There has been no weight loss, bleeding, or family history of IBD or celiac disease. Exam reveals only mild LLQ tenderness. Laboratory test results, including celiac panel, tissue-transglutaminase, C-reactive protein, and stool PCR tests, were all negative. A trial of fiber, then a low-FODMAP diet seemed to increase the bloating. Breath testing for SIBO was equivocal. What is the best next step in her management?

A. Colonoscopy with biopsies of the terminal ileum and right colon
B. Empiric trial of metronidazole for possible Giardia
C. EGD with small bowel biopsies
D. Rifaxamin 550 mg 3 times a day for 14 days

8. A 34-year-old woman is referred to you for intractable right upper quadrant pain. She had her gallbladder removed 3 years ago. The pain is episodic and has no relation to food. It does not awaken her in the night. Her liver function tests are normal. An upper endoscopy was performed with normal gastric and duodenal biopsies. A recent abdominal ultrasound was normal without biliary ductal dilation. What is the best next step in management for this patient's abdominal pain?

A. Sphincter of Oddi manometry
B. ERCP with sphincterotomy
C. Endoscopic ultrasound***?
D. Low-dose tricyclic antidepressant

9. A previously healthy 48-year-old man presents with 3 episodes of *C. difficile* infection over an 8-week period. Each time he gets better with antibiotic therapy, but symptoms recur within 5-7 days after cessation of the antibiotic course. He has received a 10-day course of metronidazole 500 mg orally 3 times a day, 10 days of vancomycin 125 mg orally 4 times a day, and most recently, a prolonged vancomycin taper over 8 weeks with a course of fidaxomicin chaser. Within a week of completion of each therapy, he has the return of multiple liquid (Bristol 7) stools daily accompanied with cramping abdominal pains. What is the best next step in management?

A. Oral vancomycin 125 mg 4 times a day for 10 days, followed by a pulse/taper regimen
B. Fidaxomicin 200 mg bid for 10 days, then 1 pill a day for 10 more doses
C. A course of vancomycin therapy and referral for fecal microbiota transplant (FMT)
D. Suppressive vancomycin therapy for 6 months with probiotic *Lactobacillus GG*

10. A 23-year-old woman presents to an outpatient clinic with a 2-year history of daily lower abdominal pain. Initially, she noted a decrease in stool frequency and harder stools. Her pain transiently improves with bowel movements. The pain is worse in the

afternoon and evening but never wakes her from sleep. She has associated bloating but does not have blood in her stool and has not lost weight with the development of these symptoms. The symptoms started when she went through a difficult break-up. She has tried a lactose-free and gluten-free diet with no symptom relief. She has tried over-the-counter laxatives including polyethylene glycol with some improvement in stool form and frequency but no improvement in the abdominal pain. She is otherwise healthy and on no regular medications. She does not smoke or drink alcohol. There is no family history of inflammatory bowel disease or gastrointestinal cancer. Her physical exam reveals mild left lower quadrant abdominal discomfort on palpation. A digital rectal exam reveals no palpable masses. She has normal resting and squeeze anal sphincter pressures. On bare down, she demonstrated appropriate contraction of the abdominal muscles and relaxation of the anal sphincter. What is the best next step in management of this patient?

A. Colonoscopy***?
B. Anorectal manometry
C. Anti-tissue transglutaminase antibody
D. A therapeutic trial of linaclotide

11. A 45-year-old man has had watery diarrhea for many years. He typically has 5-6 stools daily, mostly in the mornings, but sometimes after lunch and dinner. He does not wake at night with diarrhea and has not lost weight. He saw a gastroenterologist before moving to your city 3 years ago and had a full work-up including stool studies, blood work, colonoscopy with biopsies, and upper endoscopy; all were normal, including CT of the abdomen and pelvis. You have him collect a 24-hour stool on a 100 gram fat diet. It shows 560 grams of stool, 5 grams of fat. This is abnormally high. What is the best treatment option?

A. Octreotide
B. Cholestyramine
C. Gluten free diet
D. Pancreatic enzymes??