



Gastroenterology & GI Surgery

2019 HIGHLIGHTS

Complex Case: Redo Surgery for IBD

Multi-step plan for complex pouch failure ultimately leads to ileostomy reversal

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Resolving Dysphagia and Restoring Quality of Life

Advanced diagnostics and robotic surgery help tackle achalasia with concurrent GERD and hiatal hernia

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Evaluating Cuff-Assisted Colonoscopy

Reducing exam times while enhancing results

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Unique

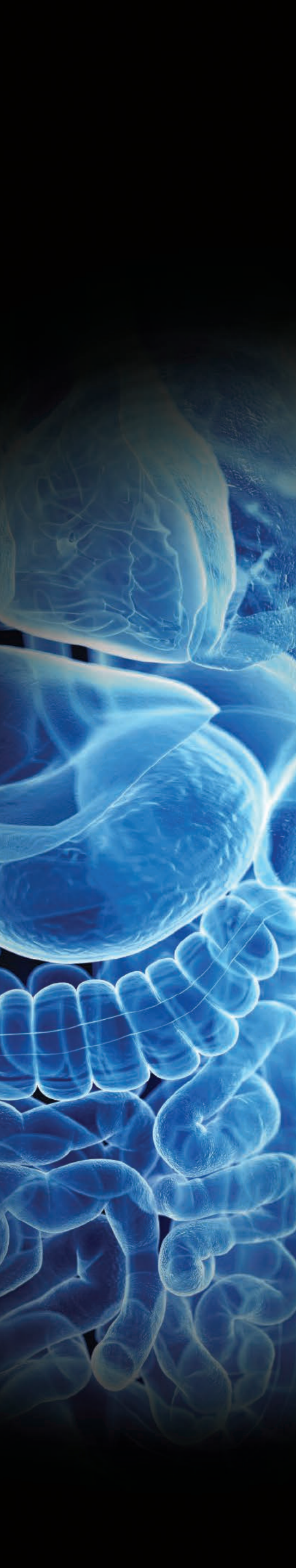
Living donor liver transplantation program

Specialized

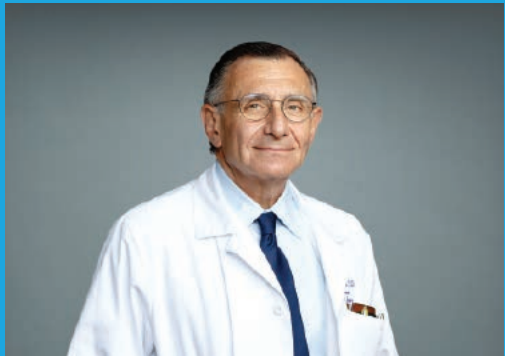
Advanced fellowships in transplant hepatology, advanced endoscopy, and IBD

Diverse

Public, private, and VA health systems



MESSAGE FROM THE CHAIR/DIRECTOR



H. LEON PACHTER, MD

George David Stewart Professor of Surgery
Chair, Department of Surgery



MARK B. POCHAPIN, MD

Sholtz/Leeds Professor of Gastroenterology
Director, Division of Gastroenterology & Hepatology
Vice Chair, Clinical Affairs
Department of Medicine

We are thrilled to share with you some of the highlights of our work in Gastroenterology and GI Surgery over the past year.

We invite you to read about how our multidisciplinary team worked to diagnose and treat a patient with an unusual case of esophageal achalasia with concurrent GERD and hiatal hernia; how our IBD Center experts performed a redo surgery for complex pouch failure; about the innovative new educational programming being offered by our physician leaders, and other highlights. As always, this year we look forward to collaborating with our colleagues nationwide to help lead the advancement of scientific knowledge, medical education and, ultimately, the provision of state-of-the-art clinical care.

Please read on to learn more about these and other exciting advances.



Redo Surgery for Complex Pouch Failure Requires Unique Expertise

A 31-year-old female was referred to the IBD Center from an outside hospital 10 years after she had undergone a 2-stage subtotal colectomy and ileostomy, with ileal-pouch anal anastomosis (IPAA), for ulcerative pancolitis that was unresponsive to medical management.

PATIENT SOUGHT SURGICAL OPTION TO PRESERVE FAILED IPAA

The patient, having developed abdominal pelvic septic complications and IPAA-related recurrent strictures, required at least 15 dilatations over 10 years. Her quality of life had diminished and was marked by dietary restrictions, straining with bowel movements, and continuous drainage that necessitated wearing a pad. She had increased abdominal pain and bleeding, diarrhea, and a weight loss of over 30 pounds. Later in her course of treatment, she also developed perineal fistulas, at which point she was diagnosed as having Crohn's disease.

Her condition did not improve after treatment with two different biologics. The perineal fistulas were drained with seton insertion, and her strictures required continued dilatation. Having received a recommendation to pursue a pouch excision and end ileostomy, she decided to get a second opinion at NYU Langone Health.

Restorative proctocolectomy with IPAA is the gold standard procedure in patients with ulcerative colitis. Removal of the colon and the rectum creates a reservoir out of the small

bowel, reestablishes gastrointestinal continuity, and provides improved quality of life and functionality, with minimal restrictions. However, the failure rates can range from 4 to 15 percent according to various study series (Remzi et al., *Colorectal Dis*, 2017; see Esen et al., 2019, for further reading). Additionally, 2 to 7 percent of the patients who receive the ileal pouch procedure for ulcerative colitis may have their diagnosis convert to Crohn's disease in the long term.

For patients who experience pouch failure within one year of the original surgery, the failure is likely due to a mechanical or technical problem related to the procedure itself rather than the Crohn's disease. But if the patient has had an uneventful surgical course of treatment, followed by great outcomes for several years, and then develop symptoms later in their journey, then the diagnosis is likely Crohn's disease. When failures occur, redo pouch surgery is the only option to preserve gastrointestinal continuity for patients unwilling to live with a permanent stoma and ileostomy. At NYU Langone, a dedicated infrastructure is in place to address these complex problems.

NICHE SURGICAL EXPERTISE EXPANDS OPTIONS

The patient was experiencing a significant amount of restrictions and poor quality of life when she was seen by Feza Remzi, MD, professor of surgery and director of the NYU Langone IBD Center. Dr. Remzi, a leader in the field of complex inflammatory bowel disease and re-operative abdominal pelvic surgery, says the collective experience accrued daily in a high-volume quaternary care center plays a key factor when tackling the most complex redo cases. The IBD Center offers expertise in pelvic pouch reconstruction and a multidisciplinary approach to patient assessment and perioperative planning. This allows the center to offer innovative treatment options to patients who are turned away by other institutions for complex revision procedures after failed ileal pouch surgery. IPAA allows patients who have a severe aversion to living with a permanent stoma to establish their gastrointestinal continuity.

After their initial assessment, Dr. Remzi and colorectal surgeon Tarik Kirat, MD, clinical assistant professor of surgery, offered the patient a three-stage plan. This three-stage strategic approach, historically, has had an over 80 percent success rate in 10 years (Remzi et al., *Ann Surg*, 2015; see Remzi et al., 2019, for further reading). Highly motivated to avoid a permanent ileostomy, the patient understood the risks and benefits and proceeded with the planned three-stage procedure.



CT scan of a distended, obstructed pouch secondary to ileal pouch-anal anastomotic stricture and chronic pelvic sepsis.
PHOTO: COURTESY OF DR. FEZA REMZI



Colorectal surgeons Dr. Tarik Kirat and Dr. Feza Remzi are part of the multidisciplinary team who provide relief to patients living with inflammatory bowel disease.
PHOTO: NYU LANGONE STAFF

MULTI-STEP PLAN ULTIMATELY LEADS TO ILEOSTOMY REVERSAL

After the initial workup of gastrografin enema, pelvic MRI, and exam under anesthesia in which a flexible pouchoscopy was done, the pouch was revealed to be twisted 180 degrees. The exam under anesthesia revealed a severe ileal pouch-anal anastomosis stricture with multiple fistulas. The pouch was also severely dilated due to years of obstructive defecation related to the chronic IPAA stricture. At the first stage of the three-stage procedure, a laparoscopic loop ileostomy was created. A segment of the ileum [distal small bowel] was brought up as an ileostomy proximal to the pouch to create a diversion. This strategy paved the way for a normal life and rehabilitated her so she could be physically, mentally, and psychologically prepared for the second stage of the procedure. The

patient met with the stoma therapist before the ileostomy creation and throughout the nine months, where she required the ileostomy. She also spoke to several patients who underwent a similar experience in our center to hear about the process and outcomes from the patient perspective. During the second stage, which was six months after the ileostomy creation, the surgeons planned exploratory laparotomy and J-pouch revision. Entry into the abdominal cavity revealed severe adhesions. This was further complicated by the severe abdominal pelvic infection due to years of ongoing phlegmonous changes related to the chronic obstruction, secondary to the anastomotic stricture. After lysis of multiple adhesions, the ileostomy was taken down. The twisted pouch was untwisted after the disconnection, and it was found to be still usable for the new anastomosis. Multiple severe strictures at the anastomosis in the pelvis were

encountered and resected, including the perianal fistulas. The chronic pelvic infection was addressed with excision, the pouch was revised, and a new hand-sewn IPAA (in the presence of diverting ileostomy), was created. Dr. Remzi notes, “this procedure was very complicated from beginning to the end. A team approach and meticulous dissection was needed to clean the chronic infection.” As part of the third stage, and before the loop ileostomy closure six months later, a water-soluble contrast enema was performed and showed anastomosis without any leaks or obstruction. The ileostomy reversal was completed successfully without major complications, and the patient tolerated the procedure well. She has been doing great, and her one year follow-up revealed no major issues. For the ongoing care of her pouch, the patient has seen pouch specialist and gastroenterologist Shannon Chang, MD, assistant professor in the Department of Medicine within the Division of Gastroenterology and Hepatology. At a multidisciplinary center such as NYU Langone’s, outcomes are optimized through a coordinated continuum of care provided by a team that works side by side to meet the unique needs of patients living with the complexities of IBD.

“This procedure was very complicated from beginning to the end; a team approach and meticulous dissection was needed to clean the chronic infection.”

Feza Remzi, MD

Reimagining IBD training for GI fellows



Dr. Lisa B. Malter
PHOTO: NYU LANGONE STAFF

This year NYU Langone launched IBD 101, a national course for first-year gastroenterology fellows. The inaugural course—directed by Lisa Malter, MD, along with David P. Hudesman, MD, co-director of NYU Langone’s IBD Center; Sunanda V. Kane, MD, MSPH, Mayo Clinic; and David T. Rubin, MD, University of Chicago Medicine—was taught by leading IBD specialists from across the United States. Dr. Malter is director of education for the Division of Gastroenterology & Hepatology at NYU Langone Health as well as the director of the Inflammatory Bowel Disease program, NYC Health + Hospitals Corporation/Bellevue.



For more on this story and other topics, visit nyulangone.org/gastroenterology2019

Save the Date

Continuing Medical Education:

MARCH 27, 2020
Big Gut Seminars: Focus on Complex Inflammatory Bowel Disease



To register and for more information, visit nyulmc.org/ibdcme

Subspecialty Training:

SEPTEMBER 25–26, 2020
IBD 101 Course for First-Year Gastroenterology Fellows



Gastroenterologist Dr. Abraham R. Khan and surgeon Dr. Tanuja Damani collaborate to bring their expertise to patients at the Center for Esophageal Health.
PHOTO: NYU LANGONE STAFF

Team Tackles Unusual Case of Esophageal Achalasia with Concurrent GERD & Hiatal Hernia

Recently, a patient presented at NYU Langone's multidisciplinary Center for Esophageal Health with an unusual case of esophageal achalasia with concurrent gastro-esophageal reflux disease (GERD) and hiatal hernia.

The patient was a 71-year-old woman with a longstanding history of heartburn, which responded to treatment with a proton pump inhibitor. However, the patient's sensation of dysphagia, which she described as “food feels stuck,” had been going on for several years, rendering her unable to enjoy meals.

DIAGNOSIS AND RELIEF REMAIN ELUSIVE WITH TRADITIONAL TESTING

The patient's sensation of obstruction, characteristic of esophageal dysphagia, had progressively worsened over the years. Subsequently, she noted additional symptoms of increasing cough and hoarseness.
Diagnostic testing at another institution included conventional

esophageal manometry and a barium esophagram, used to assess esophageal emptying and the morphology of the gastroesophageal (GE) junction. In this case, the esophagram suggested an esophageal stricture, a complication of GERD usually found in proximity to the GE junction.
Upper endoscopy excluded neoplasm as the cause of dysphagia. Esophageal dilation of the stricture, performed during endoscopy, did not result in improving the patient's symptoms.
Achalasia was suggested, but not confirmed, by subsequent high-resolution esophageal manometry, a more sensitive test for diagnosing achalasia compared with conventional manometry. Achalasia, a rare neuromuscular disorder affecting the esophagus, affects about only 1 to 3 per 100,000 people per year.

PATIENT REFERRED TO NYU LANGONE FOR ADVANCED DIAGNOSTIC TESTING

The patient's out-of-state physician referred her to Tanuja Damani, MD, surgical director of the Center for Esophageal Health. As with other complex cases, Dr. Damani conferred with Abraham R. Khan, MD, the center's medical director. The diagnosis was not certain when the patient met with Dr. Khan, who specializes in neurogastroenterology and motility disorders of the gastrointestinal (GI) tract.
After thoroughly reviewing and analyzing the patient's history and previous diagnostic test results, Dr. Khan, assistant professor of medicine within the Division of Gastroenterology and Hepatology, suggested advanced diagnostic testing with careful interpretation. The patient underwent endoscopy with a functional lumen imaging probe (FLIP), which revealed likely achalasia. FLIP technology uses high-resolution impedance planimetry during volume-controlled distension to measure luminal pressure and geometry, assess the mechanical properties of the esophageal wall, and evaluate the opening dynamics of the GE junction. Repeated high-resolution esophageal manometry was performed under a specialized protocol to include solid food and rapid drink challenges.
Careful analysis by Dr. Khan confirmed the likelihood of achalasia as the underlying physiology causing the difficulty in swallowing. When interpreted in total, the tests also confirmed the patient's persistent GERD physiology with a hiatal hernia, which rarely occurs concurrent with achalasia.

TEAMWORK LEADS TO
SUCCESSFUL PLANNING AND
RESOLUTION OF CONDITIONS

Collaborative planning by a team with broad shared expertise in esophageal gastroenterology and foregut surgery led to a decision to proceed with a robotic Heller myotomy. This surgery widened the lower esophageal sphincter by cutting individual muscle fibers of the esophagus. Dr. Damani, assistant professor of surgery, also accomplished concurrent robotic repair of the hiatal hernia with a Toupet fundoplication as an antireflux procedure.

The patient recovered rapidly and was discharged after 36 hours. She required no pain medications, as the surgery had been performed using minimally invasive techniques, with quarter-inch incisions. The patient continues to do well, reporting complete resolution of dysphagia and significant improvement of GERD symptoms.

SERVICES EXPAND AT
OUR CENTER FOR
ESOPHAGEAL HEALTH

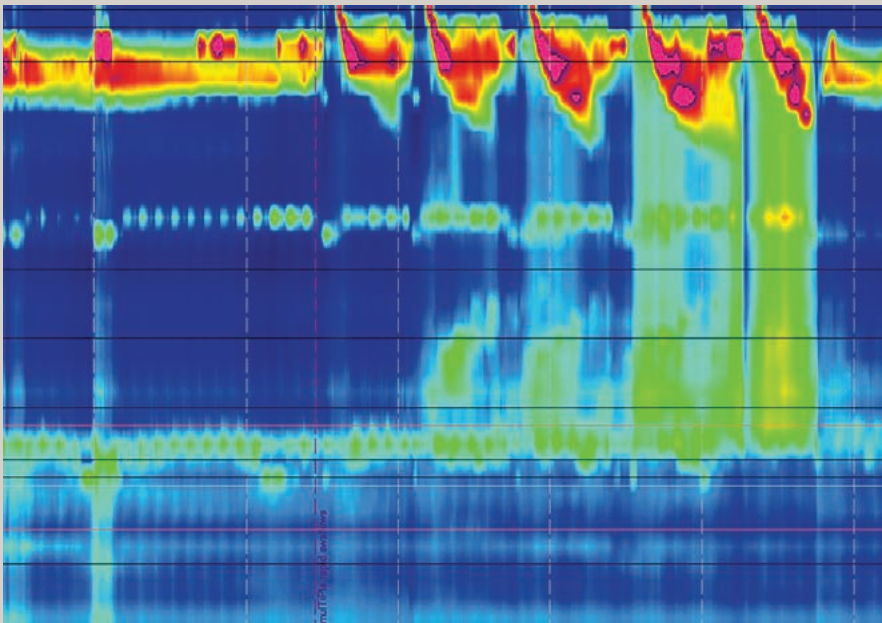
NYU Langone’s experts are specially trained in advanced treatment for people with all types of conditions affecting the esophagus, including chronic gastroesophageal reflux disease (GERD); hiatal hernia; Barrett’s esophagus; eosinophilic esophagitis; esophageal varices; and swallowing disorders such as achalasia, stricture, or spasm. NYU Langone’s team also specializes in the prevention and diagnosis of these disorders. In addition, we offer treatment for people who have gastroparesis. Providing comprehensive diagnostic testing, advanced and interventional endoscopy services, minimally invasive procedures, and a range of options including magnetic sphincter augmentation with LINX® Reflux Management System, gastroenterologists and GI surgeons collaborate closely with other specialists as needed to ensure that patients receive a comprehensive, patient-centered approach to their care.

“Achalasia is a rare neuromuscular disorder affecting the esophagus at an incidence of about only 1 to 3 per 100,000 people per year.”

Abraham R. Khan, MD

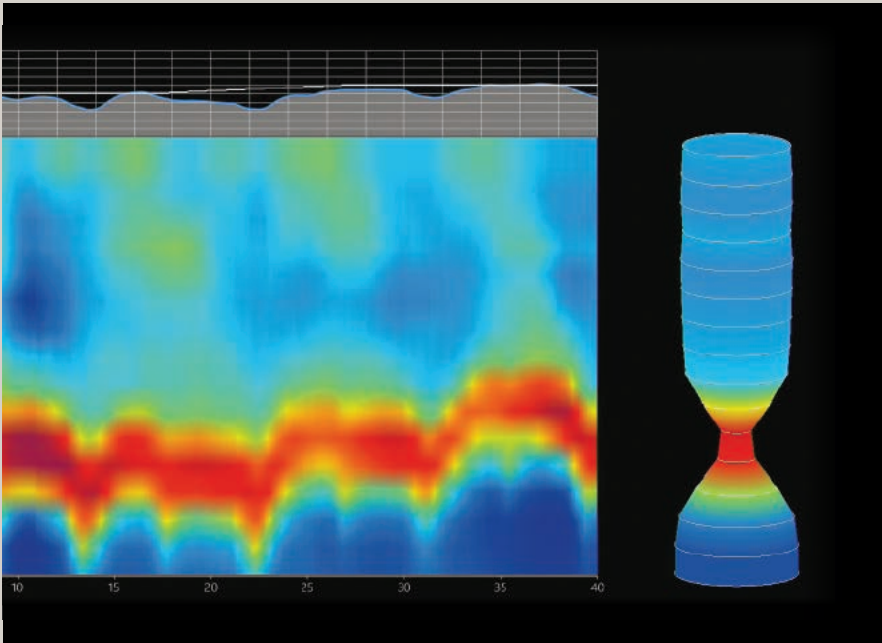
Advanced diagnostic tests help NYU Langone experts provide a more complete assessment of digestive disease.

→ High-resolution esophageal manometry measures the pressures in the esophagus at rest and during swallowing.



→ A complement to traditional diagnostic tests, FLIP panometry sheds light on swallowing function measuring the cross-sectional area and intraluminal pressure of the esophagus while under distension.

PHOTOS: COURTESY OF
DRS. KHAN AND DAMANI



Heavy Alcohol Use Raises Mortality Risk in Patients with Fatty Liver Disease & Metabolic Syndrome

Nonalcoholic and alcohol-related fatty liver disease (NAFLD and AFLD) are overlapping diseases in which metabolic syndrome and alcohol consumption each contribute to progressive liver disease.

NYU Langone researchers aimed to assess the effects of alcohol consumption and metabolic syndrome on mortality in individuals with fatty liver. The study, headed by Dr. Zobair M. Younossi with a number of co-authors from other institutions including Ira M. Jacobson, MD, professor of medicine and director of hepatology at NYU Langone within the Division of Gastroenterology and Hepatology, indicates that the risk of mortality increases significantly in patients with both excessive alcohol use and metabolic syndrome—the main drivers of progressive liver disease.

Investigators reviewed data from the National Health and Nutrition Examination Survey III on 4,264 patients with hepatic steatosis, including 46 percent with metabolic syndrome and 6.2 percent with excessive alcohol use. Over a period of up to 20 years, overall mortality was highest among patients with excessive

alcohol consumption, particularly among those who also had metabolic syndrome. The findings were published in the July 2019 issue of *Clinical Gastroenterology and Hepatology*.

The results indicate that the harmful effects of substantial alcohol consumption are accentuated in patients with metabolic syndrome, and conversely, metabolic syndrome is associated with higher risk in patients who drink excessively. In patients without metabolic syndrome, the harmful effects of drinking were not observed until consumption reached six drinks per day for men or three drinks per day for women.

The authors caution that data used in the study may not be reflective of the current fatty liver population, as the subjects were enrolled nearly 30 years ago. However, the findings have the potential to inform clinical practice as both metabolic syndrome and excessive alcohol use are modifiable risk factors.

“One immediate implication for clinicians is the importance of taking



PHOTO: DENIA FERNANDEZ/GETTY

a careful alcohol consumption history from patients with fatty liver disease, many of whom have metabolic syndrome, with a view toward limiting such consumption in patients who drink heavily. The present study provides quantifiable information that can be imparted to patients,” says Dr. Jacobson. “Importantly, the paper also acknowledges that milder effects of lower amounts of alcohol

may not have been captured in this study population.”

Disclosures: Dr. Jacobson is a consultant to or received research funds from Gilead Sciences, Inc.; Intercept Pharmaceuticals, Inc.; GENFIT; and Novo Nordisk.

“One immediate implication for clinicians is the importance of taking a careful alcohol consumption history from patients with fatty liver disease, many of whom have metabolic syndrome, with a view toward limiting such consumption in patients who drink heavily.”

Ira M. Jacobson, MD

Five Things You Should Know About Nonalcoholic Fatty Liver Disease

Despite its prevalence, nonalcoholic fatty liver disease is a largely silent epidemic, with insufficient awareness among patients and, surprisingly, even many physicians. In a 2019 NYU Langone News & Views article, Dr. Jacobson highlights five things to know about this complex, poorly understood disease.



For more on this story and other topics, visit nyulangone.org/news

PHOTO: KARSTEN MORAN



A new study by gastroenterologist Dr. Seth A. Gross and colleagues shows encouraging results using cuff-assisted colonoscopy to screen for colorectal cancer.

PHOTO: NYU LANGONE STAFF

New Study Shows Cuff-Assisted Colonoscopy Can Improve Detection of Polyps

The incidence and mortality rates of colorectal cancer have steadily declined over the past decades in adults age 50 and older, due in part to the dramatic increase in screening across the United States.

Equally important have been the ongoing efforts to enhance the quality of screening tests, according to Seth A. Gross, MD, associate professor of medicine and director of clinical care and quality in the Division of Gastroenterology and Hepatology at NYU Langone.

TRIAL TARGETS EXAM TIME FOR COMPLETE MUCOSAL INSPECTION

As part of this effort, medical professionals are evaluating technological advances to improve detection of polyps and other lesions during colonoscopy. In a recent study, Dr. Gross and colleagues studied cuff-assisted colonoscopy using Endocuff Vision®, a mechanical colonoscopy enhancement. Compared with standard colonoscopy, cuff-

assisted colonoscopy showed decreased inspection time without reducing adenoma and sessile serrated polyp detection rates.

To ensure optimal adenoma detection and cancer prevention, viewing polyps and lesions is critical. But they may be hidden by folds along the lining of the colon and rectum. The Endocuff Vision® is a small device that fits on the tip of the colonoscope and features fingerlike extensions that help pull back the folds and increase mucosal exposure.

“This randomized trial was focused on colonoscopy withdrawal times for complete mucosal inspection as the primary endpoint, in addition to measuring detection of polyps,” says Dr. Gross.

The researchers randomly assigned 200 adults over age 40 to receive colorectal cancer screening or surveillance using either the

Endocuff-assisted or standard colonoscopy, performed by two experienced endoscopists. Mean inspection time with the cuff-assisted procedure was reduced by 23 percent without impairing lesion detection compared with standard colonoscopy (6.5 versus 8.4 minutes). Also, the adenoma detection rate (61.4 percent versus 52 percent; $P = 0.21$) and sessile serrated polyp detection rate (19.8 percent versus 11.1 percent; $P = 0.09$) were higher with the cuff-assisted procedure.

The trial demonstrates that physicians can perform an efficient colonoscopy without compromising colonoscopy exam quality. The learning curve to use Endocuff Vision® is short, since gastroenterologists are proficient in colonoscopy.

“These findings suggest that the cuff device may allow for easier visualization of the mucosa, thereby

maintaining adenoma detection rates while decreasing withdrawal time compared with standard colonoscopy methods,” explains Dr. Gross.

The findings were published online on January 17 in the journal *Clinical Gastroenterology and Hepatology*.

ENHANCED VISUALIZATION, SHORTER INSPECTION TIMES

Findings from the current study suggest that Endocuff Vision® could potentially achieve the dual goals of improving detection and offering a more efficient colonoscopy. The authors also observe that previous, larger studies have reported

that when inspection times are equal, the Endocuff Vision® is better at detecting lesions compared with standard colonoscopy.

“Overall, these findings suggest that technological advances, such as the cuff-assisted colonoscopy, can help us optimize efficiency and increase quality in endoscopy,” says Dr. Gross. “Together with increased screening rates, we hope that a continued focus on quality in screening will result in further innovations and increased numbers of precancerous polyps removed and lives saved.”

Investigators caution that, based on previous studies, a small fraction of patients will require removal of the Endocuff Vision® for safe navigation

through the sigmoid colon. Colonoscopy without the device should be considered in patients with known severe sigmoid diverticular disease.

PERSPECTIVES ON EFFICIENCY

Dr. Gross notes that “perspectives on whether the reduced inspection time observed in this trial with the Endocuff Vision is clinically important, will depend on individual perspectives on efficiency in endoscopy.”

The study authors conclude that “for extremely efficient endoscopists, 1 or 2 minutes time saving per procedure could be considered a significant gain when many procedures in a day or week are considered. Efficiency, which should never take place at the expense of quality, is often achieved through the accumulation of numerous measures, each of which by itself may have a quantitatively small impact. In any case, there are few situations described in which improvement in efficiency (reduction of inspection time) can be made without loss of detection.” It is recommended that other investigators examine the impact of cuff-assisted colonoscopy on inspection and withdrawal times in addition to detection endpoints.

Disclosure: Dr. Gross is a consultant to Olympus Corporation.

“Together with increased screening rates, we hope that a continued focus on quality in screening will result in further innovations and increased numbers of precancerous polyps removed and lives saved.”
Seth A. Gross, MD

Clinical Trials and Research Studies

NYU Langone Health offers a variety of clinical trials for gastrointestinal-related cancers as well as other conditions.



For more on this story and other topics, visit clinicaltrials.med.nyu.edu

PHOTO: PRATHAN CHORRUANGSAK/GETTY



Risk of Portal Vein Thrombosis in Obese Patients Undergoing Laparoscopic Sleeve Gastrectomy

Recent research led by Manish S. Parikh, MD, associate professor of surgery at NYU Langone, reveals that thrombophilia is common among patients seeking laparoscopic sleeve gastrectomy (LSG), potentially putting them at increased risk for portomesenteric vein thrombosis (PMVT) postoperatively. The findings suggest that extending postoperative therapy may help prevent this rare but potentially life-threatening complication.

PMVT is an unusual but well-known postsurgical complication in obese patients who undergo sleeve gastrectomy. However, the condition is difficult to predict because most patients do not have obvious risk factors that show up in a medical history.

BLOOD WORKUP IDENTIFIES RISK

In previous research, Dr. Parikh and colleagues reported that most patients who developed PMVT tested positive for factor VIII—an essential blood-clotting protein. The findings prompted the investigators to order thrombophilia workups for all patients undergoing LSG and to extend chemoprophylaxis postoperatively for those with positive results.

For their latest study, the researchers recorded the prevalence of thrombophilia among 1,075 of these patients and assessed whether extended therapy was effective in reducing

PMVT. Just over half tested positive for thrombophilia and most of those (91.5%) showed elevated factor VIII. At the American Society for Metabolic and Bariatric Surgery's Obesity Week, held in November 2019 in Las Vegas, the data were presented by Dr. Parikh, who is also director of bariatric surgery and chief of perioperative services at NYC Health + Hospitals/Bellevue.

REDUCING RATE OF PORTO-MESENTERIC VEIN THROMBOSIS POSTOPERATIVELY

Patients who tested positive for thrombophilia received extended chemoprophylaxis for four to six weeks. During that time, there were 1 diagnosis of PMVT (0.1%) and 5 bleeding occurrences (0.6%). By comparison, there were 18 (0.4%) PMVT diagnoses and 17 (0.4%) bleeding episodes over 4 years prior to introducing routine testing. The findings were highlighted in a

manuscript submitted for publication in an upcoming issue of *Surgery for Obesity and Related Diseases*.

“The findings suggest that consideration should be given to routine thrombophilia testing (including factor VIII levels) preoperatively, combined with selective extended chemoprophylaxis (for those patients who test positive) to potentially reduce the risk of developing PMVT. However, clinicians should take into account the potential downsides of extended therapy, including longer hospital stays and patient compliance with extended prophylaxis.

“While longer-term studies are needed in this patient population, the current data suggest that routine thrombophilia testing should be considered,” says Dr. Parikh. “Combined with extended chemoprophylaxis, this strategy has the potential to significantly reduce the incidence of PMVT, which can lead to other serious complications.”



“The findings suggest that consideration should be given to routine thrombophilia testing (including factor VIII levels) preoperatively, combined with selective extended chemoprophylaxis (for those patients who test positive) to potentially reduce the risk of developing PMVT.”

Manish S. Parikh, MD

Dr. Manish S. Parikh collaborates with other specialists and researchers to enhance the safety and effectiveness of various bariatric procedures.

PHOTO: NYU LANGONE STAFF

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Awards & Recognition

Mitchell Bernstein, MD, was nominated to the Steering Committee for the American Society of Colon and Rectal Surgeons (ASCRS) Committee on Pelvic Floor Disorders.

Seth A. Gross, MD, was named Chair of the International Committee, American College of Gastroenterology.

David P. Hudesman, MD, received the Rosenthal Humanitarian of the Year award from the Crohn's and Colitis Foundation (Greater New York Chapter).

H. Leon Pachter, MD, George David Stewart Professor of Surgery, was appointed to the editorial board of the Journal of Laparoscopic Surgery.

Mark B. Pochapin, MD, Sholtz/Leeds Professor of Gastroenterology, was elected President of the American College of Gastroenterology.

Paresh Shah, MD, was reappointed to SAGES Board of Governors and appointed to the board of the American Foregut Society.

Renee L. Williams, MD, MHPE, continues to serve on the Board of Trustees of the American College of Gastroenterology.

ABOUT NYU LANGONE HEALTH

Leader in Quality

NYU Langone has achieved top rankings by Vizient, and is the only full-service health system in New York City with an “A” Leapfrog safety grade and a CMS 5-star rating in 2020. These accolades are reflective of a shared culture of quality that permeates our growing network, now inclusive of NYU Winthrop Hospital and its ambulatory sites on Long Island. All of our sites are held to the highest quality standards set at an institutional level.



#9 in the Nation

Ranked ninth by *U.S. News and World Report* for both Best Hospitals and Best Medical Schools (Research)



Transforming Medical Education

To address some of today’s most pressing issues in medical education such as physician shortages, debt burden, and lack of diversity, we have introduced accelerated pathways to the MD degree and full-tuition scholarships regardless of need or merit at the recently renamed **NYU Grossman School of Medicine** and the new primary-care focused **NYU Long Island School of Medicine**.



Quality and excellence guide our ongoing pursuit of advances in scientific knowledge, medical education and state-of-the-art care. We invite you to read a few recent insights into **reversing ileostomy, innovative new educational programming, and a complex case of achalasia with comorbidities.**

Read More



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