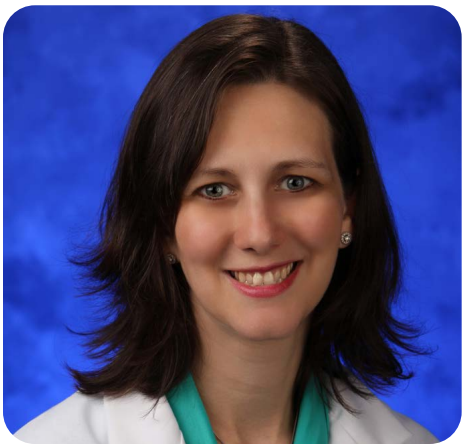
SPRING 2025

Rumblings

PENNSYLVANIA SOCIETY OF GASTROENTEROLOGY / NEWSLETTER

President's Message / Karen Krok, MD, FAASLD, FACG

www.pasg.org



@Klkrok

Be an advocate! The role of a physician extends beyond diagnosis and treatment; it encompasses supporting patients through every stage of their healthcare journey. As March was Colorectal Cancer Awareness month, I thought it appropriate to remind us how we need to continue to advocate for our patients everyday—from colorectal cancer screening and prevention to access to liver transplant to obtaining much needed medications for our patients with IBD – we can improve outcomes and enhance their quality of life!

One of the most significant forms of advocacy in our field is promoting early detection of colon cancer through regular screening. Colorectal cancer remains one of the leading causes of cancer-related deaths in the United States. Yet, it is preventable with appropriate screening. When we remove a large polyp, we should say to ourselves, "Today I did a good thing for this patient. This is why I am doing these procedures!" As part of our advocacy, we must emphasize the importance of colon cancer screenings for all patient aged 45 and older. Patients often neglect or delay screenings due to fear, misinformation, or lack of awareness. We have all heard all of the excuses and fears! Our role as advocates is to educate patients and their primary care physicians on the importance of early detection and to provide information about the various screening methods available.

Moreover, it is crucial to advocate for vulnerable populations—such as those in underserved communities or with limited access to healthcare—who may face barriers to screening. This may include working to bridge gaps in access, whether through community outreach programs, advocating for insurance coverage, or working with local health systems to reduce logistical barriers.

Another critical aspect of advocacy is ensuring that patients with liver diseases, particularly those with cirrhosis, receive timely and appropriate care, including access to liver transplantation when necessary.

The process of liver transplantation is complex and challenging for many patients. As our patients get sicker, they will require time away from work, more help from caregivers and often require frequent doctor visits and hospital admissions. In addition, some of these patients are often marginalized in our society. As

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PSG/SOCIAL: @PAGastroSoc

INSIDE

President's Message

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gastroenterologists, we must advocate for these patients by ensuring they receive comprehensive care that addresses all aspects of their condition, from medical management to psychological support. We also should continue to provide education to all physicians from PCPs to hospitalists to other GIs ensuring they are aware of the changes in the transplant landscape – including listing patients for liver transplant with acute alcohol-associated hepatitis.

While colon cancer and liver transplant are two prominent areas of focus, the role of patient advocacy in gastroenterology extends across a wide spectrum of diseases. From IBD, to viral hepatitis and fatty liver, many of our patients face challenges in accessing proper care and treatment. As a Hepatologist, I encourage you to ensure that all of your patients get their one-time test for Hepatitis C. Why is this left up to the PCP? We should ensure that patients are being screened if we want to prevent cirrhosis and hepatocellular cancer.

It is imperative that we collectively advocate for policies that improve access to care and reduce disparities in treatment. Whether by supporting research initiatives, pushing for insurance reform, or engaging in community outreach, the PSG actively works to play a vital role in ensuring that patients with gastrointestinal and liver diseases receive the best possible care.

In honor of one of the longstanding members of the PSG Board who was an advocate for his patients, we will be starting a new award from the PSG—**the Harvey Lefton Gastroenterology Luminary of the Year award!** A call for nominees will be forthcoming for a deserving colleague! This award will recognize an individual who has made exceptional contributions to improving their community through selfless service, dedication, and effective action. Through their commitment to improving the lives of those around them, the nominee should exemplify the spirit of community, compassion, and leadership. This award highlights the invaluable work of someone who goes above and beyond to address social, environmental, educational, and economic challenges, fostering unity and empowerment.

By prioritizing patient and physician education, increasing awareness of preventative measures like colon cancer screening, and working to expand access to life-saving treatments such as liver transplants and IBD medications, we can make a profound difference in the lives of our patients. Be the advocate that you would want if you were a patient!

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Advancing Early-Stage Colorectal Cancer Management: Nuances of Endoscopic Resection

Danial H. Shaikh, MD

Clinical Assistant Professor Medicine,
Geisinger Commonwealth School of Medicine
Center for Advanced Therapeutic Endoscopy,
Department of Gastroenterology, Hepatology, & Nutrition,
Geisinger Medical Center,
Danville, PA

Colorectal cancer remains a significant public health concern, ranking as the third most common cancer worldwide. In the general population, the lifetime risk of developing colorectal cancer is approximately 4.1% for men and 3.9% for women[1]. Early-stage or T1 colorectal cancer—where the tumor is confined to the innermost layers of the colon—accounts for roughly 10–15% of all diagnosed cases[2].

For appropriately selected patients, endoscopic techniques offer curative potential for treatment of T1 colorectal cancer. Endoscopic Submucosal Dissection (ESD) and Endoscopic Full-Thickness Resection (eFTR) allow for complete removal of early lesions without the need for surgical resection, chemotherapy, or radiation. These minimally invasive approaches are "organ sparing", reduce recovery time, and have lower complication rates compared to surgical resection, making them ideal for patients without high-risk features. At Geisinger, we utilize advanced endoscopic strategies, including ESD, eFTR, and hybrid techniques, to provide personalized, organ-sparing treatment for early-stage colorectal cancer. These approaches are particularly beneficial in lesions that are difficult to resect with conventional methods or when surgery poses significant patient risk. The National Comprehensive Cancer Network (NCCN) guidelines support endoscopic resection as a definitive treatment option for T1 colorectal cancers that are node-negative and lack high-risk histologic features[3]. High-risk features include positive or indeterminate resection margins, poor tumor differentiation (grade 3 or 4), lymphovascular invasion, and high tumor budding. When these features are absent, endoscopic resection alone may be sufficient. On the other hand, if histologic high-risk features are identified following endoscopic resection, additional therapy, typically surgery, is recommended to ensure complete disease control and assess locoregional lymph node metastasis.

Alongside these guideline-based recommendations, there is a growing trend toward less invasive treatment for early rectal cancer—particularly through nonoperative approaches in patients who achieve a clinical complete response (cCR) after neoadjuvant therapy. This "watch-and-wait" strategy involves close surveillance with regular imaging and endoscopic evaluation, and is increasingly supported by both the NCCN and the American Society for Radiation Oncology (ASTRO) (3). In carefully selected patients, this approach may allow for organ preservation without compromising cancer control. This shift underscores the expanding role of advanced endoscopic procedures—such as ESD and eFTR—not only as curative tools, but also as part of a more conservative treatment pathway that may help some patients avoid major surgery while still receiving high-quality, effective care.

Technical Considerations: ESD, FTRD, and Hybrid Approaches

ESD enables en bloc removal of superficial neoplasms by dissecting within the submucosal layer using specialized endoscopic knives. This method is particularly useful for large, fibrotic, or non-lifting lesions that are not amenable to standard EMR. ESD demands advanced technical expertise and has a perforation risk of approximately 5%, though most complications can be managed endoscopically[4].

Endoscopic full-thickness resection (eFTR) enables the removal of deeper or more complex gastrointestinal lesions by excising the entire bowel wall. This technique can be categorized into two primary approaches: exposed and non-exposed eFTR.

In the exposed eFTR approach, the lesion is resected first, creating an intentional perforation, which is subsequently closed using endoscopic methods. This technique allows for direct visualization during resection but carries a higher risk of peritoneal contamination and tumor seeding due to the temporary exposure of the peritoneal cavity to luminal contents. Conversely, the non-exposed eFTR approach involves securing the lesion with a specialized over-the-scope clip (OTSC) device before resection. This "close-then-cut" method ensures that the gastrointestinal wall defect is sealed prior to resection, minimizing the risk of peritoneal contamination and tumor dissemination. The Full-Thickness Resection Device (FTRD) system (OVESCO, Cary NC) exemplifies this technique. However, due to device size constraints, the FTRD is generally limited to lesions smaller than 20 mm. The overall complication rate for non-exposed eFTR is approximately 10%, with minor bleeding being the most common adverse event[5].

To address limitations of size and fibrosis, a hybrid approach combining ESD and FTRD has been developed. In this method, ESD is first used to dissect and mobilize the lesion as

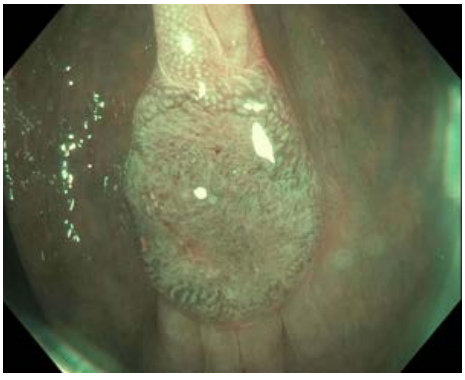
extensively as possible, followed by FTR to resect any remaining areas with submucosal or muscularis involvement. This technique has demonstrated safety and efficacy in case series involving complex colorectal lesions, including those in anatomically challenging locations like the cecum and appendix[6].

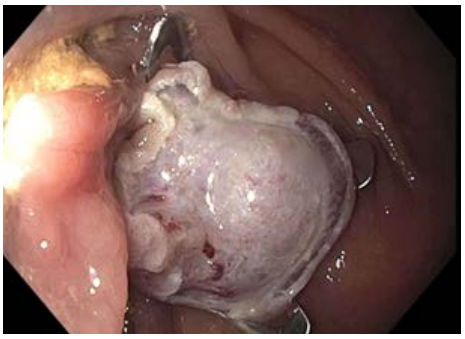
Sample Cases

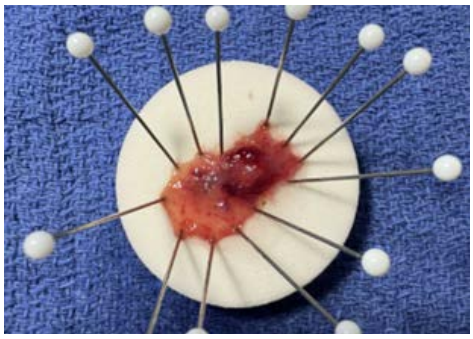
Recent cases at our institution highlight the expanding role of advanced endoscopic resection techniques—namely, ESD, eFTR, and hybrid approaches—in the treatment algorithm of early-stage colorectal cancer.

CASE #1

A 62-year-old woman was referred following the discovery of a malignant-appearing lesion in the splenic flexure on screening colonoscopy. Biopsies confirmed moderately differentiated adenocarcinoma. The lesion demonstrated Paris IIa+IIc morphology and was classified as JNET type 3. Despite suboptimal bowel preparation, an endoscopic full-thickness resection was successfully performed using the FTRD system. Final pathology revealed a 0.9 cm T1 adenocarcinoma with submucosal invasion <1 mm, negative margins, and no lymphovascular invasion. After review by the multidisciplinary tumor board and confirmation by a second pathology review, the patient was deemed low risk for lymph node metastasis. She elected surveillance over surgery and is scheduled for follow-up colonoscopy in three months.

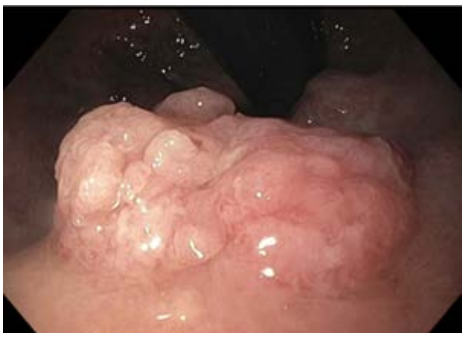


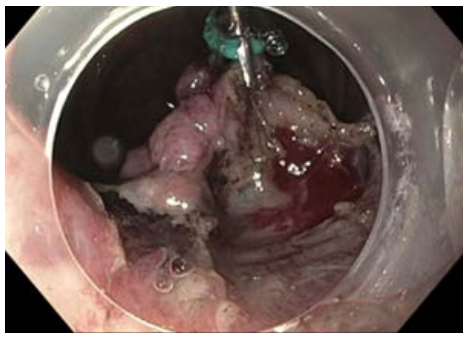


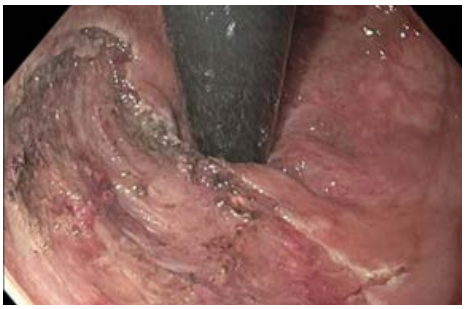


CASE #2

A 77-year-old man with multiple comorbidities, including chronic kidney disease and heart failure presented with a 2.5 cm sessile lesion on the posterior rectal wall, previously biopsied as intramucosal carcinoma. Endoscopic evaluation demonstrated a Paris 1s, JNET type 2B lesion. En bloc resection was performed via ESD, and the post-resection defect was closed with endoscopic suturing. Histopathology confirmed moderately differentiated adenocarcinoma arising in a background of tubulovillous adenoma with high-grade dysplasia. Superficial submucosal invasion was present on the resection specimen, all margins were negative, and there was no evidence of angiolymphatic invasion. Given complete resection and comorbid conditions, the patient could avoid surgery, chemotherapy, and radiotherapy.







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Advancing Early-Stage Colorectal Cancer Management: Nuances of Endoscopic Resection

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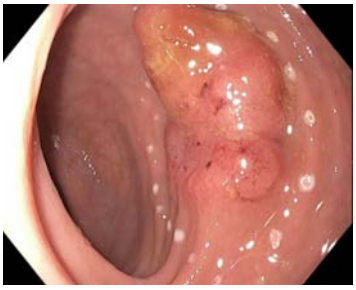
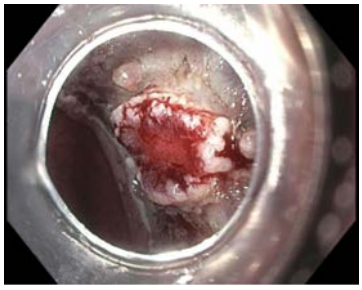
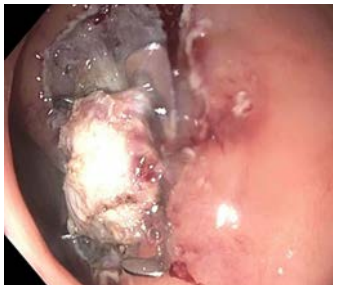
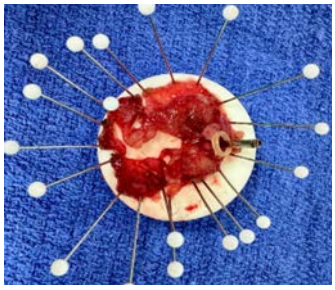
CASE #3

A 56-year-old woman was referred for removal of a 25 mm rectosigmoid polyp previously biopsied as tubulovillous adenoma with high-grade dysplasia. The lesion showed Paris IIa+IIc morphology with a central depression suggestive of invasive disease. A hybrid approach utilizing ESD followed by FTRD enabled complete removal. Final pathology revealed a well-differentiated adenocarcinoma with invasion into the muscularis propria (T2).

Although the endoscopic resection was not curative in this case, it played a critical role in staging the cancer. The patient was referred to colorectal surgery and oncology for further staging and definitive management. For patients with lesions of uncertain depth or morphology, endoscopic resection offers a minimally invasive, organ-sparing first step that can help guide the need for subsequent surgical treatment. In select patients, this approach may reduce the extent of surgery required or confirm the necessity of more definitive intervention—supporting a more personalized, evidence-based treatment algorithm.

Advanced endoscopic techniques are transforming the management of early-stage colorectal cancer—offering not only the potential for curative treatment but also critical diagnostic insight that helps guide and optimize a surgical strategy if resection is ultimately required. As technology and expertise continue to evolve, these approaches are helping shape a more tailored, minimally invasive, and patient-centered standard of care. Proper patient selection, pre-procedural imaging, and multidisciplinary planning are essential. At Geisinger, our integrated team of gastroenterologists, colorectal surgeons, oncologists, and pathologists work collaboratively to develop individualized treatment strategies that maximize benefit and minimize risk.

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Pennsylvania Society of Gastroenterology

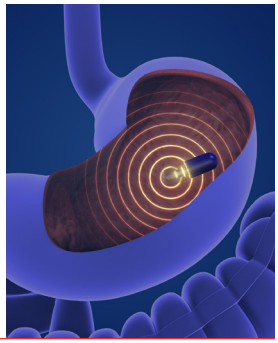
Geisinger

You are cordially invited to attend:

Small Bowel Capsule Endoscopy Course & Fellowship Networking Event 2025

Overview:

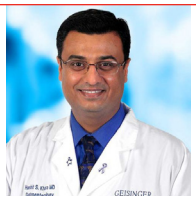
This program, hosted by Geisinger as part of the Pennsylvania Society of Gastroenterology Training Committee event, will provide an overview of the indications, appropriate patient selection, diagnostic algorithms for small bowel capsule endoscopy, and a hands-on review of case studies on laptop stations preloaded with PillCam Rapid Reader software.



Target Audience:

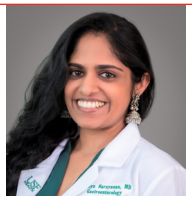
This program is intended for all Gastroenterology Fellows-in-Training and Advanced Practice Providers as part of PSG membership.

Course Director:



Harshit S. Khara, MD, FACG, FASGE
Associate Professor of Medicine
Director of Endoscopy, System Director of Interventional Endoscopy
Program Director, Advanced Endoscopy Fellowship Chair,
PSG Training Committee
Geisinger Medical Center, Danville, PA

Course Faculty:



Shreya Narayanan, MD
Assistant Professor of Medicine
Associate Program Director, USF Gastroenterology Fellowship
University of South Florida Morsani College of Medicine
Tampa, FL

Agenda:

Friday, August 15, 2025

12 noon - 1 pm:	Lunch
1 pm - 5 pm:	Capsule Endoscopy Course
5 pm - 7 pm:	Fellows Networking Event Kayaking and Boating on Lake Chillisquaque
7 pm - 9 pm:	Dinner

Location:

Heron Cove Pavilion A, Montour Preserve,
374 Preserve Rd, Danville, PA 17821

Lodging:

A complimentary 1-night stay will be offered to all attendees traveling from out of town at Pine Barn Inn in Danville, PA on Friday 8/15/25

Fees:

This course is being offered with complementary registration supported by an educational grant from Medtronic

Registration Link (click or scan to register):
https://forms.office.com/r/sxfLHP2Fu5

Deadine for Registration is August 8, 2025

Career Paths in GI: The GI Hospitalist

R. Fraser Stokes, MD, FACG

PSG Practice Management Committee Chairman

In the past, I have written in Rumblings about GI career opportunities in large single specialty supergroups, in hospital employed models, and in locum tenens arrangements. In this issue, I'll focus on the new, evolving, and increasingly popular subspecialty of the GI hospitalist (GIH).

A hospitalist is a board certified or board eligible physician who manages the care of hospitalized patients. Hospitalists started to emerge in the mid 1990's. A paper published by Wachter and Goldman in 1996 in the New England Journal of Medicine was seminal to the introduction of hospitalists to the general medical community. This career path has undergone astronomical growth. In 2003 there were approximately 11,000 hospitalists in the U.S.; by 2019 that number had risen to over 62,000.

Hospitalists can have different specialties in Internal Medicine and Surgery. Studies have shown that these specialized hospitalists lead to cost savings, reduced length of stay, and improved quality metrics. These positive effects have been shown to occur in Gastroenterology also. GIHs tend to work at larger hospitals (e.g. over 500 beds). Large practices of over 10 gastroenterologists also derive benefit from GIHs. These practices often have professional service agreements with hospitals that pay them a stipend to provide inpatient care.

GIHs have a unique skill set. They have expertise in high acuity GI patients and are highly experienced with hemostasis, foreign body removal, and feeding tube placement and management. They are highly competent in caring for patients hospitalized for IBD flares, as well as decompensated cirrhosis and acute pancreaticobiliary disorders. They are facile in managing anti-thrombotics. Some GIHs may have advanced endoscopy skills, such as ERCP, EUS, deep enteroscopy, stenting, and video capsule endoscopy. Their jobs involve extensive interdisciplinary collaboration, and when appropriate require working closely with a palliative care team.

There are multiple factors driving the growth of GIHs. First, it is increasingly challenging to care for inpatients. Inpatients skew older each year. They often have multiple comorbidities and are frequently on numerous medications, some of which present unique challenges, like biologics, chemotherapy, immune checkpoint inhibitors, and GLP-1 agents. In addition, hospital EMRs require a sizable amount of provider documentation time and energy. As outpatient GI care is also become more demanding, it is harder for a gastroenterologist to balance the responsibilities of both inpatient and outpatient practice while continuing to spend time on other work priorities, like administrative tasks, academic responsibilities, and trainee education.

Often, a GIH can greatly help with these challenges. GIHs cite many benefits of their effort:

1. Reliable access to specialty services
2. Increased inpatient care expertise
3. Improved consult ownership
4. Consistent presence
5. Improved continuity of care
6. Improved care quality
7. Reduced burden on outpatient practitioners
8. Increased GI physician productivity
9. Increased endoscopy suite time efficiency
10. Timely care There are several common staffing strategies for a GIH program. The first is 7 days of 24 hour care on and 7 days off. This gives the GIH ample time off but can be quite demanding and tiring when they are working. A second strategy is to have the GIH provide primary weekday coverage with weeknights and weekends being covered by a call pool. A third staffing model involves having a GIH cover the hospital some of the days while having others from a call pool cover other days. The fourth model involves having coverage provided by a locum tenens GI Hospitalist. This is the most cost-intensive solution.

When the decision is made to start a GIH program, it is vital for leaders to do a strategic assessment of their practice and hospital staffing needs. Seeing what time of day work demands are greatest and allocating appropriate staffing levels at those time is crucial.

Dr. Andy Tau of Austin Gastroenterology has proposed a potentially useful formula to estimate the number of providers needed on a GI hospitalist team. Ideally T should be less than or equal to 10.

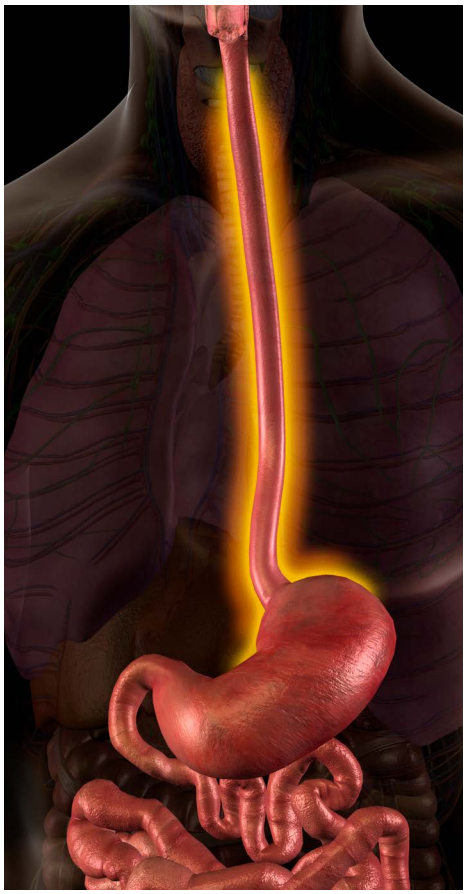
T = Patient census / (GIH + APP/2 + Fellow/2 + Superspecialist/2)

Note: APP refers to Advanced Practice Provider (Physician assistant or Nurse practitioner).

It is also vital before establishing a GIH program to determine who will be paying for the position, and hospitals are often expected to help fund this. Other important considerations include: estimated salary, RVU targets, and whether there will be a practice buy-in for the GIH.

If you are considering a GIH career, there are a few important things to keep in mind. First, you need to be adaptable and expect the unexpected. Your daily work life can become quite unpredictable and sometimes stressful. Second, it's important to avoid burn-out that may come with a GIH position, perhaps by intermixing Hospitalist work with outpatient practice, research, trainee education, or leadership / administrative tasks. Taking time to decompress with wellness-focused activities is key. One benefit GIHs enjoy is not having long term patient care concerns that outpatient Gastroenterologists struggle with. You may want to consider joining a GIH program that is somewhat flexible and committed to fit the needs of the GIHs, the practice, and the hospital. The ASGE has a newer special interest group (SIG) for GIHs that can provide valuable networking opportunities.

There are many exciting career opportunities now for a gastroenterologist. The GI Hospitalist track is becoming increasingly attractive to gastroenterologists, as well as larger GI practices, and busy hospitals.



The Harvey Lefton Gastroenterology Luminary of the Year Award

Call for Nominations:

The Pennsylvania Society of Gastroenterology is pleased to announce the Harvey Lefton Gastroenterology Luminary of the Year Award, which recognizes an individual or individuals who have made exceptional contributions to improving their community through selfless service, dedication, and effective action. We are seeking nominations for this award to honor those whose efforts have had a lasting, positive impact on the lives of others. Through their commitment to improving the lives of those around them, the nominee should exemplify the spirit of community, compassion, and leadership. This award highlights the invaluable work of someone who goes above and beyond to address social, environmental, educational, and economic challenges, fostering unity and empowerment.

This award is in honor of Dr. Harvey Lefton, who was a founding member of the Pennsylvania Society of Gastroenterology, as well as an advocate for healthcare in Philadelphia and the state of Pennsylvania.

Eligibility Criteria:

- **Be a member of the Pennsylvania Society of Gastroenterology**
- **Can be a physician, APP, Social Worker, Nurse or anyone else who practices in the field of Gastroenterology and Hepatology**

Nominees should meet one of the following criteria:

- **Demonstrated Impact:** The nominee has led or significantly contributed to a community-focused initiative that has improved the quality of life for individuals, families, or groups within the community.
- **Community Engagement:** The nominee has worked collaboratively with others, encouraging community involvement and inspiring positive change.
- **Developed innovative programs:** The nominee has developed a new program to enhance the lives of their patients (for example, a nutrition clinic, endobariatric program, MASLD multi-disciplinary clinic, etc.)
- **Master Clinician Educator:** The nominee has developed or contributed to a novel education program for students, fellows or the community.

Nomination Process:

To submit a nomination for the Community Outreach Award, please provide the following:

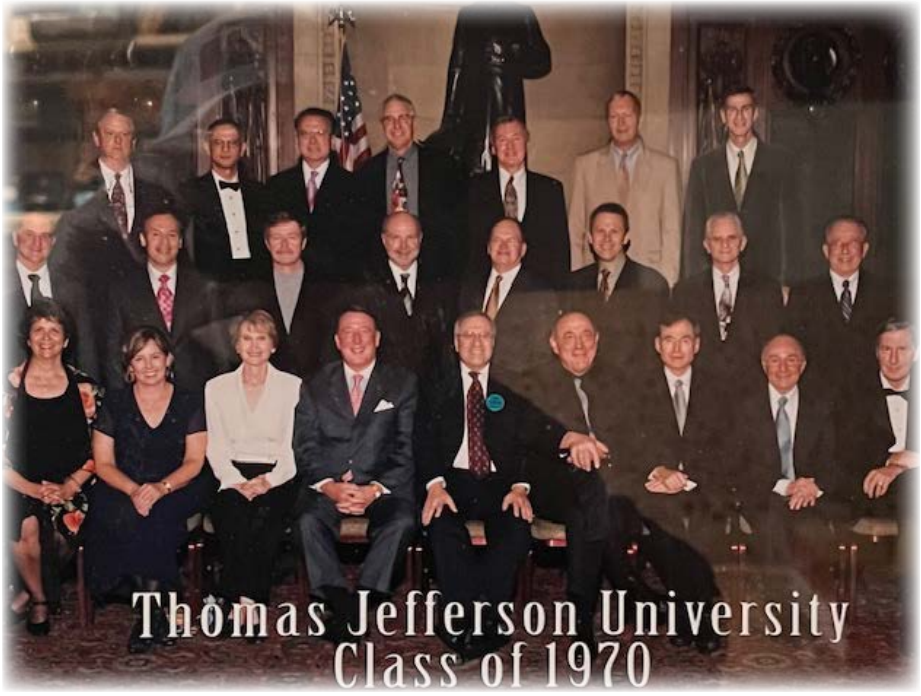
1. **Nominee's Information:** Name, contact details, and brief background information on the nominee.
2. **Description of Contributions:** A detailed description of the nominee's contributions to the community, including specific projects or initiatives that have had a positive impact. (No more than 250 words)
3. **Nomination Statement:** A written statement explaining why the nominee deserves to be recognized with the Award, highlighting their dedication, leadership, and long-term impact. (No more than 250 words)

Nomination Deadline: 7/28/25

Click here to make a nomination

Or scan QR Code below

Any questions, please email the PSG at **info@PASG.org**



Selection Process:

Nominations will be reviewed by a selection committee comprised of members of the Pennsylvania Society of Gastroenterology. The winner will be selected based on the significance of their contributions and the lasting positive change they have created in the community. The recipient will be honored at Pennsylvania Society of Gastroenterology annual meeting in Philadelphia on 9/20/2025.

Celebrate Those Who Make a Difference:

This award provides an opportunity to celebrate and recognize those who have worked tirelessly to improve our community. Whether through organizing charitable events, advocating for social causes, providing vital services, or inspiring others to take action, these individuals deserve to be honored for their unwavering commitment.

We encourage you to nominate someone whose efforts have truly made a difference. Help us celebrate the spirit of community and the power of positive change!

Let's come together to recognize the champions of our community!

Allegheny Health Network's Comprehensive Approach to Colorectal Cancer Awareness in March 2025

For March's Colorectal Cancer Awareness Month, the Allegheny Health Network (AHN) Division of Gastroenterology, Hepatology, and Nutrition launched a multifaceted campaign to educate and engage the community.

Our central theme, "Colonoscopy MythBusting," directly tackled common excuses people give for avoiding colonoscopies. Videos featured gastroenterologists Drs. Elie Aoun and Sandra El-Hachem which addressed common concerns such as, "But, I'm healthy," "But, I'm too young," "But, the prep is awful," and "But, it's uncomfortable." These videos were strategically distributed across various online platforms, including Paramount+, ESPN, Hearst TV, Disney+, and Prime Video, reaching a wide audience.

In addition, posters featuring the campaign's message were displayed in over 200 GI and primary care offices. This widespread placement ensured maximum visibility and accessibility of vital information.

We also extended our outreach into underserved communities. Dr. Akash Gadani did a presentation on colon cancer and screening to the Macedonia Family and Community Enrichment Center (Macedonia FACE), a faith-based non-profit serving the Hill District of Pittsburgh.

Another educational session was done by Dr. Aakash Desai with KDKA Radio Medical Frontiers host Dr. Pifer and colorectal surgeon Dr. Richard Fortunato. This targeted effort addressed colon cancer risks and prevention, the importance of getting screened at age 45, and was designed to dispel the myths of colonoscopy.

Recognizing the challenges of scheduling colonoscopies during the work week, the GI division offered convenient Saturday screening colonoscopy appointments at five outpatient endoscopy centers during the month of March. This initiative provided 72 additional appointments, significantly increasing access for busy individuals. Information regarding the Saturday screenings was disseminated via a press release by Department Chief Dr. Gursimran Kochhar, who highlighted the life-saving benefits of early screening, detection, and treatment. The screenings were also promoted through email updates to physicians, leaders, and team members throughout Allegheny Network.

Our commitment was also extended internally, with over 600 employees wearing a specially designed T-shirt created by the GI staff throughout March. The shirts featured the "MythBusting" campaign theme, and reinforced our dedication to raising awareness within our workforce and patient community.

A screensaver was displayed on AHN employee computer screens throughout the network reminding them that it was Colorectal Cancer Month and to schedule a colonoscopy. A QR code on the screensaver linked employees to the ahn.org website for colorectal cancer awareness. The screensaver had the potential to reach 21,000 AHN employees.

Our comprehensive approach shows a strong commitment to educating the community about colorectal cancer. The innovative use of digital media, targeted community outreach, and improved access to screenings demonstrate a clear strategy to improve early detection and prevention.

The continued success of these initiatives relies on sustained outreach and the ongoing effort to address barriers to screening.

Future campaigns will build on this foundation to further engage the community and address persistent health disparities impacting colorectal cancer rates.

YOU MATCHED!

Congratulations! Matching into Gastroenterology (GI) fellowship is a great accomplishment.

Michael Makar, MD
Geisinger Medical Center

Matching into Fellowship

It is a competitive specialty which requires a combination of academic excellence, clinical experience, research involvement and strong interpersonal skills. As you start your career, becoming a specialist is a completely different practice. You are no longer the primary care physician in the outpatient setting or managing inpatient admissions or discharges. You will now develop a unique skill set in managing a specific patient population and learn how to become an endoscopist. With that in mind, all of your skills from becoming a strong internal medicine doctor are the foundation of your starting your new career as a gastroenterologist.

Starting Fellowship

As you start fellowship, it is important to keep a few things in mind. First, try to see if you can find an interest within the field of gastroenterology that you really enjoy. Subspecialty fellowships within GI include transplant hepatology, advanced endoscopy, third space endoscopy, bariatric endoscopy, inflammatory bowel disease or motility. Gastroenterologists can also specialize in others area such as nutrition and obesity medicine or focus on clinical and academic research. Some physicians become experts in specific procedures such removing large polyps called endoscopic submucosal dissection, performing interventional Endoscopic ultrasound (EUS) or complex endoscopic retrograde cholangiopancreatography (ERCP).

Second, there has recently become a huge demand for GI physicians throughout the country. This means that your program may be looking to hire you as after graduation! As you go through your fellowship, work hard, and remember that your attendings may soon be your colleagues. You want to build a reputation as someone who is reliable, honest, treats others with respect, builds positive relationships and is professional in all settings. By the end of your three years of fellowship, everyone will learn how to perform endoscopy. However, that will not make you stand out among your colleagues. You are the leader of a big team. Medical students, resident and fellows will look up to you. You will also set the tone for your team in the endoscopy room. Your team will be made of nurses, nurse assistants, and anesthesia providers. The way you treat your staff, the clinic team and schedulers is a reflection of who you are as a physician. Act with integrity, be accountable and foster trust wherever you go.

Life after Fellowship

You will be surprised how fast fellowship goes by. Before you know it, you will be looking for your first attending job. A lot of hospitals and jobs are also looking to hire fellows at the start of your fellowship! They want to lock you in early and will offer incentives such as a monthly stipend during your fellowship. Do not feel pressured or rushed. You are in the driver seat. You are in demand. Take your time, interview broadly and keep an open mind. It will be important to start thinking about what you want your life to look like after fellowship. While we spend most of our time in academic settings through medical school, residency and fellowship, most jobs are at community hospitals. Where you want to settle down and location is a good place to start. Then you can think of the opportunities in that area such as academic vs private, small vs large hospital and whether you want to be involved with fellows, teaching and a medical school. When deciding on a specialty within GI, keep in mind that your job opportunities may vary based on your specific interests. For example, if you want to be an advanced endoscopist or transplant hepatologist that will impact your job opportunities. Find a mentor early in your fellowship and connect with alumni and graduating fellows. Do not be afraid to ask a lot of questions. Congratulations and welcome to the incredible field of gastroenterology. You will do great.

2025

PSG Annual Scientific Meeting

September 19-21, 2025

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Pennsylvania Society of Gastroenterology

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