
COMMUNITY PHYSICIAN PROFILE



Interview with Mark J. Silversmith, MD
*Section Chief of Gastroenterology
and New Technology Director,
Catholic Medical Center
Bedford, NH*

Briefly describe your practice and what portion is related to esophageal disease / Barrett's Esophagus:

I have a community GI practice which is about 20% Upper GI, with a growing focus on Barrett's diagnosis, surveillance and treatment. The balance of my practice is focused on colonoscopy.

How long have you been using WATS^{3D} and in what clinical situations do you use it?

I started using WATS^{3D} in September 2017, so it's been over a year. I use it in conjunction with forceps biopsy for all cases where I suspect BE. This includes screening and surveillance and also follow-up after RFA. I have found that I'm much more likely to find significant pathology/dysplasia with WATS^{3D} than with forceps biopsy.

What was your reaction to the Progression Data?

I never knew what to do with a patient whose diagnosis was "indefinite for dysplasia" even if I suspected something more serious. Most often, I would keep that patient in surveillance and just keep taking biopsies. The Progression Data showed me that Crypt Dysplasia can replace Indefinite because the WATS^{3D} image allows the pathologist to "look beyond" the FB image and see the cells in a different way. It also showed that Crypt Dysplasia progresses like Low Grade Dysplasia.

Is there any other data you have not yet seen regarding WATS^{3D} that you think is important for us to collect and share?

I'm amazed that Esophageal Cancer is still climbing. I think we need to study Short Segment Barrett's more because even though the major societies and physicians say SS BE doesn't need to be biopsied, I've had SS BE with HGD. I would like to see a study of SS BE and Irregular Z-Lines using FB and WATS^{3D}. Maybe there is an argument for just using WATS^{3D} for SS BE.

Do you think Primary Care Physicians are aware that chronic heartburn can lead to something more serious?

Many physicians are aware of this, but they often don't refer their patients. Also, long-term PPI users may fly under the radar because they don't talk about their heartburn. Middle-aged white males with chronic heartburn should be referred to a gastroenterologist. Physicians should also ask about a history of GERD or a family history of esophageal disease.

Would it be a good idea for patients getting a screening colonoscopy to also get an EGD?

Yes, I think this would be an excellent idea. If a physician has a patient who will be seeing a gastroenterologist for a screening colonoscopy, it makes good sense to ask whether the patient has a history of heartburn or a family history of esophageal disease. This would allow the patient to be screened for colonic and esophageal disease in the same visit.