

Gastroenterology Viewed Through a Glass Darkly – An IDI Focused Perspective

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ABSTRACT

The linear expansion of medical information has already precipitated fragmentation of physician-based clinical care into multiple subspecialties predicated on site of disease dysfunction. Through the widespread expansion and dissemination of information in the areas of diagnostic and case-management, Artificial Intelligence (AI) stands to erode exclusivity of patient care and redirect committed populations to alternate healthcare providers.

Governing a broad area of patient care, gastroenterologists have the responsibility to identify the canaries in the coal mine within their area of expertise. When canaries have been disregarded, the fiscal fallout has been significant: e.g. Individuals lacking production of gastric acid who developed peptic ulcer disease are just such canaries. When it was documented that PUD was of infectious disease causation and curable using antibiotics, the income of gastroenterologists dramatically decreased.

Largely due to disease entities grouped under the term, Inflammatory Bowel Disease (IBD), gastroenterologists are currently the second-best compensated subspecialists within internal medicine. Not having addressed the discipline's scientific deficiencies that were unmasked by the PUD debacle, gastroenterologists have set the stage for another fall from fiscal grace.

This IDI Perspective is an analysis of gastroenterology's vulnerable scientific underbelly, why history stands to repeat itself, and what can be done to minimize the consequences.

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Introduction

Currently, Gastroenterologists are second only to cardiologists as the best compensated subspecialists within internal medicine. Gastroenterologists' revenues are both procedure-based and serviced-based. This combination of revenue sources has largely insulated gastroenterologists from the necessity of aggressively pursuing scientific quest of disease causation. The resultant limitation on the discipline's core knowledge as to pathogenesis of its prime diseases has rendered it vulnerable to both manipulation by the pharmaceutical industry and future redirection of clientele to more effective healthcare providers.

Diseases unique to the gastrointestinal tract have created symbiotic relationships between gastroenterologists and the pharmaceutical industry which have been mutually beneficial. Gastroenterologists had been the primary health care providers for individuals suffering from peptic ulcer disease (PUD). By virtue of rendering direct patient care, gastroenterologists should have been in the unique position of doing something that AI does poorly, identify when an individual disease occurrence (experiment-in-nature) contradicts prevailing scientific dogma and obligates its reinterpretation.

The uncritical acceptance of hyperproduction of gastric acidity as causation and the mutually benefits derived had fostered a symbiosis that persisted for some two decades until external third-

party intervention documented PUD being an infectious disease that was curable with antibiotics.

Dismantlement of PUD symbiosis removed a significant source of revenue. The financial short fall in income was initially addressed by increasing the cost of services rendered and, ultimately, by the progressive servicing of diverse disease entities grouped under the title, Inflammatory bowel disease (IBD). Without addressing the discipline's deficiency of basic science foundation, IBD created gastroenterology's next major symbiosis.

IBD is currently a catchall label for uncured diseases of the gastrointestinal tract lacking definitive diagnostic tests, and undocumented pathogenesis. Its two principal disease groupings are Crohn's disease (CD) and ulcerative colitis (UC). Having been chronic diseases with no definitive diagnostic test and allegedly no cure, they recreated the requisites needed for a physician/industry symbiosis that again left the pharmaceutical industry in the apparent driver's seat. Like the previous PUD's physician/industry symbiosis, the IBD symbiosis has ruled unchallenged for over two decades without validation of pathogenesis. The factors that precipitated the PUD fiscal debacle for gastroenterologists have largely been left unaddressed, leaving the fiscal underbelly of the discipline exposed.

Canaries are kept in coal mines for a specific function: to warn of impending danger. Their message left unheeded leads to disaster. Within the PUD symbiosis, the prime canaries were those cases of PUB developing in individuals whose gastric lining lacked the ability to produce acid. For CD, the principal canaries have been the isolated individual self-cures with diet alone, induced sustained remissions in individuals who had failed therapy with biologics using a Mediterranean diet, the specificity of the site of transmural penetration and its movement following removal of diseased bowel, and the ability of breastfeeding to afford protection [1-5].

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Within a single decade, CD had progressed from a rare entity to a global pandemic limited to industrialized nations. Again, third party intervention was required to document that CD is an immune-mediated disease, initiated by newborn infection by a mycobacterium, and created by its widespread adulterated presence primarily in milk-based foods and readily treatable using relatively simple dietary manipulations [6-9]. Negative fiscal consequences of gastroenterology's therapeutic underperformance in CD have long been effectively buffered by third party expenditure of hundreds of millions of dollars directed at controlling the dialogues concerning pharmaceutical product efficacy. In CD, the money spent on advertising has prolonged drug utilization despite limited the prototype drug's initial failure rate of 60% and ultimately 100% long-term failure rate [10]. When patent expiration remove is corporate advertising sponsorship, public awareness that CD is preventable, easily and economically treatable by dietary manipulation, and curable disease, the resultant fallout will be significant [11].

There are multiple canaries singing in gastroenterology's UC's gold mine: why does appendectomy protect from the development of ulcerative colitis, why duodenitis or gastroduodenal colitis can co-exist with UC, why the appendix is a "skip" area of involvement in UC, why is rectosigmoid ulcerative colitis amenable to dietary manipulations, why does colonic cancer preferentially occur in the rectosigmoid area, why is gastrointestinal cancer rare to nonexistent in financially disadvantaged countries? [12]. AI stands to unclutter the therapy of a number of disease entities embedded within the label of UC.

AI's projected unmasking of, diagnostic tests for gastrointestinal diseases will progressively negate the need for surgical validation. The diagnosis of Crohn's disease can be documented by incubating an individual's large mononuclear with selected *Mycobacterium avium* subspecies *paratuberculosis* antigens and demonstrating the appearance of proinflammatory cytokines in the supernatant [7]. AI stands to render anyone possessing 10 grams of fecal material, 5 ccs of serum, and computer access an effective diagnostician of inflammatory bowel diseases.

The underlying threat of AI is that the disciple's avoid standard of care and its rigid commitment to it in CD and UC will be found seriously wanting. Once appropriate therapy is identified, gastroenterology's abandonment of the Public Trust stands to motivate individuals with gastrointestinal disease to seek alternate care.

If gastroenterology is to avert significant patient redirection and resultant loss of client-based revenue, it needs to hypertrophy its academic arm to achieve greater alignment with the patient long-term welfare. The technology now exists that allows for both characterization of the gastrointestinal microbiota and quantitative assessment of resultant biosynthetic metabolites that mediate acquired immunity and, more importantly, the bidirectional communication between the enteric nervous system and the central nervous system (brain/gut axis). If gastroenterology fails to make manipulation of the gastrointestinal microbiota and endogenous biosynthesis a therapeutic offering, not doing so will open a portal for internists to once more assimilate a portion of gastroenterology's clinical base. Endogenously directed therapeutics is future therapy for most gastrointestinal diseases manipulations [6-9].

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Gastroenterology has perhaps suffered more than other subdisciplines of internal medicine and surgery from American medicine's curse of intellectual isolation that undermines patient care and applied scientific progress. The compartmentalization of medical care has created situations analogous to churches of a different religion, but the same god, existing in isolation across the street from each other. Effective communication of ideas and information do not readily traverse that street. AI is about to demolish the street that divides the multitude of churches of patient care medicine in the United States. When that occurs, there will be a free-for-all scramble for patient-derived revenues [12].

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gastroenterology's clinical base. Endogenous microbiota-directed intervention is future therapy.

Conflict of Information: None

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