

令和4年後 同門会賞 優秀賞



北部医療センター—安佐市民病院 才野 正新

研修病院の紹介

旧病院
(可部南)



新病院
(亀山南)



2022年5月に新病院へと移転しました。

救急救命センターも設置され、
より高度急性期・急性期に特化した
病院となりました。

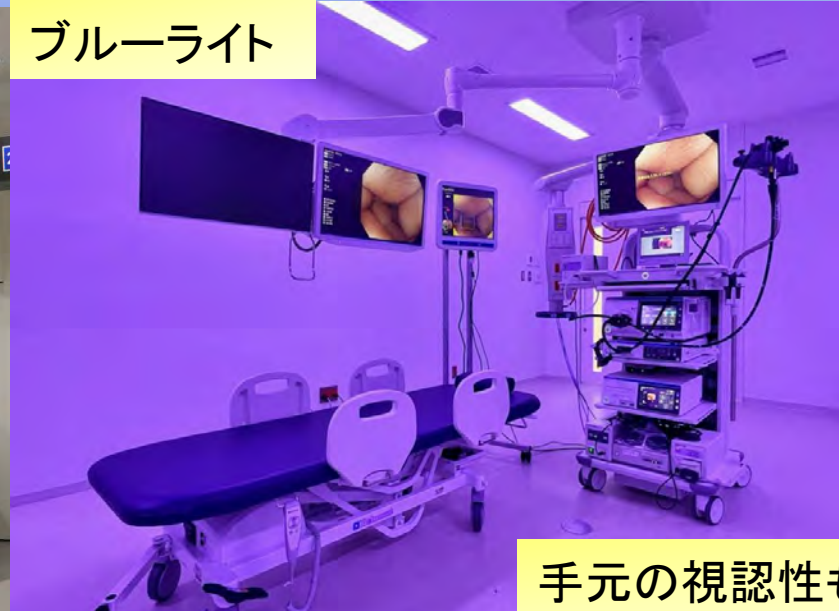


研修病院の紹介 ～内視鏡センター～

内視鏡センターも
大きくなりました



ブルーライト



手元の視認性も良好です

リカバリーベッド



検査後ベッドごと
移送可能です



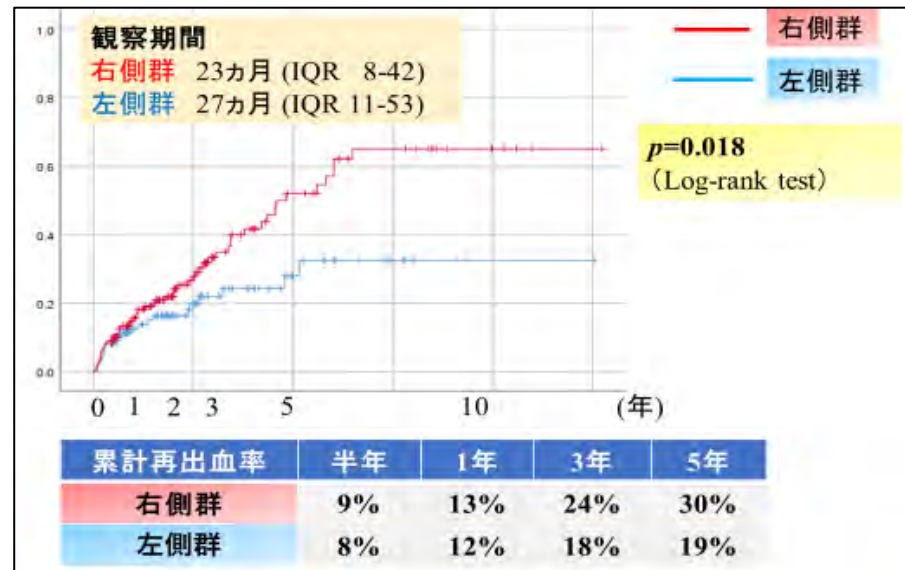
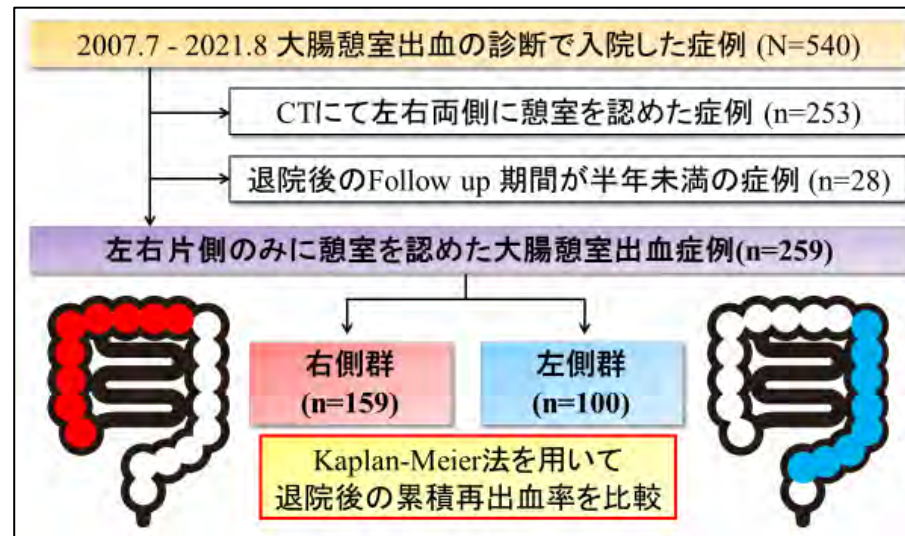
麻酔器が内視鏡室に常備
内視鏡室で全身麻酔可能です

研修病院の紹介 ～学会～



第128回 日本消化器病学会中国支部例会では
当院の永田信二副院長が会長を務めました

私自身も一般演題で発表しております



業績 2021年10月～2022年9月

論文

1. Masachika Saino, Taiki Aoyama , Akira Fukumoto, Kenjiro Shigita, Naoki Asayama, Shinichi Mukai, Shinji Nagata;
Tracking the target in colonic diverticular bleeding using red dichromatic imaging,
Endoscopy.2021 Nov;53(11):E425-E426. (2021.11)
2. Masachika Saino, Taiki Aoyama, Masahiro Yamane, Satoshi Masuda, Risa Nomura, Kenjiro Shigita, Naoki Asayama, Akira Fukumoto, Shinichi Mukai, Shinji Nagata;
Optimal candidates for early colonoscopy in the management of acute lower gastrointestinal bleeding,
Journal of Gastroenterology and Hepatology.2022 jul;37(7):1290-1297. (2022.9)
3. 山根 大寛, 朝山 直樹, 才野 正新, 益田 啓志, 野村 理紗, 嶋田 賢次郎, 青山 大輝, 福本 晃,
向井 伸一, 永田 信二 経口腸管洗浄剤服用に加えて大量飲水後に症候性低Na血症 を呈した2例
日本消化器病学会誌 第119巻9号 846-852 (2022.9)

業績 2021年10月～2022年9月

口演

1. 才野 正新, 青山 大輝, 永田 信二. パネルディスカッション6「下部消化管における緊急内視鏡診療」
「急性下部消化管出血におけるearly colonoscopyと受診前最終血便」 JDDW 2021 (2021.11)
2. 才野 正新, 青山 大輝, 本田 洋士, 山根 大寛, 野村 理紗, 益田 啓志, 關藤 剛
嶋田 賢次郎, 榎木 慶一, 朝山 直樹, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「経皮的に直接穿刺しバルーン閉塞下逆行性経静脈的塞栓術(B-RTO)を施行した小腸静脈瘤の1例」
第116回日本消化器病学会中国支部例会 (2021.11)
3. 長尾 暁憲, 青山 大輝, 野村 理紗, 山根 大寛, 才野 正新, 益田 啓志, 關藤 剛, 嶋田 賢次郎,
榎木 慶一, 朝山 直樹, 本田 洋士, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「浸水下で診断し得た胃Dieulafoy潰瘍の1例」 第116回日本消化器病学会中国支部例会 (2021.11)
4. 本田 洋士, 榎木 慶一, 山根 大寛, 才野 正新, 野村 理紗, 益田 啓志, 關藤 剛, 嶋田 賢次郎,
朝山 直樹, 青山 大輝, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「抗ウイルス療法とC型慢性肝炎及び肝硬変の予後について」 第108回日本消化器病学会総会(2022.4)
5. 青山 大輝, 山根 大寛, 才野 正新, 野村 理紗, 益田 啓志, 關藤 剛, 嶋田 賢次郎,
榎木 慶一, 朝山 直樹, 本田 洋士, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「大腸憩室出血に対するCT colonography上の戦略的マーキングの有用性」
第103回日本消化器内視鏡学会総会(2022.5)

業績 2021年10月～2022年9月

6. 才野 正新, 朝山 直樹, 山根 大寛, 向井 伸一, 永田 信二.
ワークショップ「中国地方におけるがん診療の最先端」
「コロナ禍における広島安佐地区胃がんESD/EMR地域連携クリニカルパスの有用性」
第117回日本消化器病学会中国支部例会 (2022.6)
7. 山根 大寛, 朝山 直樹, 才野 正新, 關藤 剛, 嶋田 賢次郎, 榎木 慶一, 本田 洋士,
行武 正伸, 福本 晃, 向井 伸一, 三田 耕司, 金子 真弓, 永田 信二.
「腎盂癌を原発とした転移性大腸癌の1例」第117回日本消化器病学会中国支部例会 (2022.6)
8. 才野 正新, 青山 大輝, 山根 大寛, 野村 理紗, 益田 啓志, 關藤 剛, 嶋田 賢次郎,
榎木 慶一, 朝山 直樹, 本田 洋士, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「右側？左側？大腸憩室出血はどちらが再発しやすいか」第128回日本消化器内視鏡学会中国支部例会 (2022.7)
9. 山根 大寛, 嶋田 賢次郎, 才野 正新, 關藤 剛, 朝山 直樹, 榎木 慶一, 本田 洋士, 青山 大輝,
行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「薬物治療性GERDに内視鏡的噴門部粘膜焼灼術 (ARMA) が有効であった1例」
第128回日本消化器内視鏡学会中国支部例会 (2022.7)
10. 頼近 恭典, 青山 大輝, 山根 大寛, 才野 正新, 益田 啓志, 野村 理紗, 關藤 剛, 嶋田 賢次郎,
朝山 直樹, 榎木 慶一, 本田 洋士, 行武 正伸, 福本 晃, 向井 伸一, 永田 信二.
「留置クリップが責任病変同定に有用であったS状結腸憩室出血の1例」
第128回日本消化器内視鏡学会中国支部例会 (2022.7)

JDDW 2021

Japan Digestive Disease Week 2021
 PD6-3. The role of early colonoscopy in lower gastrointestinal disease
 2021.11.5 Kobe

Clinical suitable candidate of early colonoscopy in acute lower gastrointestinal bleeding

Performance of early CS

Outcome	All patients	Recent bleeding group	Non-recent bleeding group
30-day rebleeding	×	○	×
Diagnostic yield	○	○	×
Endoscopic treatment	○	○	×
IVR/surgery needed	×	×	×
Blood transfusion	×	○	×
Prolonged LOS	○	○	×
30-day mortality	—	—	—

JDDW 2021 パネルディスカッション6

下部消化管出血におけるEarly colonoscopyは来院前6時間以内に血便を認めた患者群 (Recent bleeding group) では早期再出血率を低下させるため、有効であると報告しました。



若手奨励賞を受賞しました

論文①

ORIGINAL ARTICLE - GASTROENTEROLOGY (CLINICAL)

Optimal candidates for early colonoscopy in the management of acute lower gastrointestinal bleeding

Masachika Saino, Taiki Aoyama, Masahiro Yamane, Satoshi Masuda, Risa Nomura, Kenjiro Shigita, Naoki Asayama, Akira Fukumoto, Shinichi Mukai and Shinji Nagata

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Key words

colonic diverticular bleeding, colonoscopy, gastrointestinal hemorrhage, hospitalization.

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Email: taoyama@asa-hosp.city.hiroshima.jp

Declaration of conflict of interest: The authors have no conflict of interest to disclose.

Ethical approval: This study was approved by the Institutional Review Board of the Hiroshima City Asa Citizens Hospital on March 29, 2021 (IRB no. 02-14), which waived the requirement for informed consent given the retrospective nature of the study.

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Introduction

Acute lower gastrointestinal bleeding (ALGIB) is a common cause of hospitalization and consumes significant medical resources. Unlike upper gastrointestinal bleeding, which can be controlled with antacid therapy, there is no effective prophylactic treatment for ALGIB.¹

Some guidelines and nationwide studies recommend colonoscopy as the initial diagnostic procedure for patients with ALGIB because it can accurately determine the etiology of bleeding and help stratify patients according to the risk of adverse outcomes.¹⁻³ The timing of colonoscopy has been controversial, and early colonoscopy may improve the detection of the definitive source of bleeding and increase endoscopic treatment rates. However, the primary endpoint must be achieved to validate the effectiveness of early colonoscopy (≤ 24 h) for patients with ALGIB. Rebleeding was chosen as the primary outcome in several meta-analyses,⁴⁻⁷ following the recommendation for its use in most randomized controlled trials (RCTs) for upper UGIB management.⁸

Abstract

Background and Aim: Early colonoscopy has not shown any advantages over elective colonoscopy in reducing the risk of early rebleeding (≤ 30 days) after acute lower gastrointestinal bleeding (ALGIB). Considering the heterogeneity among patients with ALGIB, we sought to evaluate appropriate candidates for early colonoscopy.

Methods: A total of 592 patients with ALGIB were enrolled, and the clinical outcomes of early colonoscopy were investigated. Thereafter, the participants were divided into two groups: the recent bleeding group ($n = 445$), with hematochezia 0–6 h before hospital arrival, and non-recent bleeding group ($n = 147$). The clinical outcomes yielded by early colonoscopy were assessed in each group.

Results: The multivariate analysis including the entire population revealed that early colonoscopy (< 24 h) did not reduce the risk of early rebleeding (adjusted odds ratio [AOR], 0.88; 95% confidence interval [CI], 0.55–1.39). However, in the subgroup analysis, early colonoscopy independently reduced the risk of early rebleeding in the recent bleeding group (AOR, 0.56; 95% CI, 0.33–0.94). Moreover, a reduction in the need for radiological or surgical intervention (AOR, 0.34), transfusion (AOR, 0.62), and prolonged hospitalization (AOR, 0.42), as well as improvement in diagnostic yield (AOR, 1.78) and endoscopic treatment rates (AOR, 1.66), were observed. Early colonoscopy did not improve the outcomes of the non-recent bleeding group.

Conclusions: Early colonoscopy is not required for all patients with ALGIB. However, it may be suitable for those with hematochezia 0–6 h before hospital arrival, as it reduces early rebleeding and improves clinical outcomes.

Meta-analyses,⁴⁻⁷ as well as RCTs and observational studies, have concluded that early colonoscopy does not improve the 30-day rebleeding rate.⁹⁻²² Therefore, the latest guideline²³ does not recommend early colonoscopy over elective colonoscopy in patients with ALGIB. However, the robustness of the evidence was low because the definitions and selection criteria for the pooled data were heterogeneous, and the limited sample sizes of the RCTs led to wide confidence intervals (CIs) for all outcomes assessed in the meta-analyses.²³

Given the heterogeneous backgrounds of patients with ALGIB, routine early colonoscopy may not achieve uniformly preferable outcomes in all patients. Nevertheless, we should consider opportunities to help achieve superior outcomes by employing early colonoscopy in selected patients. Because no previous studies have stratified and analyzed the ALGIB population according to the timing of the most recent hematochezia, this study sought to determine the relationship between this variable and the outcomes of subsequent early colonoscopy.

Table 3 Clinical outcomes of early colonoscopy compared with elective colonoscopy

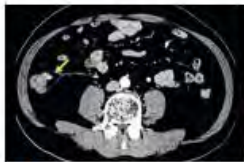
All patients	Early colonoscopy (n = 354)	Elective colonoscopy (n = 238)	Crude OR (95% CI)	P value	Adjusted OR [†] (95% CI)	P value
30-day rebleeding (n = 108)	57 (16)	51 (21)	0.70 (0.46–1.07)	0.10	0.88 (0.55–1.39)	0.57
Diagnostic yield (n = 275)	192 (54)	86 (36)	2.10 (1.50–2.94)	< 0.01	1.83 (1.26–2.66)	< 0.01
Endoscopic treatment ^{††} (n = 230)	159 (45)	71 (30)	1.92 (1.35–2.27)	< 0.01	1.73 (1.18–2.55)	< 0.01
NR/surgery required (n = 19)	9 (3)	10 (4)	0.60 (0.24–1.49)	0.27	0.42 (0.16–1.14)	0.09
RBC transfusion (n = 208)	113 (32)	95 (40)	0.71 (0.50–0.99)	0.046	0.83 (0.65–1.24)	0.35
Prolonged LOS ≥ 7 days (n = 278)	144 (41)	134 (56)	0.53 (0.38–0.74)	< 0.01	0.56 (0.39–0.82)	< 0.01
30-day mortality (n = 1)	1 (0.3)	0 (0)	NA	NA	NA	NA
Recent bleeding group	Early colonoscopy (n = 290)	Elective colonoscopy (n = 155)	Crude OR (95% CI)	P value	Adjusted OR [†] (95% CI)	P value
30-day rebleeding (n = 88)	45 (16)	41 (26)	0.51 (0.32–0.82)	< 0.01	0.56 (0.33–0.94)	0.029
Diagnostic yield (n = 224)	164 (57)	63 (41)	1.90 (1.28–2.82)	< 0.01	1.78 (1.16–2.72)	< 0.01
Endoscopic treatment ^{††} (n = 199)	144 (50)	55 (35)	1.79 (1.20–2.68)	< 0.01	1.66 (1.08–2.56)	0.021
NR/surgery required (n = 16)	7 (2)	9 (6)	0.40 (0.15–1.10)	0.080	0.34 (0.12–0.98)	0.046
RBC transfusion (n = 159)	93 (32)	66 (43)	0.64 (0.43–0.95)	0.028	0.62 (0.39–0.99)	0.046
Prolonged LOS ≥ 7 days (n = 206)	113 (39)	93 (60)	0.43 (0.29–0.63)	< 0.01	0.42 (0.27–0.65)	< 0.01
30-day mortality (n = 1)	1 (0.3)	0 (0)	NA	NA	NA	NA
Non-recent bleeding group	Early colonoscopy (n = 84)	Elective colonoscopy (n = 83)	Crude OR (95% CI)	P value	Adjusted OR [†] (95% CI)	P value
30-day rebleeding (n = 22)	12 (19)	10 (12)	1.69 (0.68–4.19)	0.26	2.60 (0.90–7.48)	0.078
Diagnostic yield (n = 51)	28 (44)	23 (28)	2.03 (1.02–4.04)	0.044	1.92 (0.87–4.21)	0.11
Endoscopic treatment ^{††} (n = 31)	15 (23)	16 (19)	1.28 (0.58–2.84)	0.54	1.08 (0.41–2.73)	0.90
NR/surgery required (n = 3)	2 (3)	1 (1)	2.65 (0.24–29.8)	0.43	1.44 (0.11–19.4)	0.79
RBC transfusion (n = 49)	20 (31)	29 (35)	0.85 (0.42–1.67)	0.64	1.22 (0.65–2.70)	0.62
Prolonged LOS ≥ 7 days (n = 72)	31 (48)	41 (49)	0.96 (0.5–1.85)	0.91	1.33 (0.62–2.84)	0.47
30-day mortality (n = 0)	0 (0)	0 (0)	NA	NA	NA	NA

JDDWで発表した内容を論文化し、
Journal of Gastroenterology and Hepatology
に投稿しました。

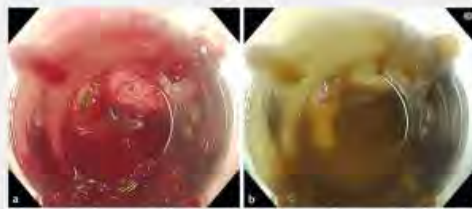
論文②

*Endoscopy E-video*にて大腸憩室出血におけるRDI (Red Dichromatic Imaging) の有用性について報告しました。

Tracking the target in colonic diverticular bleeding using red dichromatic imaging

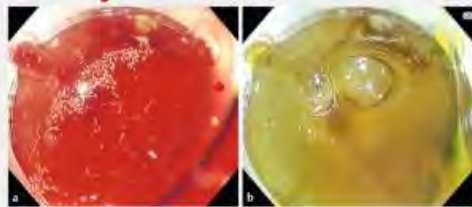


▶ Fig. 1 Contrast-enhanced computed tomography at admission. Extravasation was observed in the ascending colon (yellow arrow).



▶ Fig. 2 Endoscopic view of the ascending colon. **a** On white-light endoscopy, evidence of recent bleeding was difficult to obtain owing to the surrounding environment consisting of pooled residual blood. **b** Red dichromatic imaging enhanced the evidence of recent bleeding and easily distinguished it from the surrounding environment.

“Red” is indistinguishable from “red.” Pooling of blood in the colon is often encountered during urgent colonoscopy and is reportedly useful for detecting the lesion responsible for acute lower gastrointestinal bleeding [1]. However, discerning active or recent bleeding is cumbersome in an environment containing blood that has accumulated over various time points. The novel image-enhanced endoscopic technique, red dichromatic imaging (RDI), may overcome this problem. It clearly demarcates active bleeding from the surrounding residual blood based on the color-contrast principle (i. e. the difference in the target’s hemoglobin concentration and thickness) [2]. A 66-year-old man was admitted to our hospital with hematochezia. Contrast-enhanced computed tomography revealed extravasation in the ascending colon (▶ Fig. 1). Urgent colonoscopy was performed using the CF-HQ290I endoscope (equipped with a waterjet) and EVIS X1 device (Olympus Co., Tokyo, Japan) after bowel preparation with polyethylene glycol (PEG). Massive blood pooling was observed in the ascending colon (▶ Fig. 2a), which hindered endoscopic vision and obscured the bleeding points. Upon switching from white-light endoscopy (WLE) to the RDI mode, an amber stream, clearly demarcated from the translucent surroundings, was identified at the medial aspect of the ascending

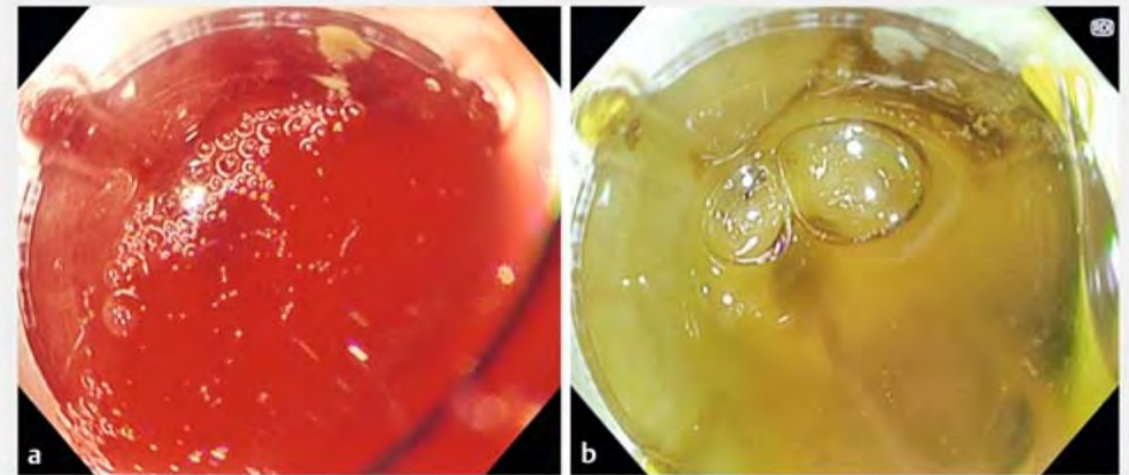


▶ Fig. 3 Causative diverticulum with active bleeding. **a** The blood stream was difficult to identify using white-light endoscopy. **b** The blood stream was clearly depicted amidst blood pooling on the red dichromatic imaging mode.

colon (▶ Fig. 2b). The amber stream was found to be fresh blood or active bleeding, while the surrounding environment contained blood diluted with PEG. The causative diverticulum with active bleeding from the dome was successfully identified on RDI, having been obscured by residual blood on WLE (▶ Fig. 3, ▶ Video 1). Hemostasis was successfully achieved using endoscopic band ligation. The patient was discharged 5 days after treatment without any rebleeding or adverse events.

This case demonstrated the clinical utility of the RDI mode, which enhances only fresh blood that is otherwise missed on WLE and may help to identify the lesion responsible for bleeding, especially in the presence of residual blood in the colon.

Endoscopy_UCTN_Code_TTT_1AQ_2AB



▶ Fig. 3 Causative diverticulum with active bleeding. **a** The blood stream was difficult to identify using white-light endoscopy. **b** The blood stream was clearly depicted amidst blood pooling on the red dichromatic imaging mode.

白色光観察では周囲の水も赤く染まってしまい、出血が視認しにくい。
RDIでは薄まった血液は透過され、新鮮な血液が視認しやすくなる。

後期研修3年間の学術活動・経験した手技

●論文(First authorのみ)

英語論文 2 日本語論文 1

●口演(筆頭演者のみ)

全国学会 主題 4

地方会 主題 1 一般演題 4

研究会 2

臨床・学術活動ともに
多くの経験を
させていただきました。

●経験した症例、検査、手技

入院担当患者数 1,547

上部消化管内視鏡 1,189

大腸内視鏡 1,075

胃EMR 16

大腸EMR 307

胃ESD 83

食道ESD 9

大腸ESD 9

肝生検・肝腫瘍生検/RFA 15/2

EVL/EIS 29/4

ERCP 267

謝辞



この度は栄誉ある賞を受賞させていただき、誠にありがとうございます。

3年間ご指導いただいた北部医療センター
安佐市民病院の先生方・スタッフの皆様
この場を借りてお礼申し上げます。

