AJG Special Issue

AI CLINICAL APPLICATIONS IN GI AND HEPATOLOGY

Submit your clinically relevant manuscript

SUBMISSIONS ARE NOW OPEN!

Submission Window Closes: August 31, 2025

1

ACG 2025

OCTOBER 24 - 29, 2025 | PHOENIX, ARIZONA

REGISTER TODAY: ACGMEETINGS.GI.ORG

2


2025
ACG'S ESOPHAGUS SCHOOL
& ACG/VGS/MASGNA REGIONAL
POSTGRADUATE COURSE
SEPTEMBER 5-7, 2025 | WILLIAMSBURG LODGE
WILLIAMSBURG, VA
click for course information

3


IBD Circle
CROHN'S & COLITIS FOUNDATION
ACG Special Edition IBD Circle VGR
Bringing Latest ACG Guidelines to Life:
Practical, Case-Based Insights for IBD Care
Wednesday, August 20, 2025
8:00 PM- 9:00 PM Eastern Time
*CME Offered
Jean-Paul Achkar, MD, FACG
Sunanda V. Kane, MD, MSPH, MACG
David T. Rubin, MD, FACG
Anita Afzali, MD, MPH, MHCM, FACG
This activity is sponsored by AbbVie

4

Virtual Grand Rounds

universe.gi.org

Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.


Moderators:
Sunanda V. Kane, MD, MSPH, MACG
and
Jean-Paul Achkar, MD, FACG

Exit

5

Virtual Grand Rounds

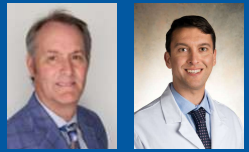
universe.gi.org

ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 34 – Thursday August 21, 2025
GI Nutrition Care Series: Micronutrient Deficiencies and Malabsorption
Faculty: Kristen Roberts, PhD, RDN, CNSC, FASPEN, FAND, and
Holly Estes Doetsch, DCN, RD, LD
Moderator: Lindsey Russell, MD, MSc, CNSC
At Noon and 8pm Eastern

Special VGR - Week 35 – Tuesday August 26, 2025
Leveraging the Mentor-Mentee Relationship: Successes in Fellowship to Practice
Faculty: Lisa B. Malter, MD, FACG, Aileen Bui, MD, Lauren D. Feld, MD and Samir A. Shah, MD, FACG
Moderator: Nikki Duong, MD and Alana B. Persaud, MD
At 8pm Eastern



Week 35 – Thursday August 28, 2025
Short Bowel Syndrome/Intestinal Failure: Recognition, Complications, and Basic Management
Faculty: John K. DiBaise, MD, FACG
Moderator: Dejan Micic, MD, FACG
At Noon and 8pm Eastern

Visit **gi.org/ACGVGR** to Register

6


ACG 2025
OCTOBER 24 - 29, 2025 | PHOENIX, ARIZONA
REGISTER TODAY: ACGMEETINGS.GI.ORG

7


JANUARY 30 – FEBRUARY 1, 2026
2026
ACG'S IBD SCHOOL &
ACG BOARD OF GOVERNORS /
ASGE BEST PRACTICES COURSE
ACG
ASGE
LAS VEGAS

8

Virtual Grand Rounds

Disclosures

universe.gi.org

David T. Rubin, MD, FACG:
AbbVie: Consultant/Advisor; Abivax SA: Consultant/Advisor; AltruBio: Consultant/Advisor; Athos Therapeutics, Inc.: Consultant/Advisor; Bristol-Myers Squibb: Consultant/Advisor; Celltrion: Consultant/Advisor; Connect BioPharma: Consultant/Advisor; Eli Lilly & Co.: Consultant/Advisor; Genentech (Roche) Inc.: Consultant/Advisor; Iterative Health: Consultant/Advisor; Janssen Pharmaceuticals: Consultant/Advisor; Johnson & Johnson: Consultant/Advisor; Merck & Co.: Consultant/Advisor; Odyssey Therapeutics: Consultant/Advisor; Pfizer: Consultant/Advisor; Sanofi: Consultant/Advisor; Spyre: Consultant/Advisor; Takeda: Grant support; Takeda Pharmaceuticals: Consultant/Advisor; Vedanta Biosciences: Consultant/Advisor; Ventyx: Consultant/Advisor.

Anita Afzali, MD, MPH, MHCM, FACG: AbbVie: Advisory Committee/Board Member, Consultant, Grant/Research Support, Speakers Bureau; BMS: Advisory Committee/Board Member, Consultant, Grant/Research Support, Speakers Bureau; IBDHorizons: Advisory Committee/Board Member; Board Member, Founder; Johnson & Johnson: Advisory Committee/Board Member, Consultant, Grant/Research Support, Speakers Bureau; Lilly: Advisory Committee/Board Member, Consultant, Grant/Research Support; Pfizer: Advisory Committee/Board Member, Consultant, Grant/Research Support, Speakers Bureau; Scrubs & Heels Foundation: Advisory Committee/Board Member; Board Member, Founder; Takeda: Advisory Committee/Board Member, Consultant, Grant/Research Support, Speakers Bureau.

Sunanda V. Kane, MD, MSPH, MACG:
Boehringer Ingelheim: Consultant; Bristol Meyers Squibb: Advisory Committee/Board Member; Fresenius Kabi: Advisory Committee/Board Member; Gilead: Advisory Committee/Board Member; Janssen: Consultant; Lilly: Advisory Committee/Board Member; Pfizer: Advisory Committee/Board Member; Takeda: Advisory Committee/Board Member; UptoDate: Independent Contractor

Jean-Paul Achkar, MD, FACG:
No relevant financial relationships with ineligible companies.

Jill Gaidos, MD, FACG, CFFC:
Pfizer: Consultant

David B. Sachar, MD, FACG:
No relevant financial relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

9

IBD Circle

Bringing Latest ACG Guidelines to Life: Practical, Case-Based Insights for IBD Care

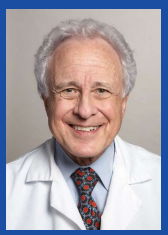
Sunanda V. Kane, MD, MSPH, MACG

Jean-Paul Achkar, MD, FACG

David T. Rubin, MD, FACG

Anita Afzali, MD, MPH, MHCM, FACG

Jill Gaidos, MD, FACG, CFFC



David B. Sachar, MD, FACG

10

Virtual Grand Rounds IBD Circle CROHN'S & COLITIS FOUNDATION

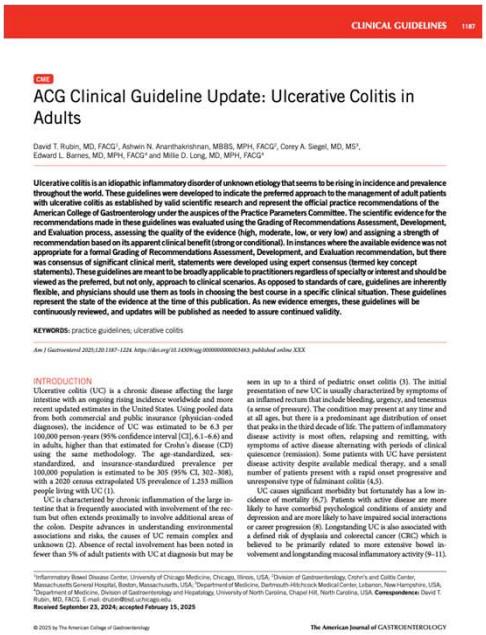
universe.gi.org

The New American College of Gastroenterology Ulcerative Colitis Guidelines

UChicagoIBD
90 years of Discovery and Innovation

David T. Rubin, MD, FACG
Joseph B. Kirsner Professor of Medicine
Chief, Section of Gastroenterology, Hepatology, and Nutrition
Director, Inflammatory Bowel Disease Center
University of Chicago

11



CLINICAL GUIDELINES 1187

CME

ACG Clinical Guideline Update: Ulcerative Colitis in Adults

David T. Rubin, MD, FACG[1], Ashwin N. Ananthakrishnan, MBBS, MPH, FACG[2], Corey A. Siegel, MD, MS[3], Edward L. Barnes, MD, MPH, FACG[4] and Millie D. Long, MD, MPH, FACG[5]

Ulcerative colitis is an idiopathic inflammatory disorder of unknown etiology that seems to be rising in incidence and prevalence throughout the world. These guidelines were developed to indicate the preferred approach to the management of adult patients with ulcerative colitis as established by valid scientific research and represent the official practice recommendations of the American College of Gastroenterology under the auspices of the Practice Parameters Committee. The scientific evidence for the recommendations made in these guidelines was evaluated using the Grading of Recommendations Assessment, Development, and Evaluation process, assessing the quality of the evidence (high, moderate, low, or very low) and assigning a strength of recommendation based on its apparent clinical benefit (strong or conditional). In instances where the available evidence was not appropriate for a formal Grading of Recommendations Assessment, Development, and Evaluation recommendation, but there was consensus of significant clinical merit, statements were developed using expert consensus (termed key concept statements). These guidelines are meant to be broadly applicable to practitioners regardless of specialty or interest and should be viewed as the preferred, but not only, approach to clinical scenarios. As opposed to standards of care, guidelines are inherently flexible, and physicians should use them as tools in choosing the best course in a specific clinical situation. These guidelines represent the state of the evidence at the time of this publication. As new evidence emerges, these guidelines will be continuously reviewed, and updates will be published as needed to assure continued validity.

KEYWORDS: practice guidelines; ulcerative colitis

Am J Gastroenterol 2025;120:1187–1224. https://doi.org/10.14309/ajg.0000000000003483. published online XXX

INTRODUCTION

Ulcerative colitis (UC) is a chronic disease affecting the large intestine with an ongoing rising incidence worldwide and more recent updated estimates in the United States. Using pooled data from both commercial and public insurance (physician-coded diagnoses), the incidence of UC was estimated to be 6.3 per 100,000 person-years (95% confidence interval [CI], 6.1–6.6) and in adults, higher than that estimated for Crohn's disease (CD) using the same methodology. The age-standardized, sex-standardized, and insurance-standardized prevalence per 100,000 population is estimated to be 305 (95% CI, 302–308), with a 2020 census extrapolated US prevalence of 1.253 million people living with UC (1).

UC is characterized by chronic inflammation of the large intestine that is frequently associated with involvement of the rectum but often extends proximally to involve additional areas of the colon. Despite advances in understanding environmental associations and risks, the causes of UC remain complex and unknown (2). Absence of rectal involvement has been noted in fewer than 5% of adult patients with UC at diagnosis but may be seen in up to a third of pediatric onset colitis (3). The initial presentation of new UC is usually characterized by symptoms of an inflamed rectum that include bleeding, urgency, and tenesmus (a sense of pressure). The condition may present at any time and at all ages, but there is a predominant age distribution of onset that peaks in the third decade of life. The pattern of inflammatory disease activity is most often, relapsing and remitting, with symptoms of active disease alternating with periods of clinical quiescence (remission). Some patients with UC have persistent disease activity despite available medical therapy, and a small number of patients present with a rapid onset progressive and unresponsive type of fulminant colitis (4,5).

UC causes significant morbidity but fortunately has a low incidence of mortality (6,7). Patients with active disease are more likely to have comorbid psychological conditions of anxiety and depression and are more likely to have impaired social interactions or career progression (8). Longstanding UC is also associated with a defined risk of dysplasia and colorectal cancer (CRC) which is believed to be primarily related to more extensive bowel involvement and longstanding mucosal inflammatory activity (9–11).

[1]Inflammatory Bowel Disease Center, University of Chicago Medicine, Chicago, Illinois, USA. [2]Division of Gastroenterology, Crohn's and Colitis Center, Massachusetts General Hospital, Boston, Massachusetts, USA. [3]Department of Medicine, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, USA. [4]Department of Medicine, Division of Gastroenterology and Hepatology, University of North Carolina, Chapel Hill, North Carolina, USA. **Correspondence:** David T. Rubin, MD, FACG. E-mail: drubin@bsd.uchicago.edu.

Received September 23, 2024; accepted February 15, 2025

IBD Circle CROHN'S & COLITIS FOUNDATION

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

12

Virtual Grand Rounds

universe.gi.org

New Ulcerative Colitis Practice Guidelines in Adults 2025

7	Sections
1	NEW section on positioning therapies
9	New therapies discussed
8	Tables
54	GRADEd Recommendations (Table 2)
57	Key Concept Statements (Table 3)
3	Figures

- Colorectal cancer surveillance removed

1. Ustekinumab
2. Upadacitinib
3. Ozanimod
4. Etrasimod
5. Mirikizumab
6. Risankizumab
7. Guselkumab
8. Infliximab SC
9. Vedolizumab SC

IBD Circle

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

13

Virtual Grand Rounds

universe.gi.org

Sections of the New Ulcerative Colitis Practice Guidelines in Adults 2025

1. Diagnosis, assessment, monitoring, and prognosis of ulcerative colitis
2. Goals for managing patients with ulcerative colitis
3. Induction and maintenance of remission in mildly to moderately active UC
4. Induction of remission in moderately to severely active UC
5. Maintenance of remission in patients with previously moderately to severely active UC
6. **NEW! Positioning considerations for the patient with moderately to severely active UC**
7. Management of the hospitalized patient with acute severe UC

IBD Circle

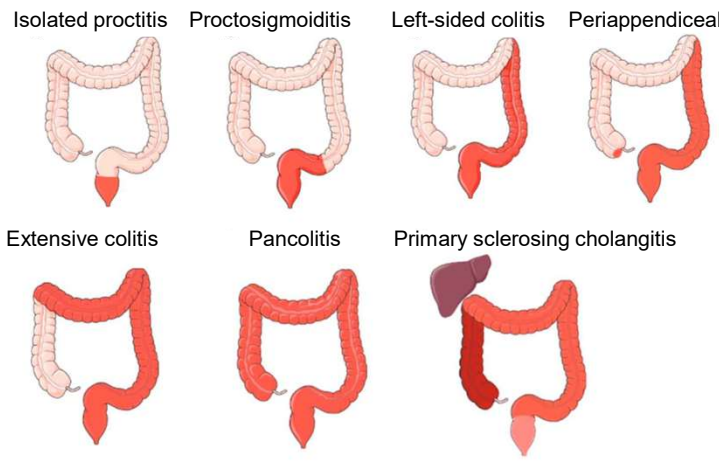
Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

14

Virtual Grand Rounds

universe.gi.org

Different UC Clinical Phenotypes



IBD Circle CROHN'S & COLITIS FOUNDATION

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

15

Virtual Grand Rounds

universe.gi.org

Updated ACG Ulcerative Colitis Activity Index

	Remission	Mild	Moderate-severe	Fulminant
Stools (#/day)	Formed stools	<4	>6	>10
Blood in stools	None	Intermittent	Frequent	Continuous
Urgency	None	Mild, occasional	Often	Continuous
Hemoglobin	Normal	Normal	<75% of normal	Transfusion required
ESR				
CRP				
Feca				
End				
Endoscopy (UCEIS)	0–1	2–4	5–8	7–8
Intestinal ultrasound	Colonic BWT≤3 mm Rectal BWT ≤4 mm mLimberg = 0		Colonic BWT >3 mm Rectal BWT >4 mm mLimberg >0	

ACG GRADEd Recommendation

5. We recommend the use of fecal calprotectin in ulcerative colitis to assess response to therapy, to evaluate suspected relapse, and during maintenance (Strong recommendation, moderate quality of evidence)

IBD Circle CROHN'S & COLITIS FOUNDATION

BWT: Bowel Wall Thickness (mm; mucosa, submucosa, muscularis propria, and serosa).
mLimberg: Modified Limberg Score of hypervascularity in the submucosa (0-3).
Modified from Truelove SC & Witts LJ. *Br Med J*. 1955; 2(4947):1041-8; Maaser C et al. *Gut*. 2020; 69(9):1629-1636;
Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

16

Virtual Grand Rounds

universe.gi.org

Treatment Options for Ulcerative Colitis, 2025

Class of Therapy Treatment	Treatment	Comment	
5-ASA	Mesalamine Sulfasalazine	Oral and rectal	Conventional Therapies (Traditional)
Corticosteroids	Budesonide Prednisone/Methylpred	Oral and rectal	
Thiopurines	6-mercaptopurine Azathioprine	Pharmacogenomics TPMT, NUDT15	Conventional Synthetic Therapies (Immunomodulators)
Calcineurin inhibitors	Cyclosporine Tacrolimus	IV and oral	
Anti-integrin	Vedolizumab	IV and SC maintenance	Biological Therapies
Anti-IL-23 (p40: IL-12/23 p19: IL-23)	Guselkumab (p19/CD64) Mirikizumab (p19) Risankizumab (p19) Ustekinumab (p40)	IV and SC maintenance Biosimilars to ustekinumab	
Anti-TNF	Adalimumab Golimumab Infliximab	Infliximab IV and SC maintenance Biosimilars to IFX and ADA	
Janus kinase inhibitors	Filgotinib (JAK1) Tofacitinib (JAK1,2,3) Upadacitinib (JAK1)	Oral Filgotinib EU only	Targeted Synthetic Small Molecules
S1P receptor modulators	Etrasimod ($S1P_{1,4,5}$) Ozanimod ($S1P_{1,5}$)	Oral	

IBD Circle

CROHN'S & COLITIS FOUNDATION

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

17

Treatment Options for Ulcerative Colitis, 2025

New since 2019 ACG Guideline

Class of Therapy Treatment	Treatment	Comment	
5-ASA	Mesalamine Sulfasalazine	Oral and rectal	Conventional Therapies (Traditional)
Corticosteroids	Budesonide Prednisone/Methylpred	Oral and rectal	
Thiopurines	6-mercaptopurine Azathioprine	Pharmacogenomics TPMT, NUDT15	Conventional Synthetic Therapies (Immunomodulators)
Calcineurin inhibitors	Cyclosporine Tacrolimus	IV and oral	
Anti-integrin	Vedolizumab	IV and SC maintenance	Biological Therapies
Anti-IL-23 (p40: IL-12/23 p19: IL-23)	Guselkumab (p19/CD64) Mirikizumab (p19) Risankizumab (p19) Ustekinumab (p40)	IV and SC maintenance Biosimilars to ustekinumab	
Anti-TNF	Adalimumab Golimumab Infliximab	Infliximab IV and SC maintenance Biosimilars to IFX and ADA	
Janus kinase inhibitors	Filgotinib (JAK1) Tofacitinib (JAK1,2,3) Upadacitinib (JAK1)	Oral Filgotinib EU only	Targeted Synthetic Small Molecules
S1P receptor modulators	Etrasimod ($S1P_{1,4,5}$) Ozanimod ($S1P_{1,5}$)	Oral	

IBD Circle

CROHN'S & COLITIS FOUNDATION

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

18

Treatment Positioning in the New UC Guidelines

GRADED RECOMMENDATIONS
44. In patients with moderately to severely active UC who are responders to anti-TNF therapy and now losing response, we suggest measuring serum drug levels and anti-drug antibodies (if there is not sufficient drug present) to assess reason for loss of response (Conditional recommendation, very low quality of evidence)
45. In patients with moderately to severely active UC, we recommend vedolizumab as compared to adalimumab for induction and maintenance of remission (Strong recommendation, moderate quality of evidence)
KEY CONCEPT STATEMENTS
40. There are no validated therapeutic biomarkers or companion diagnostic tests to enhance selection or predict response to treatment for the patient with active UC
41. Patients with UC should have available all medical options as recommended by their doctor and health care team. Third-party payers and requirements for step therapy should not come between the patient and their health care team in making decisions about treatment for UC
42. Patients with moderately to severely active UC have higher rates of response and remission with their first therapies than after failure of one or more other advanced therapies
43. Given the expanding number of therapies per mechanistic class, a distinction between primary nonresponse and secondary nonresponse is important to select the next therapeutic option
44. *Post hoc* subgroup analyses and network meta-analyses provide hypothesis-generating data but are not sufficient to stratify therapies for individual patients
45. Infliximab is the preferred anti-TNF therapy for patients with moderately to severely active UC
46. Some patients with moderately to severely active UC who are at higher risk for infectious complications may benefit from vedolizumab or an anti-IL-23 strategy over more systemically immunosuppressive medical options
47. Initial and subsequent therapies for moderately to severely active UC may be chosen based on extra-intestinal manifestations, including the involvement of joints or skin, in which therapies which have efficacy in both UC and in the extraintestinal organ is known

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

19

Virtual Grand Rounds

universe.gi.org

Miscellaneous Updates: Histology, Dysplasia Risk, ASUC Considerations

Key Concepts
13. Histologic remission is associated with some improved clinical outcomes but has not yet been validated prospectively as a preferred target for treatment
14. Control of mucosal inflammation may reduce dysplasia risk
56. In patients with ASUC failing to adequately respond to IVCS by 3 d or to infliximab induction, there are insufficient data to routinely recommend treatment with tofacitinib or upadacitinib
57. In patients with ASUC initiating infliximab, dose intensification should be considered for those patients with low serum albumin (<2.5 g/dL)

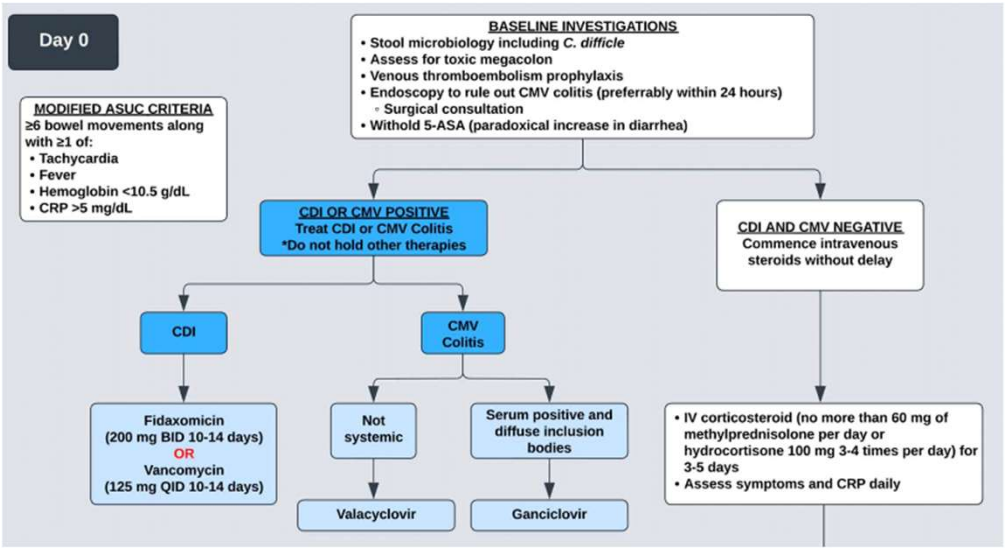
IBD Circle

FC, fecal calprotectin; UC, ulcerative colitis; ASUC, acute severe ulcerative colitis; IVCS, intravenous corticosteroids

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

20

ACG Algorithm for the Management of Hospitalized Patients With Acute Severe UC



IBD Circle CROHN'S & COLITIS FOUNDATION

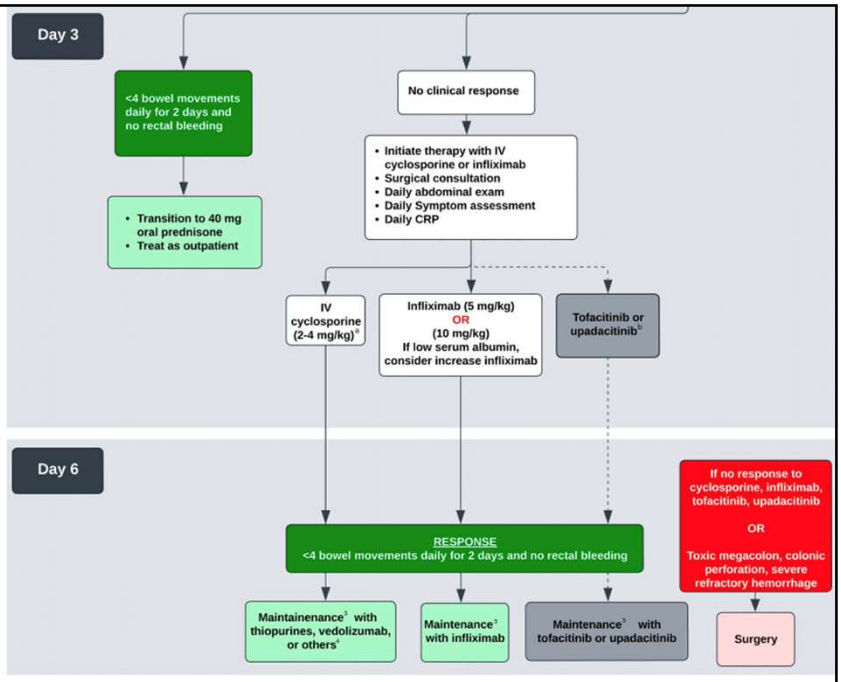
BID = twice daily; CDI = *Clostridium difficile* infection; CMV = cytomegalovirus; QID = 4 times a day.

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

21

Virtual Grand Rounds

ACG Algorithm for the Management of Hospitalized Patients With Acute Severe UC



IBD Circle CROHN'S & COLITIS FOUNDATION

Rubin DT, Ananthakrishnan AN, Siegel CA, Barnes EL, Long MD. *Am J Gastroenterol*. 2025;120(6):1187-1224.

22

IBD Circle | Crohn's & Colitis Foundation

Virtual Grand Rounds
universe.gi.org

Thursday, September 11, 2025 (11 AM ET or 8 PM ET)

Week 37: Update in UC and the New ACG Guidelines

Faculty: David T. Rubin, MD, FACG
Moderator: Shannon Chang, MD, FACG

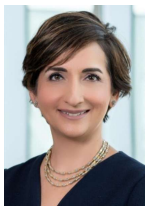
23

IBD Circle | Crohn's & Colitis Foundation

Virtual Grand Rounds
universe.gi.org

ACG Crohn's Disease Guidelines

Anita Afzali MD, MPH, MHCM, FACG
James F. Heady Endowed Chair and Professor of Medicine
Executive Vice Chair, Department of Internal Medicine
Associate Chief Medical Officer, UC Health
University of Cincinnati College of Medicine



University of Cincinnati College of Medicine

University of Cincinnati

24

IBD Circle | CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

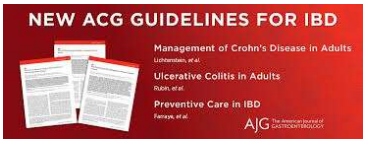
AJG The American Journal of GASTROENTEROLOGY

ACG Clinical Guideline: Management of Crohn's Disease in Adults

Gary R Lichtenstein [1], Edward V Loftus [2], Anita Afzali [3], Millie D Long [4], Edward L Barnes [4], Kim L Isaacs [4], Christina Y Ha [5]

Affiliations + expand

PMID: 40701562 DOI: 10.14309/ajg.0000000000003465



25

IBD Circle | CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

ACG 2025 Clinical Guidelines for Crohn's Disease

Summary of Recommendations, Key Concepts, and Clinical Approach

- 35 Formal Recommendations
- 59 Key Concepts
- Covers diagnosis, treatment, monitoring, and surgical care

26

IBD Circle | Crohn's & Colitis Foundation | ACG Virtual Grand Rounds universe.gi.org

Primary Sections

- Diagnosis & Disease Features
- Risk Stratification & Monitoring
- Medical Therapy
- Fistulizing Disease
- Surgical Indications
- Postoperative Management
- Special Situations

27

IBD Circle | Crohn's & Colitis Foundation | ACG Virtual Grand Rounds universe.gi.org

Guidelines Development Approach

- Evidence-Based & Expert-Guided (GRADE framework)
- Individualized, Risk-Based Care
- Strong Recommendations Against Ineffective Therapy
- Early, **Appropriate** (not 'Aggressive') Therapy
- Shared Decision-Making

28

IBD Circle | Crohn's & Colitis Foundation | ACG Virtual Grand Rounds universe.gi.org

ACG 2025 Crohn's Disease Guidelines: Key Highlights

🔍 **Diagnosis & Risk Stratification**
- Use fecal calprotectin (≥50–100 µg/g) to distinguish inflammatory vs. non-inflammatory disease
- High-risk features: young age, ileal/ileocolonic involvement, perianal disease, severe rectal disease, deep ulcers, extraintestinal manifestations

🎯 **Treatment Strategy: Focus on Early APPROPRIATE Therapy**
- No need to fail conventional therapy before starting advanced therapy
- Oral mesalamine not recommended for induction or maintenance

💊 **Advanced Therapies (Moderate-Severe CD)**
- Strong support for early biologic/oral small molecule use
- Combination therapy (e.g., infliximab + thiopurines) recommended in select patients
- Proactive, objective disease monitoring (biomarkers, endoscopy, MRE, IUS)

29

29

IBD Circle | Crohn's & Colitis Foundation | ACG Virtual Grand Rounds universe.gi.org

ACG 2025 Crohn's Disease Guidelines: Key Highlights

🦠 **Fistulizing CD**
- Infliximab (1st-line); adalimumab, ustekinumab, vedolizumab, upadacitinib conditionally recommended
- Seton placement and antibiotics may enhance outcomes

🔁 **Postoperative Management**
- Differentiate between Low- and High-Post Op Recurrence risk
- Recommend endoscopic monitoring at 6–12 months
- Anti-TNF or vedolizumab in high-risk patients to prevent recurrence

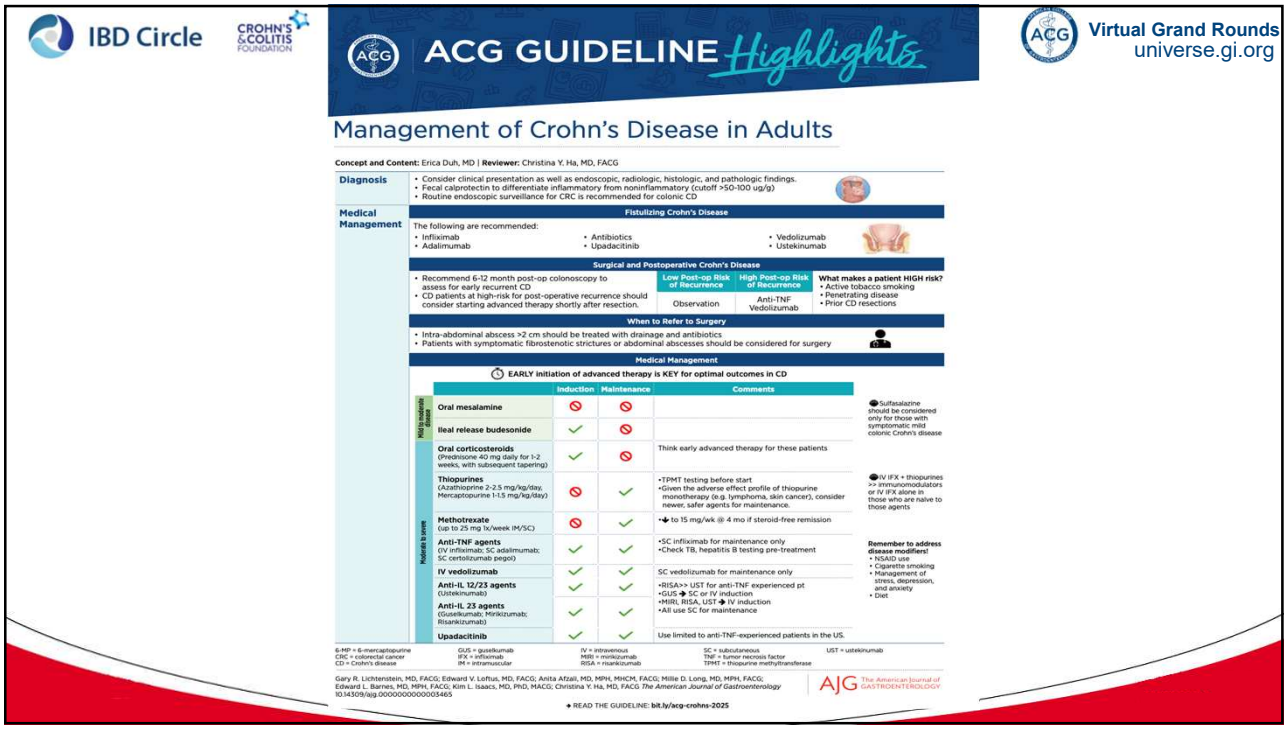
🧠 **Holistic Care Considerations**
- Smoking cessation, stress/anxiety screening, and minimizing corticosteroid dependence are essential
- Emphasis on shared decision-making

30

30

IBD Circle | CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org



31

IBD Circle | CROHN'S & COLITIS FOUNDATION

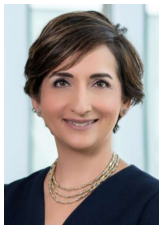
Virtual Grand Rounds
universe.gi.org

Case Discussion

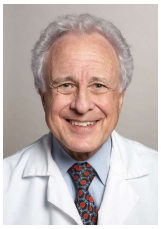

Sunanda V. Kane, MD, MSPH, MACG


Jean-Paul Achkar, MD, FACG

David T. Rubin, MD, FACG


Anita Afzali, MD, MPH, MHCM, FACG


Jill Gaidos, MD, FACG, CFFC


David B. Sachar, MD, FACG

32

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

Cases

33

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

Crohn's case #1

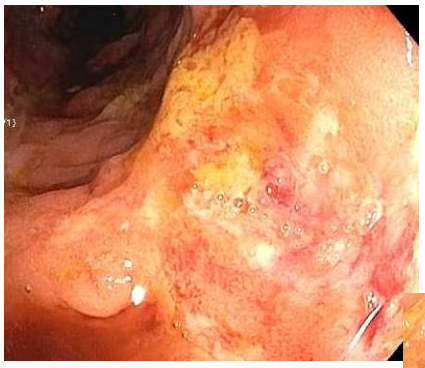
- 25 yo female presents with 1 year history of mild diarrhea and more recent onset of lower abdominal pain.
- Saw PCP who ordered labs:
  - WBC- 10.9; Hg- 10.1; MCV- 69; PLT- 610
  - Iron studies- iron deficiency
  - Alb- 4.2; liver enzymes normal
  - CRP- normal
- Notes heavy menstrual bleeding
- Referred to GI for further evaluation

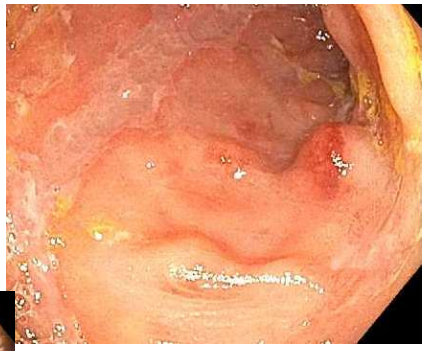
34

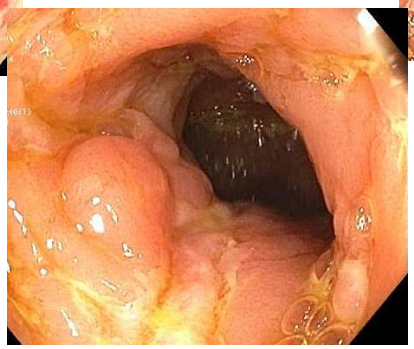
IBD Circle CROHN'S & COLITIS FOUNDATION

Scenario #1

ACG Virtual Grand Rounds universe.gi.org







35

IBD Circle CROHN'S & COLITIS FOUNDATION

ACG Virtual Grand Rounds universe.gi.org

Further evaluation

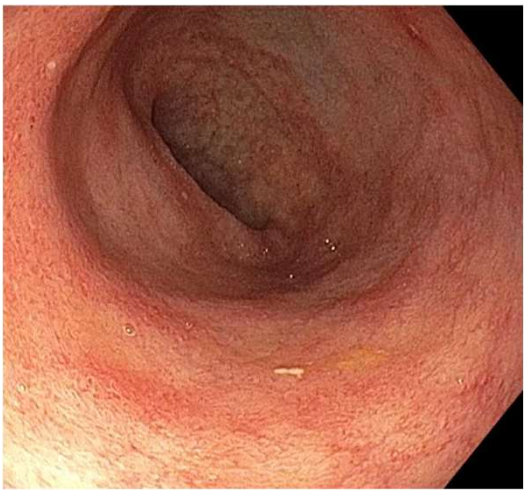
- EGD with gastric and duodenal biopsies- normal
- Fecal calprotectin- 1,500
- CT enterography- 15 cm of TI inflammation; no stricturing

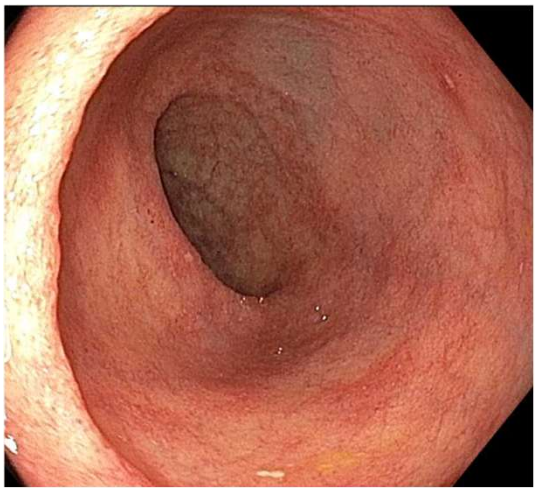
36

IBD Circle CROHN'S & COLITIS FOUNDATION

Scenario #2

Virtual Grand Rounds universe.gi.org





37

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Further evaluation

- EGD with gastric and duodenal biopsies- normal
- Fecal calprotectin- 150
- CT enterography- normal

38

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

Ulcerative Colitis Case #1

- 27 yo with pan UC diagnosed 4 weeks ago
- Started on 4.8 g mesalamine, after a week had worsening bleeding, urgency, cramping.
- Started on 40 mg pred, no better and hospitalized
- C diff negative, flex sig Mayo 3, CMV negative

39

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

What are the options?

40

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Crohn's case #2

- 43 yo female with dx of Crohn's colitis in 2018.
- Was on azathioprine for 2 years with good clinical response but then stopped meds in 2020
- 2021- developed intermittent diarrhea, epigastric pain, nausea and fatigue.
- Labs, EGD, colonoscopy and CTe in late 2021- notable only for *H pylori* gastritis
- Noted improvement in symptoms after Hp treatment

41

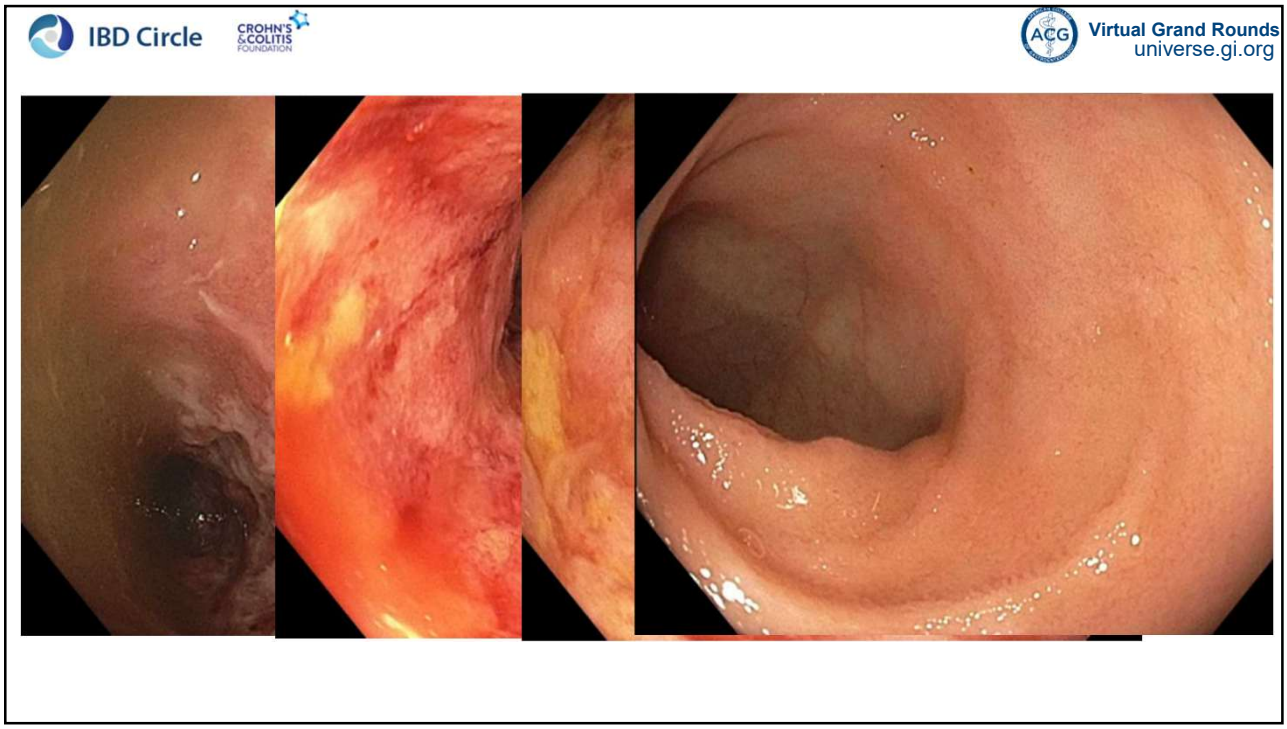
IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Crohn's case #2

- 2023- develops worsening diarrhea and pain/lump by her anal area.
- Diagnosed with a perianal abscess- has I&D in the office
- Colonoscopy done

42



43

What do we do now?

- Acute management?
- Long term management?

44

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

Ulcerative Colitis Case #2

- 32 yr old with ulcerative proctitis for several years. In past has responded well to mesalamine suppositories but now has become refractory to them.
- Has required a course of steroid foam then oral steroids.
- Flex sig shows Mayo 2 in distal 14 cm of rectum.

45

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds
universe.gi.org

What do we do now?

46

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Crohn's case #3

- 47 yo male with ileal Crohn's since 2010- S/P ileocecal resection in 2015
- No postop meds
- 2020- mild obstructive symptoms. W/U shows 10 cm of neo-TI inflammation and ICA ulceration and stricture- endoscopically dilated
- Starts adalimumab- does better clinically but still had evidence of inflammation on CTe
- 2023- recurrent, intermittent obstructive symptoms

47

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Further evaluation

- CTe: inflammation of 5-7 cm neo-TI with upstream dilation to 3 cm and pseudosacculation within the involved segment

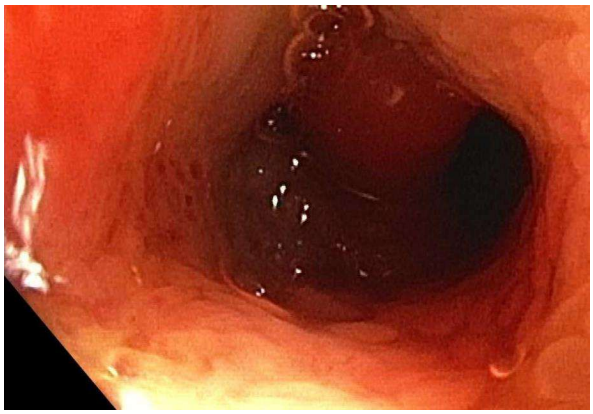
- Adalimumab TDM:
  - Drug- 4.6
  - Ab- negative

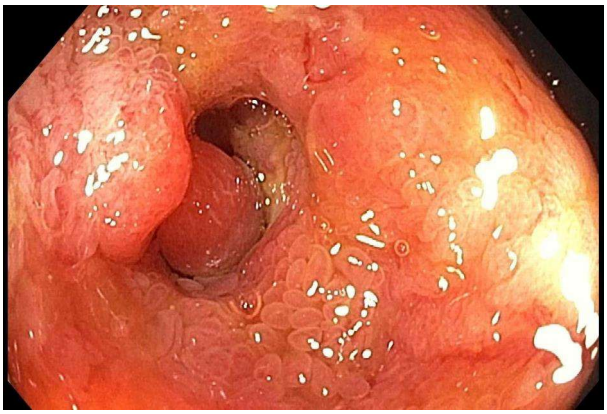
48

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Colonoscopy





49

IBD Circle CROHN'S & COLITIS FOUNDATION

Virtual Grand Rounds universe.gi.org

Next steps

- After discussion of options, patient elects to undergo surgery- has uncomplicated laparoscopic ileocolic resection:
  - Very thickened and stenotic ICA with marked upstream dilation
- What would you do in terms of medical management postop?

50

Virtual Grand Rounds

universe.gi.org

Questions

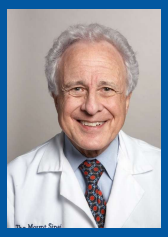
Anita Afzali, MD, MPH, MHCM, FACG

David T. Rubin, MD, FACG

Sunanda V. Kane, MD, MSPH, MACG

Jean-Paul Achkar, MD, FACG

Jill Gaidos, MD, FACG, CFFC



David B. Sachar, MD, FACG

51

52