

JANUARY 30 – FEBRUARY 1, 2026

**2026 ACG'S IBD SCHOOL &
ACG BOARD OF GOVERNORS /
ASGE BEST PRACTICES COURSE**


  | **LAS VEGAS** |




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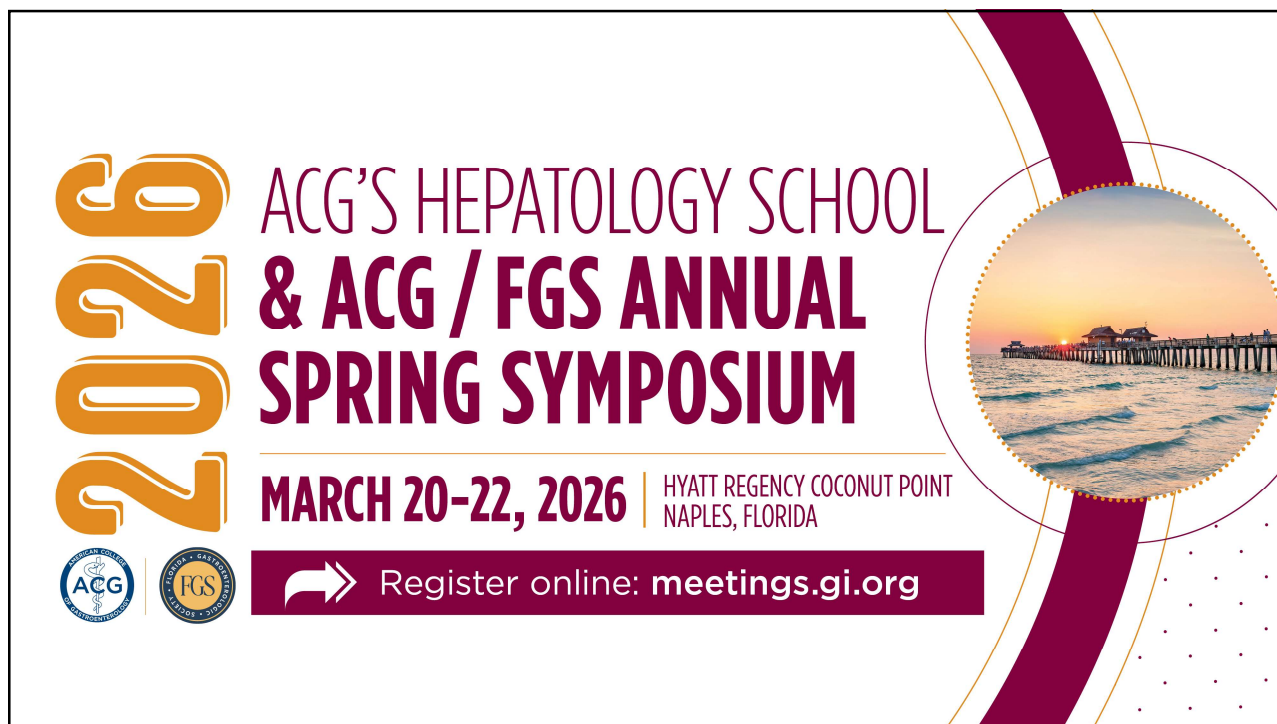
**2026 ACG'S ENDOSCOPY SCHOOL
& ACG / LGS REGIONAL
POSTGRADUATE COURSE**

MARCH 6-8, 2026 | HILTON NEW ORLEANS RIVERSIDE
NEW ORLEANS, LOUISIANA

   Register online: meetings.gi.org



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2026 ACG'S HEPATOLOGY SCHOOL
& ACG / FGS ANNUAL
SPRING SYMPOSIUM

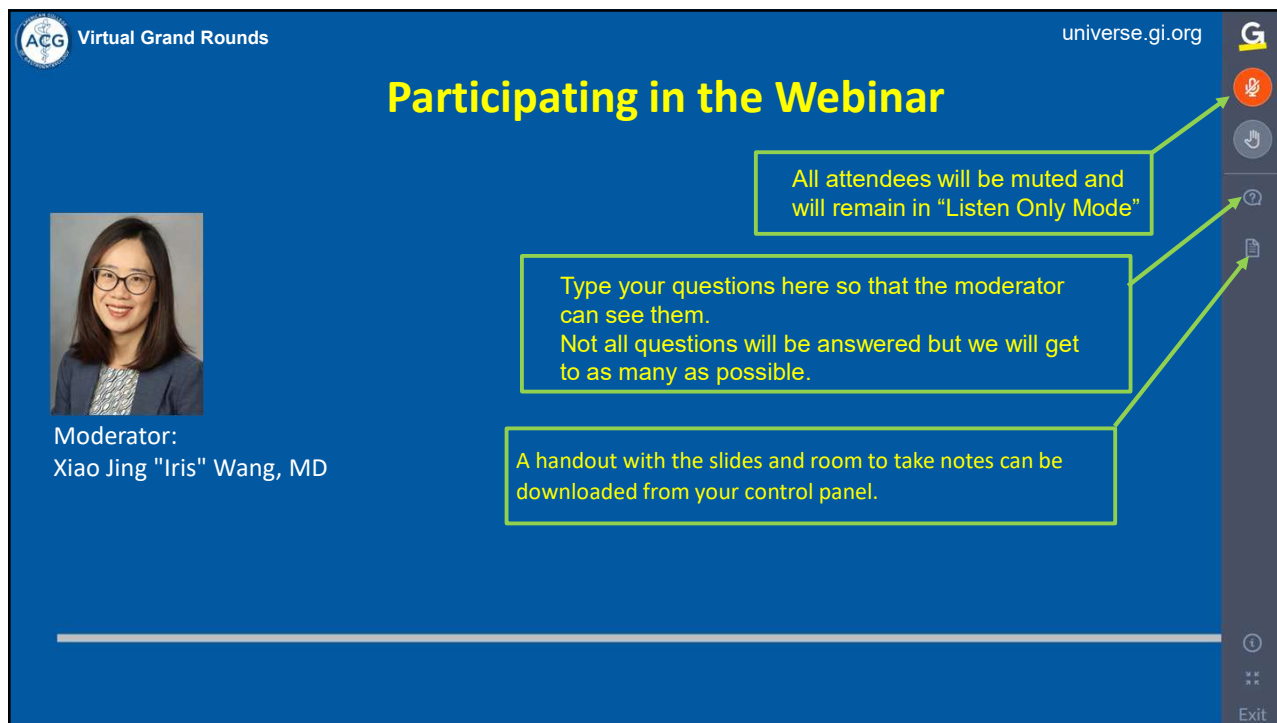
MARCH 20-22, 2026 | HYATT REGENCY COCONUT POINT
NAPLES, FLORIDA

Register online: meetings.gi.org

ACG FGS

The poster features a large '2026' in orange, a title in maroon, and a date/location in maroon. A maroon banner contains the registration link. Logos for ACG and FGS are at the bottom left. A circular inset image shows a pier over the ocean at sunset.

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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.

Moderator:
Xiao Jing "Iris" Wang, MD

ACG

The slide is blue with yellow text. It includes a moderator photo and a control panel on the right with icons for mute, chat, and download. Three callout boxes explain the mute policy, the chat function, and the download option.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!




Week 03 – Thursday, January 15, 2026
 ACG Clinical Guideline: Malnutrition and Nutritional Recommendations in Liver Disease
 Faculty: Craig J. McClain, MD, FACP
 Moderator: Manal F. Abdelmalek, MD, MPH, FACP
 At Noon and 8pm Eastern

Week 04 – Thursday, January 22, 2026
 TNF α Inhibitors for the Treatment of IBD: Therapeutic Advances and Innovative Delivery Methods
 Faculty: David T. Rubin, MD, FACP
 Moderator: Gil Y. Melmed, MD, MS, FACP
 At Noon and 8pm Eastern

Visit gi.org/ACGVGR to Register

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ACG ANNOUNCES

a New Book Series

Now Available!

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to purchase your copies!

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ACG Virtual Grand Rounds
GI Nutrition Series

universe.gi.org

2025 ACG GI Nutrition Care Series




Co-Directors
Lindsey Russell, MD, MSc, CNSC, FRCPC, and
Neha Dilip Shah, MPH, RD, CNSC, CHES

Welcome to the fourth webinar in the ACG GI Nutrition Series .
This new ACG GI Nutrition Series has been developed to provide a strong foundation in
nutrition for all members of the GI and hepatology care team.

Visit gi.org/ACGVGR to watch for future talks in this series.

**Up Next: Nutrition in Specific Patients - Dysmotility/Disorders of Gut
Brain Axis**




Week 07– Thursday February 12, 2026
GI Nutrition Care Series: Nutrition in Specific Patients - Dysmotility/Disorders of Gut
Brain Axis
Faculty: Laura Manning, RD, and Stephanie L. Gold, MD

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GI Nutrition Series

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2025-26 ACG GI Nutrition Care Series

- Micronutrient Deficiencies- Malabsorption
- Nutrition in Specific Patients- Dysmotility/Disorders of Gut Brain Axis
- Nutrition in Specific Patients- Mucosal Diseases
- Nutrition in Specific Patients- Surgical Resections
- Nutrition Applications for a GI Practice
- Nutrition Strategies for Patients with Mucosal Diseases; From Celiac, to IBD and Eosinophilic Disorders

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Disclosures



Kate Scarlata, MPH, RDN, LDN:
Activia: Speakers Bureau; Ardelyx: Speakers Bureau; BioAmerica: Speakers Bureau; BioK+: Speakers Bureau; Fody Foods: Stock Options; QOL Medical: Speakers Bureau; Salix Pharmaceuticals: Speakers Bureau; Schar: Speakers Bureau;



Xiao Jing "Iris" Wang, MD:
No relevant financial relationships with ineligible companies.

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

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Food and Function: Nutritional approaches in Motility Disorders



Xiao Jing Wang, MD
Kate Scarlata, MPH, RDN, LDN



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Objectives:

- Describe physiologic effects of FODMAPs in IBS
- Detail fiber recommendations for IBS, gastroparesis, and constipation
- Recognize factors that place patients at nutrient risk

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Case 1

26-year-old woman

CC: Loose stools with abdominal pain for 3 years

HPI:

- Pain all over abdomen but worst in the left lower quadrant, described as a cramping sensation
- 4-6 loose (Bristol type 5-6) bowel movements daily, accompanied by mild improvement of pain.
- Stools are nonbloody but can be urgent. No nocturnal awakenings
- Can have go 1-2 days intermittently with no bowel movements
- Symptoms include bloating, borborygmi, and fatigue after bowel movements

PE:

- Vitals within normal, BMI 35 kg/m²
- Exam benign, without ability to reproduce pain

She has heard of a low-FODMAP diet and is asking for more information

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Straight to nutrition?



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Obtain more history

- Medical history:
 - Thyroid dysfunction
 - Diabetes
- Surgical history
 - Cholecystectomy
- Medication use:
 - GLP1 use
 - Supplements including magnesium based
- Family history:
 - IBD
 - Celiac disease
- Social/lifestyle habits:
 - Dietary fiber content
 - Artificial sugar consumption
 - **Gum chewing**

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IBS-D Suspected: Is further work up needed?

- Fecal calprotectin and C-reactive protein
 - Rule out IBD in patients without alarm features
 - *Strong Recommendation, moderate quality of evidence*
- NO routine stool testing
 - *Conditional Recommendation, low quality of evidence*
- NO routine colonoscopy in <45 yo without warning signs
 - *Conditional Recommendation, low quality of evidence*
- NO food allergy OR sensitivity testing unless reproducible symptoms
 - *Consensus Recommendation, unable to assess quality*

Lacy, et al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. The American Journal of Gastroenterology 116(1):p 17-44, January 2021.

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Is diet therapy appropriate?

Gastroenterology 2022;162:1737-1745

CLINICAL PRACTICE UPDATE

AGA Clinical Practice Update on the Role of Diet in Irritable Bowel Syndrome: Expert Review

William D. Chey,¹ Jana G. Hashash,^{2,3} Laura Manning,⁴ and Lin Chang⁵

STEP 1: Screen with the MST

1. Have you recently lost weight without trying?

No	0
Unknown	2
Yes (2-12 Mo)	1
Yes (13-24 Mo)	2
Yes (25-35 Mo)	3
Yes (36 Mo)	4
Yes (Unknown)	5

Weight loss score:

2. Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score:

MST score:

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STEP 2: Score to determine risk

MST = 0 or 1: NOT AT RISK (Eating well with IBS or no weight loss)

MST = 2: AT RISK (Eating poorly and/or more weight loss)

STEP 3: Intervene with nutritional support

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IBS Guidelines

Guidelines IBS

ACG guidelines

10 We recommend a limited trial of a low FODMAP diet in patients with IBS to improve global IBS symptoms. Conditional recommendation; very low quality of evidence.

11 We suggest that soluble, but not insoluble, fiber be used to treat global IBS symptoms. Strong recommendation; moderate quality of evidence.

Lacy BE, et al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. *Am J Gastroenterol*. 2021;116(1):17-44.

Clinical Decision Support Tool: IBS Treatment

*Selection of the medication should be based on the clinical features and needs of the patient.
TCA, tricyclic antidepressant; SSRI, serotonin-norepinephrine reuptake inhibitor; PEG, polyethylene glycol; CRT, cognitive behavioral therapy.

ACA IBS-C Guideline, Centre: <https://www.gastrojournal.org/doi/10.1053/j.gastro.2016.08.016>; IBS-D Guideline, Centre: <https://www.gastrojournal.org/doi/10.1053/j.gastro.2016.08.016>

<https://gastro.org/clinical-guidance/guideline-tools/irritable-bowel-symptoms-tool/>

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Why FODMAPs?

- Low FODMAP diet most evidenced based nutritional therapy in IBS
- Best evidence for bloating and pain - most research in IBS-D pts.

Case 1

Diet high in FODMAP carbohydrates especially lactose and polyols (avocado, plum, peach, apple, watermelon, garlic (patient does not consume onion, doesn't like flavor))

No history of eating disorder or overt food fear. Desires better control over unpredictable symptoms so she can travel more!

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3 phases to LFD

	1	2	3
	Elimination	Reintroduction	Personalization
Time frame	2-6 weeks	6-8 weeks	As needed for symptom management
Goal	Remove all high FODMAP foods in attempt to provide symptom resolution	Systematically add FODMAP subtypes back into diet to identify food triggers	Add back successfully reintroduced FODMAP foods to expand diet to personal tolerance

Phase 1: Elimination

In full elimination LFD, all high FODMAP foods are removed from the diet and low FODMAP alternatives are subbed in.

Dietitians educate patient on the essentials to grocery shop, label read, menu plan + eat a balanced diet. *Always remind the patient that a LFD is a 3-phase diet.*

Remember: if the individual with IBS finds the diet changes are too stressful, diet change will be counterproductive. **KEEP it simple!**

www.katescarlata.com

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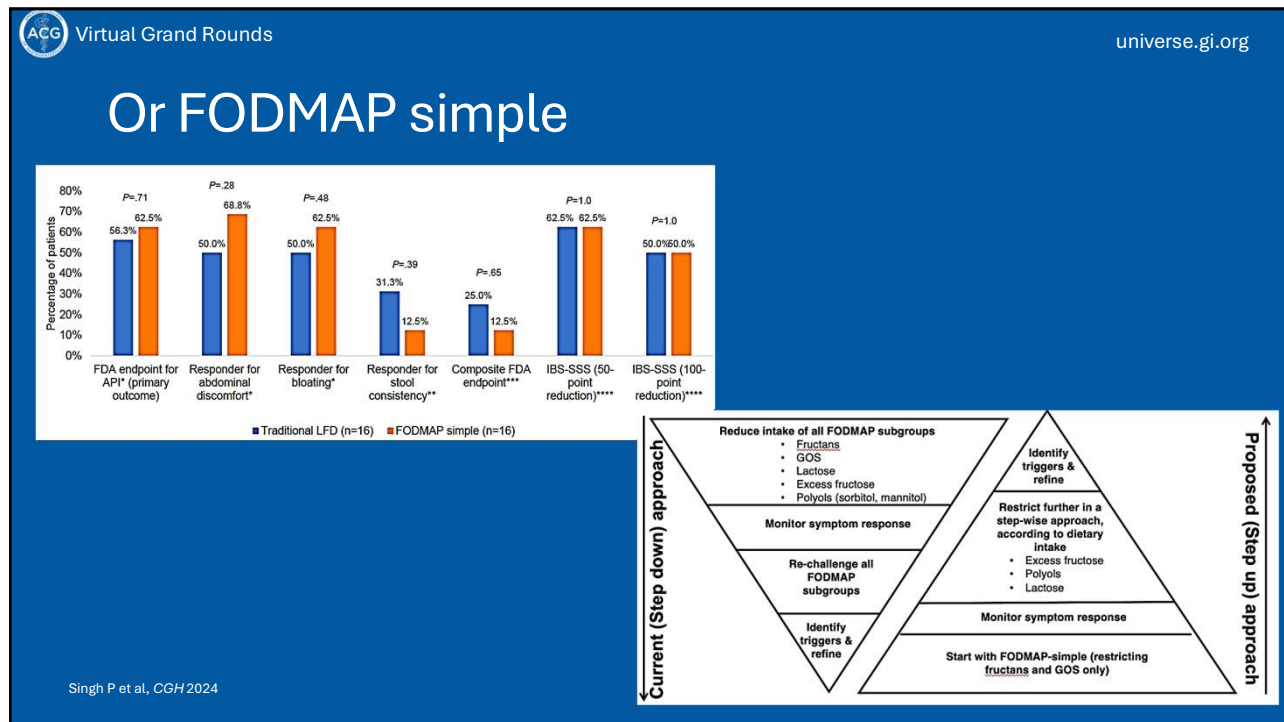
Phase 2 + 3

Phase 2: Reintroduction

<p>LACTOSE 1/2 cup milk</p>	<p>GOS 1/4-1/2 cup beans (soybean, kidney)</p>	<p>POLYOLS Mannitol: 1/2 cup button mushrooms 1/2 cup cauliflower Sorbitol: 5 blackberries</p>
<p>FRUCTOSE 1/2 raw mango 1 TB honey</p>	<p>FRUCTANS 1/2 clove garlic 1 TB onion 2 slices wheat bread</p>	

Phase 3: Personalization

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Case 1 follow up

- Opted for full low FODMAP elimination diet given that diet history reveals a mix of FODMAPs and patient is quite uncomfortable
- Short duration 2-4 weeks
- Follow up scheduled for reintroduction education in 2 weeks.
- Fiber recommendations: encourage low FODMAP produce and grains, reduce FODMAP fiber (GOS, fructans), may add psyllium as needed after trial of LFD.
- Patient follow up:
 - Reintroduction found mannitol and lactose containing foods most problematic
 - Added back other FODMAPs with good tolerance.

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Case 2

47-year-old man

CC: Bloating and early satiation, progressive in past 6 months

HPI:

- Cannot finish a full meal due to right upper quadrant discomfort/pain
- Stays full for hours even after eating a small meal
- Bowel habits are erratic, can be daily or skip 2-3 days every few weeks
- Weight loss of about 5 lbs.
- Symptoms also include more frequent heartburn

PE:

- Vitals within normal, BMI 31.5 kg/m²
- Exam shows oropharyngeal erythema, otherwise unremarkable

Medical history:

- Hypertension, hyperlipidemia, diabetes mellitus, COPD

With further discuss, he shares that in the past year, he was diagnosed with COPD and has needed several rounds of steroid bursts to control symptoms.

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Work up considerations

Dyspepsia

- Age <60: H. Pylori test and treat
- Age > 60: EGD

Gastroparesis

- NM Gastric Emptying study
- Consider EGD to rule out gastric outlet obstruction

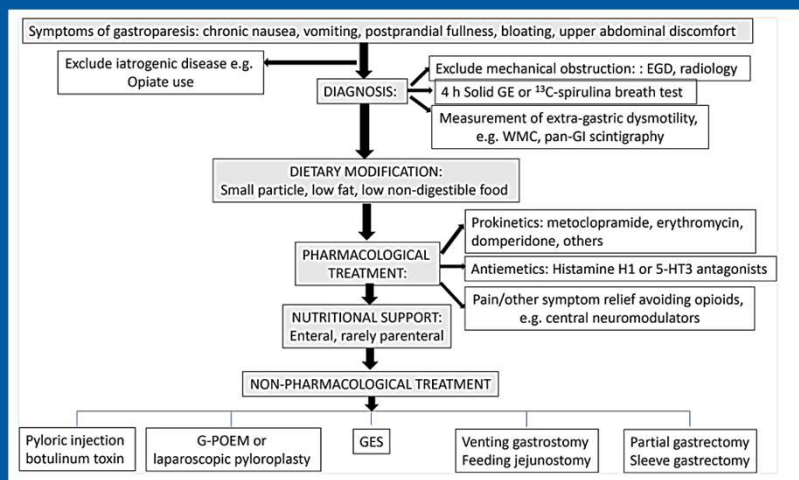
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Further work up is done

- EGD shows mild erythema of the antrum, biopsies return with mild nonspecific chronic gastritis
- NM Gastric Emptying shows:
 - 1 hour: 10% emptied
 - 2 hour: 35% emptied
 - 4 hour: 57% emptied
- HbA1c is 9.4%, increased from 6.8% last year
- With joint decision making, you proceed with dietary management while glucose control is optimized.

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What are the nutritional recommendations for Gastroparesis?



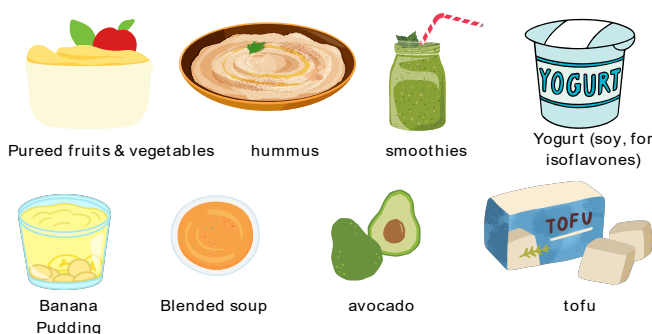
Camilleri M., Am J Gastroenterol. 2022 Aug 1;117(8):1197-1220.

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Small Particle for Gastroparesis

A **small particle diet** consists of foods that are “easy to mash with a fork into small pieces”. (1)

Give specific strategies: “Consume 1-2, 8-ounce smoothie(s) (made with 1 cup soy yogurt, 1 cup of your favorite frozen fruits) per day.”



- ✓ Balanced carbs over day, about 60 g meal for BS control
- ✓ Fat modifications per patient tolerated, encourage MUFA
- ✓ Tip—spread fat intake over all meals to ensure meeting goals while not ingesting all in one meal.
- ✓ Warmer meals empty quicker, may be better tolerated.

1. Olausson EA, et al Am J Gastroenterol. 2014;109(3):375-385. Wang R-F, et al Digestive diseases and sciences 2013;58:2550-2555.

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Case 2

- Patient is quite relieved to hear that he can eat **more than** blended soups and a fat free diet.
- Starts experimenting slowly with adding in small particle size foods at each meal, spread out over 3 meals and 2-3 snacks
- Finding his personal fiber threshold to meet goals while not becoming symptomatic (try in blended/small particle form)
- More blended foods in early part of the day—to mitigate higher early day symptoms when he is working or away from home.
- Balance carb for better glucose control encouraged

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Case 3

23 year-old woman

CC: Bloating, abdominal pain, altered bowel habits x 2 years

HPI:

- Epigastric pain and discomfort after eating, sometimes even with drinking within minutes of starting
- Feels significant bloating, sometimes with distension, after eating
- Bowel habits alternate from 2-3 days without bowel movements to 5-6 bowel movements per day with increasing looseness
- Has not found a specific dietary trigger but based on a commercial food sensitivity test has limited all "red" foods as well as gluten, dairy, and fats.

PE:

- Vitals within normal, BMI 17.3 kg/m²
- Exam unremarkable

She would like to trial a low FODMAP diet and requests a nutrition consult



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Where are the flags?

23 year-old woman

CC: Bloating, abdominal pain, altered bowel habits x 2 years

HPI:

- Epigastric pain and discomfort after eating, sometimes even with drinking within minutes of starting 
- Feels significant bloating, sometimes with distension, after eating
- Bowel habits alternate from 2-3 days without bowel movements to 5-6 bowel movements per day with increasing looseness
- Has not found a specific dietary trigger but based on a commercial food sensitivity test has limited all "red" and "orange" foods as well as gluten, dairy, and fats. 

PE:

- Vitals within normal, BMI 17.3 kg/m² 
- Exam unremarkable

She would like to trial a low FODMAP diet and requests a nutrition consult

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Maladaptive Eating Occurs in GI Pts

When diet changes put a patient at disordered eating and/or nutrient deficiency risk:

- ✓ Weight loss of 5% or more over 1 month
- ✓ Inadequate nutrient intake
- ✓ Elimination of food groups (not medically indicated) or all enjoyed foods
- ✓ Social interactions, mood, or activities of daily living negatively impacted by diet
- ✓ Negative effects of diet on mental and social health exceeds benefit of symptom management



What is your relationship with food?

➤ On the EAT-26, 13% IBD patients met the screening cutoff and 81% of patients responded affirmatively to at least one item determined by study investigators to represent pathological eating attitudes.

- 23.4% of patients with GI disease (n=691) displayed disordered eating patterns
- 2/3 IBS pts attribute foods as symptom trigger
- 41-52% of patients with eating disorders meet criteria have IBS.

Satherley et al, Appetite, 2015; 84:240-50, Sato Y, Fukudo S. Clin J Gastroenterol. 2015;8(5):255-63. Scarlata K, et al Clin Gastroenterol Hepatol. 2020 Mar;18(3):543-545, Wabich J, et al J Clin Psychol Med Settings. 2020;27(2):310-317.

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Screen for disordered eating and ED!

Conversation starters for eating behaviors in the clinic visit*	
SCOFF Questionnaire	Additional questions to facilitate discussion of eating behaviors in a clinic visit
(1) Do you make yourself sick because you feel uncomfortably full?	(1) Does eating make you anxious?
(2) Do you worry you have lost control over how much you eat?	(2) How has your appetite been?
(3) Have you recently lost more than 1 stone (14 lb) during a 3-mo period?	(3) Do you ever skip meals as a way to avoid symptoms?
(4) Do you believe yourself to be fat when others say you are too thin?	(4) Do you feel full after a couple bites?
(5) Would you say that food dominates your life?	(5) What time in the day do you typically have your first meal?
Scoring: each positive response to these questions yields a score of 1; a score of 2 or greater indicates an increased risk of ED behavior	(6) Do you eat a variety of foods or are you limited to certain things?
	(7) What kinds of beverages are you consuming throughout the day?
	(8) Do you spend much of your day thinking about food-related decision and meal planning?
	(9) Have you ever been diagnosed with an eating disorder?
	(10) I am afraid to eat outside my home
	(11) I enjoy going out for meals as much as I did before my diagnosis
	(12) I will only eat food that I have prepared myself
	(13) I have a lack of variety in my diet

*Keep in mind that adjustments in conversation starters may need to be made based on patient's eating behaviors and beliefs.

Figure 4. The multidisciplinary team approach for disordered eating in patients with gastrointestinal (GI) conditions.

Eating Disorder	Symptoms
Anorexia Nervosa (AN)	Restriction of energy intake relative to requirements leading to a significant low body weight in the context of age, sex, developmental trajectory, and physical health. An intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain is a key presentation.
Bulimia Nervosa (BN)	Eating, within any 2-hour period, an amount of food that is definitively larger than what most individuals would eat in a similar period under similar circumstances AND feeling that one cannot stop eating or control what or how much one is eating. May use self-induced vomiting, misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.
Binge Eating Disorder (BED)	Recurrent discrete periods of time (e.g., 2 hours) where the person eats a larger amount of food than most people would eat AND a feeling that one cannot stop eating or control what or how much. Can include eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of embarrassment, feeling disgusted with oneself, depressed, or very guilty after overeating.
Avoidant Restrictive Food Intake Disorder (ARFID)	Changes in eating behaviors may include being a "picky" eater or limiting one's diet to only a certain set of foods, not being interested in eating, or avoiding eating or certain foods due to fear of aversive consequences (e.g., digestive upset). This is associated with nutritional deficiencies, weight loss, use of dietary/caloric supplements, and marked psychosocial impairment.

Riehl ME, Scarlata K. J Acad Nutr Diet. 2021 Apr 20;S2212-2672(21)00172-6.

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Case 3

- Patient at high risk for eating disorder behavior
- Discuss supportive nutritional approach vs restrictive diet therapy such a low FODMAP elimination diet
 - Discuss importance of adequate nutrition for GI function and mental health.
 - In practice, I might suggest gentle food swaps: lactose free milk vs regular milk, try almond milk vs oat.
- Encourage follow with eating disorder informed psychologist/dietitian and make referral with patient's agreement
- Note: most GI psychologists do not have training in ED. Before referral to psychologist, ensure experience in ED space.

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Who needs a GI dietitian?

- ✓ Post-prandial symptoms with question of food intolerance/sensitivity/allergy
- ✓ GI conditions requiring nutrition intervention, especially in setting of nutrition-related co-morbidities
- ✓ History of eating disorder (**refer before you suggest a specialty diet**)
- ✓ Evidence of over-restricted diet (**refer before you suggest a specialty diet**)
- ✓ Poor food-related quality of life
- ✓ Nutrition education needs beyond time available in the GI office visit
- ✓ Not sure? Refer and let the RDN decide how to proceed. That's what we do!

The goal of nutrition therapy is to help guide the patient toward a balanced and varied diet while managing diet related GI symptoms!

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Nuances in adapted eating behaviors

NARRATIVE REVIEWS · Articles in Press, December 14, 2024

A Call to Action: Unraveling the Nuance of Adapted Eating Behaviors in Individuals With Gastrointestinal Conditions

Kate Scarlata ¹   · Hana F. Zickgraf ² · Rose-Marie Satherley ³ · ... · Janelle Smith ⁶ · Stacey Collins ⁷ · Tiffany Taft ⁸
 ... Show more

Affiliations & Notes  Article Info 

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Scarlata K, et al. *Clin Gastroenterol Hepatol*. Published online December 15, 2024.

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Commonly asked GI nutrition questions

- What is the difference between soluble and insoluble fiber, and when do you use each?
- What can patients do to help “rebalance” or “restore” their microbiome with foods?
- How long should a patient attempt diet changes before moving on to other treatments?

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Fiber types


TYPE	DESCRIPTION	DIET SOURCE	SUPPLEMENT SOURCE
Bulking minimally fermented (insoluble) <ul style="list-style-type: none"> Cellulose + Lignan (non-carbohydrate) 	Plant walls/skins	Cellulose + lignan: whole grains, fruits, veg, legumes, nuts	n/a
Viscous, bulking, minimally fermented (soluble) <ul style="list-style-type: none"> Psyllium Methylcellulose 	Psyllium: type of hemi-cellulose Methylcellulose: synthetic derivative of cellulose	Plantago ovata	Psyllium powder (Metamucil) Methylcellulose (Citrucel)
Viscous, fermentable (soluble) <ul style="list-style-type: none"> Beta-glucan Pectin 	Beta-glucan: type of hemi-cellulose Pectin: component of plant cell walls	Beta-glucan (oats, whole grain barley) Pectin: found in fruits and veg. used as additive (jam/jellies)	Beta-glucan: (numerous brand of oral supplements)
Fermentable <ul style="list-style-type: none"> Small chain (fructans/GOS) (rapidly fermented) (soluble) Long chain Resistant starch 	Fructan/GOS rapidly fermentable fibers Resistant starches (RS): resist digestion; 4 types	Fructan: onion, garlic, wheat, artichoke, chicory root extract GOS: legumes, pistachios, cashews, human breast milk RS: whole grains, uncooked oats, cooked and cooled potatoes and rice	Fructan: Chicory root extract, inulin GOS: <u>Bimuno</u> RS: green banana powder, high amylose maize starch

Singh P AJG 2022


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Questions



Kate Scarlata, MPH, RDN, LDN



Xiao Jing "Iris" Wang, MD

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GI Innovation Through Collaboration

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ACG GI Circle
Connect and collaborate within GI


IBD Circle
A Partnership of the American College of Gastroenterology
and the Crohn's & Colitis Foundation

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