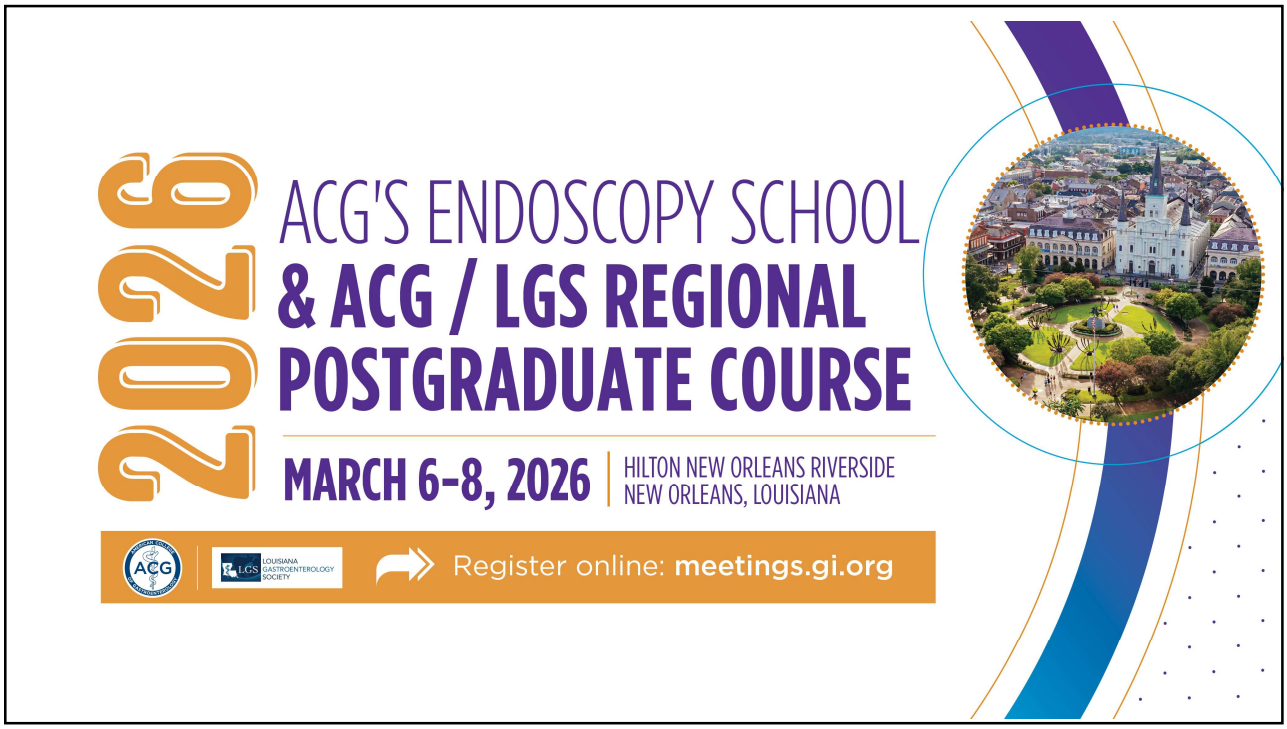
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ACG'S ENDOSCOPY SCHOOL
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POSTGRADUATE COURSE
MARCH 6-8, 2026
HILTON NEW ORLEANS RIVERSIDE
NEW ORLEANS, LOUISIANA
Register online: meetings.gi.org

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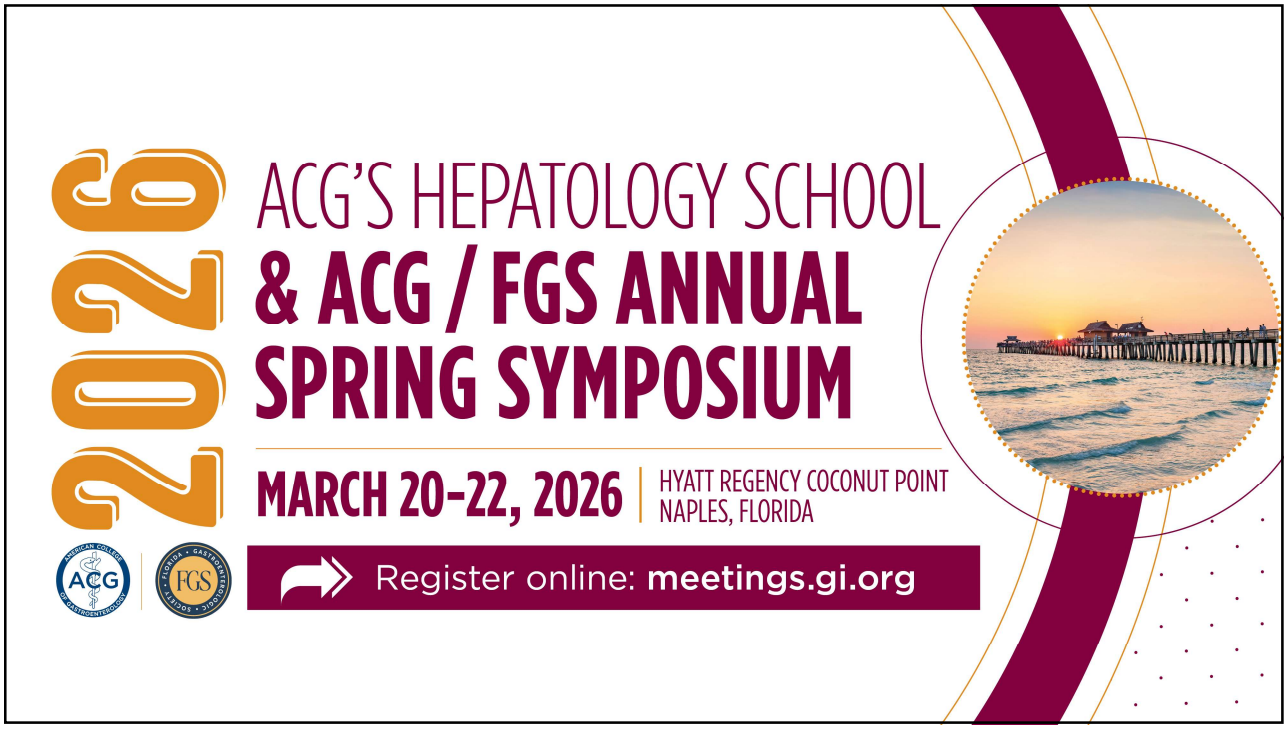
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MARCH 20-22, 2026
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Participating in the Webinar

Moderator:
Vlad Kushnir, MD, FACG

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.

Exit

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Join us for upcoming Virtual Grand Rounds!
Week 10 Special Edition – Tuesday March 3, 2026
Early-Onset Colorectal Cancer: Perspectives from Experts, Trainees, and a Survivor
Hosted by EBGI Ambassadors
Faculty: Mohammad Bilal, MD
Survivor: Ms. Vanessa Ghigliotty
Trainees: Fnu Vikash, MD, and Aimen Farooq, MD
Moderators: Sophia Dar, MD, and Eleazar Montalvan-Sanchez, MD8pm Eastern
Week 10 – Thursday, March 5, 2026
Precision Polypectomy: Mastering Techniques for Safe and Effective Removal
Faculty: Douglas K. Rex, MD, MACG
Moderator: Neha V. Patel, MD, FACG
At Noon and 8pm Eastern
Week 11 – Thursday, March 12, 2026
Update on Best Practices for Colonoscopy Bowel Preparation
Faculty: Carol A. Burke, MD, MACG
Moderator: Ryan K. Fawley, MD, FACG
At Noon and 8pm Eastern
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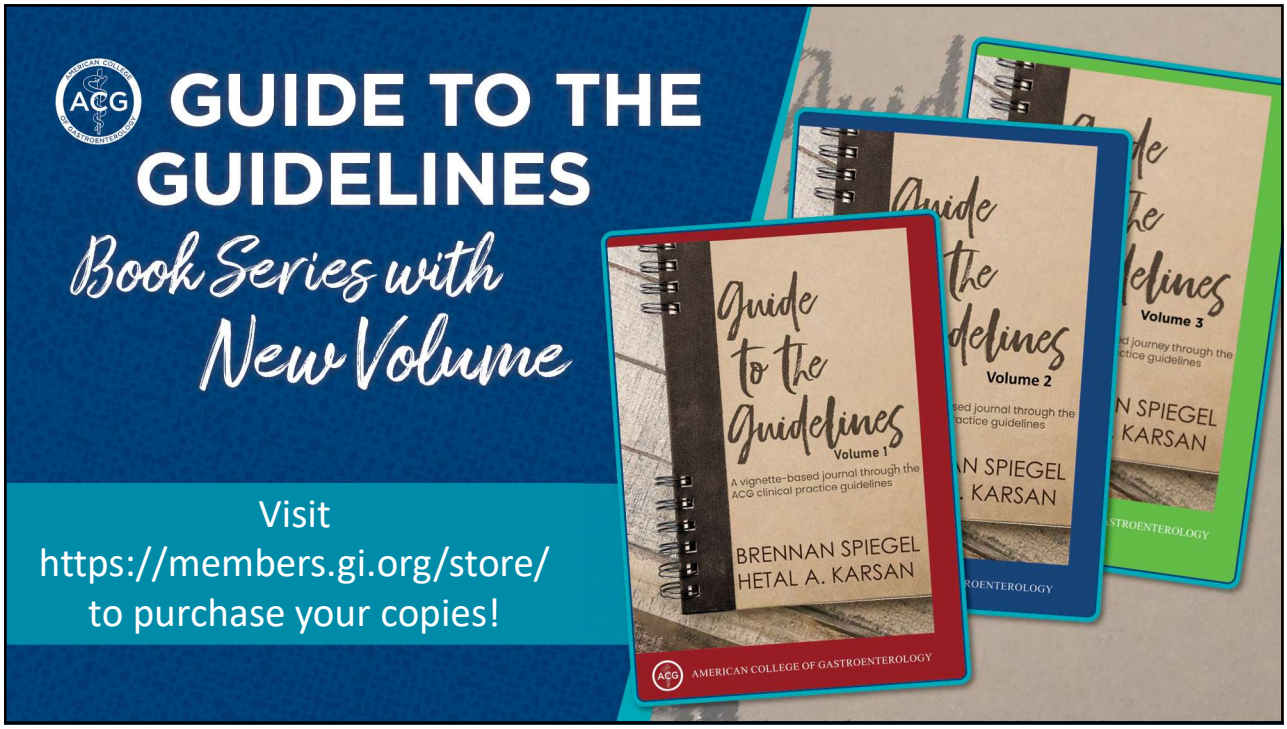
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Disclosures

Eric C. Swei, MD, MS:
No relevant financial relationships with ineligible companies.

Ekta Gupta, MD:
No relevant financial relationships with ineligible companies.

Hassam Ali, MD:
No relevant financial relationships with ineligible companies.

Vlad Kushnir, MD, FACG:
Allurion: Research Grant; Boston Scientific: Consultant; Castle Biosciences: Speakers Bureau, ConMed: Consultant.

Sangeeta Agrawal, MD:
No relevant financial relationships with ineligible companies.

Omer Shahab, MD:
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Neal A. Mehta, MD:
Castle Biosciences: Speakers bureau

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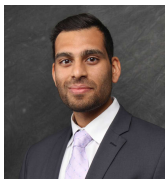

Neal A. Mehta, MD
Assistant Professor of Medicine
Program Director, Interventional Endoscopy Fellowship
Center for Interventional and Therapeutic Endoscopy (CITE)
Rush University Medical Center
Chicago, IL

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Evaluating The Cost Of Surveillance In Pancreatic Cysts with Low-risk Features in Patients Over 70-years-Old

Shaina Ailawadi, MD; Abbinaya Elangovan, MD; Apoorva K. Chandar, MD, MPH; Andrew Catanzaro, MD; Amitabh Chak, MD

Case Western Reserve University
University Hospitals
Cleveland Medical Center,
Case Western Reserve University, Cleveland, OH

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Aim and Methods

- Increase in utilization of high-resolution cross-sectional imaging → rise in incidental pancreatic cysts being diagnosed, particularly among elderly patients

Guidelines	Surveillance Interval (Low-risk features cyst)	When to Stop Surveillance
AGA 2015	MRI/CT at 1 yr, then q2 years if stable.	Stop after **5 yrs** of stability, or if patient is **not a surgical candidate.**
ACG 2018	MRI q1–2 years depending on cyst size.	**Individualize ≥75 yrs**. Stop if **no longer surgical candidate**.
ACR 2017	<1.5 cm → MRI q2 years 1.5–2.5 cm → MRI q1 years, then q2 yrs if stable.	After **age 80**, **no surveillance** unless exceptionally fit/surgical candidate.
European 2018	MRI/EUS q1–2 years depending on size.	Continue only if **surgical candidate.**

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Results: Baseline Characteristics

Characteristic	Surveillance N = 256[1]	No Surveillance N = 184[1]	p-value[2]
Age			
Cyst diagnosis of all patients	**79.78 ± 12.10**	**83.32 ± 11.22**	**0.002**
Last encounter of all patients	**87.27 ± 9.64**	**89.02 ± 9.97**	0.067
Race			0.611
Black	**36 (14.23%)**	**20 (11.49%)**	
White	**213 (84.19%)**	**150 (86.21%)**	
Ethnicity			0.769
Hispanic	**8 (3.19%)**	**4 (2.33%)**	
Not Hispanic	**243 (96.81%)**	**168 (97.67%)**	
Unknown	**5**	**12**	
Sex			0.455
Female	**168 (65.63%)**	**127 (69.02%)**	
Male	**88 (34.38%)**	**57 (30.98%)**	
Total Surveillance Scans (CT+MRI)	**4.72 ± 2.75**	**1***	**<0.001**

[1] n (%), mean ± SD ;[2] Pearson's Chi-squared test; Fisher's exact test; Welch Two Sample t-test; *Index Scan

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Results and Conclusion

- The average cost of surveillance in this population was **$17,624 per person**.
- The total cost of surveillance in our study to the healthcare system was **$4,511,867** and over the ten-year study period, **$451,187** is projected to be spent on surveillance per year.

Among patients over the age of 70 who were diagnosed with PCL of LRF, no patients in neither surveillance or no-surveillance cohort developed pancreatic cancer over a 10-year study period.

- **Conclusion:** Among patients over 70-years-old with **newly diagnosed PCL with LRF, current screening practices are associated with high costs and provide no benefit in disease-specific mortality or clinical outcomes.**
  - Reassessment of surveillance practices in the elderly **may reduce unnecessary healthcare use** and highlights the need for physician adherence to guideline-directed imaging.

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Safety and Efficacy of Per Oral Cholangioscopy (POC) in Index ERCP for Patients with Indeterminate Hilar Strictures

Muhammad Saad Faisal, Jonathan Montrose, Muhammad Salman Faisal, Ammad Javaid Chaudhary, Sumit Singla

Henry Ford Health

Detroit, MI

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Introduction and Methods

- ERCP is used for sampling and management of indeterminate strictures; however, the low yield of traditional ERCP risks increased time to diagnosis and subsequent management.
- Cholangioscopy offers direct visualization of the biliary tree and allows for targeted biopsies
  - However, index cholangioscopy concerns → increased procedural time and the increased rate of adverse events (cholangitis, pancreatitis) associated with increased instrumentation
- We aimed to assess the safety, efficacy, and adverse event profile of POC used during index ERCP for the diagnosis and management of hilar strictures, compared to standard ERCP performed at the index procedure.

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Results

- N = 117 (55.5% with POC at index ERCP)
- No major differences in age, gender, Bismuth classification, use of anticoagulation, hx of PSC, or ethnicity were found between the two groups.

	Index ERCP with POC	Index ERCP without POC	p-value
Number of patients (n)	65 (55.5)	52 (44.4)	
Age (Years)	64.56 +/- 14.2	66.06 +/- 14.0	0.57
Sex, female (n,%)	21 (32.3)	20 (38.5)	0.49

	Index ERCP with POC	Index ERCP without POC	p-value
Complications			0.15
Pancreatitis (n, %)	3 (4.6)	0 (0)	
Bleeding (n, %)	2 (3.1)	2 (3.8)	
Cholangitis (n, %)	1 (1.5)	5 (9.6)	

There was no statistically significant difference in adverse events between the two groups on index procedure.

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Results and Conclusion

- 47(72.3%) patients in the POC group were eventually diagnosed with malignancy, compared to 42 (80.8%) in the ERCP without POC group.

	Index ERCP with POC	Index ERCP without POC	p-value
Eventual diagnosis of malignancy (n, %)	47 (72.3)	42 (80.8)	0.29
Path positive on index procedure (n, %)	38 (58.5)	18 (34.6)	**0.005**
Diagnostic Yield of index ERCP (n, %)	38/47 (81)	18/42 (43)	
Time to Diagnosis from Index Procedure, Days +/- SD	8.82 +/- 22.8	37.10 +/- 100.7	**0.04**
Time to Initiation of Treatment, Days +/- SD	72.17 +/- 71.8	130.77 +/- 185.3	0.06

Index ERCP with POC	
Brushings + Cholangopscopy-directed Biopsies	87%
Brushings + Intraductal Forceps Biopsies	6.5%
Brushings alone	6.5%
Index ERCP without POC	
Brushings + Intraductal Forceps Biopsies	29%
Brushings alone	71%

Conclusion: For patients with indeterminate hilar biliary strictures, **POC used in index ERCP** increased diagnostic yield, shortens the time to establishment of diagnosis and does not have increased adverse events compared to standard ERCP during the index procedure.

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Comparison of EMR, ESD, and EFTR for Endoscopic Resection of Duodenal and Rectal Neuroendocrine Tumors

Joy Zhao, MD[1]; Adam Goodman, MD[2]; Sunil Dacha, MD[3]; Elizza Villarruel, BS[4]; Danny Issa, MD[4]; Ravishankar Asokkumar, MBBS[5]; Abdulrahman Qatomah, MBBS[6]; Daryl Ramai, MD[6]; Hiroyuki Aihara, MD, PhD[6]; Harneet S. Sangha, BS[7]; Mohit Girotra, MD[7]; Haidar Khan, MD[8]; Daniel Kurtz, DO[9]; Rashmi Advani, MD[10]; Anuroop Yekula, MBBS[11]; Vivek Kaul, MD[11]; Shivangi Kothari, MD[11]; Truptesh H. Kothari MD, MS[11]; Anand Kumar, MD, MPH[1]

(1) Department of Gastroenterology and Hepatology at Thomas Jefferson University, (2) Department of Gastroenterology and Hepatology at NYU Langone, (3) Department of Interventional Gastroenterology at Houston Methodist, (4) Department of Gastroenterology at UCLA, (5) Department of Gastroenterology and Hepatology at SingHealth, (6) Division of Gastroenterology, Hepatology, and Endoscopy at Brigham and Women's Hospital, (7) Division of Interventional Endoscopy at Swedish Medical Center in Seattle, (8) Division of Gastroenterology and Hepatology at Mount Sinai South Nassau Division, (9) Icahn School of Medicine at Mount Sinai South Nassau, (10) Division of Gastroenterology and Hepatology at Icahn School of Medicine at Mount Sinai, (11) Department of Gastroenterology at University of Rochester

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Introduction and Methods

Neuroendocrine tumors (NET) - mostly benign, but have cancerous potential

Duodenal NET and rectal NET (<2 cm) recommended resection

10-year endoscopic surveillance if fail to achieve negative margins

	EMR	ESD	EFTR w/FTRD
Advantages	• Shorter procedure time • Simpler technique	• Control over lateral margins	• Ease of use in rectum • Deeper resection
Disadvantages	• Incomplete resections	• Difficult technique • Increased risk of AE • Longer procedure	• Training • Duodenal access

Aim: To compare clinical outcomes of rectal and duodenal NET resection

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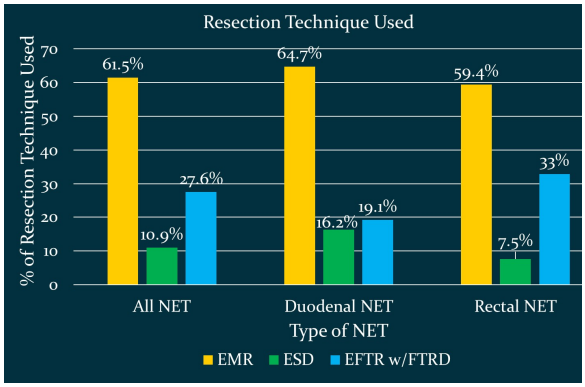
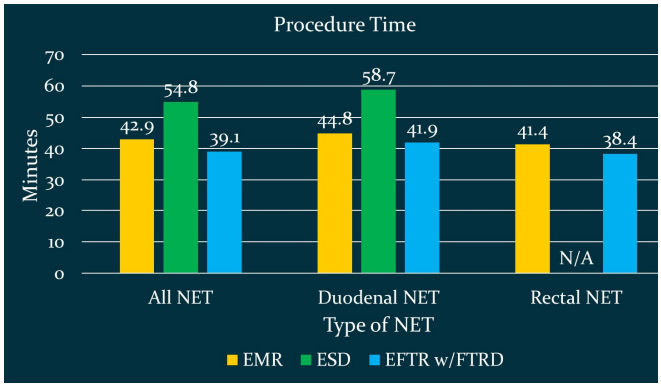
Results

	All NET	Duodenal NET	Rectal NET
Number of patients	174	68	106
Age in years, mean	57.3	60.6	55.2
Sex, % Male	51.7%	54.4%	50%
Lesion size <10mm	80.5%	73.5%	84.9%





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Results: Adverse Events

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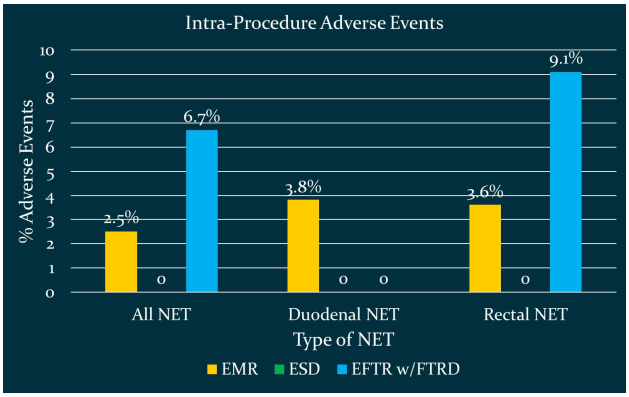

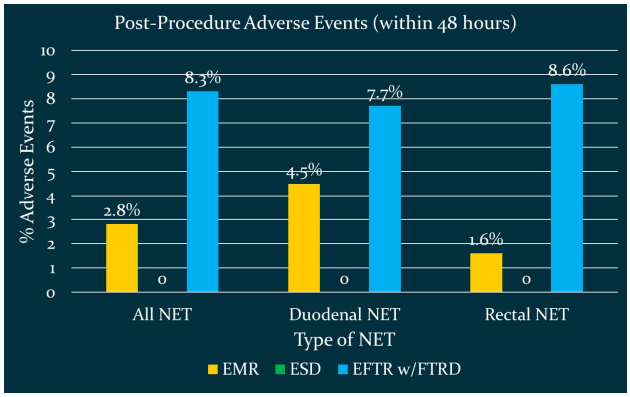

EMR: 1 bleed, 2 perforation (endoscopically managed)
EFTR: 2 bleed, 1 perforation (endoscopically managed)

EMR: 1 bleed, 1 perforation with bleeding (endoscopically managed), 1 urinary retention

EFTR: 3 bleed, 1 abdominal pain

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Results

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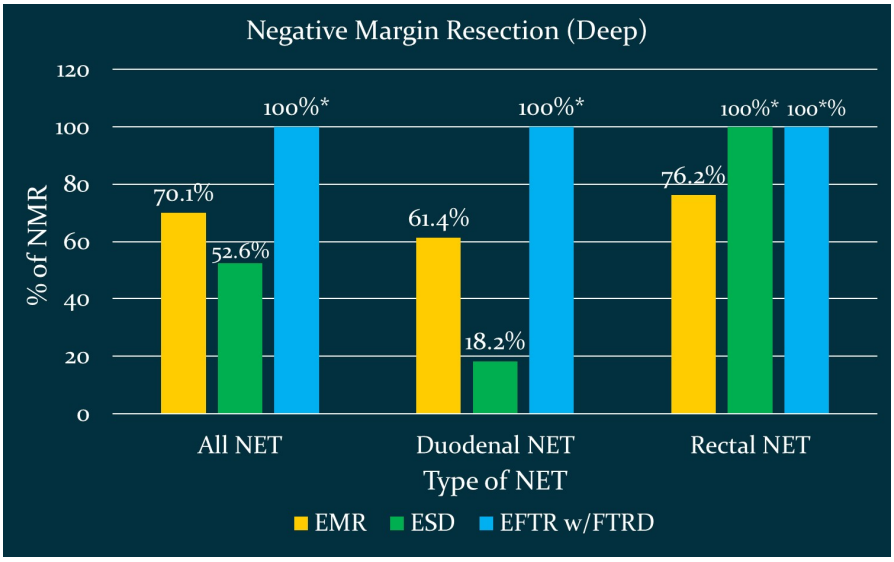

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Conclusion

- For <20 mm NET NMR:
  Overall: EFTR w/FTRD > EMR > ESD
  Duodenal: EFTR w/FTRD > EMR > ESD
  Rectal: EFTR w/FTRD = ESD > EMR
- EFTR with FTRD has favorable objective procedure times \EFTR with higher number of AE, but no significant statistical difference

EFTR may be a more efficient and successful resection technique for rectal and duodenal NET.

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Best of ACG 2025 in Interventional Endoscopy/Pancreas/Biliary

Hassam Ali, MD

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Associations Between Early Fluid Resuscitation, SIRS Status, and BUN Changes in Acute Pancreatitis: Real World Results from the APPRENTICE Consortium

Daniel Marino MD/MBA1, Stacey Culp PhD2, Peter J Lee MBChB3, Jordan Burlen MD3, Raj Shah MD Tamas Gonda MD1, Georgios Papachristou MD/PhD3

1 Division of Gastroenterology, NYU Langone Health ; 2 Department of Biomedical Informatics, Ohio State University ; 3 Division of Gastroenterology, Ohio State University

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Introduction

- Acute pancreatitis (AP): fluids = only disease-modifying therapy
- SIRS and BUN are the strongest early prognostic markers
- ACG recommends **≥1.5 mL/kg/hr**, but real-world practice varies
- Key question: Are fluids helping, or just marking severity?

Study Design

- APPRENTICE Consortium: multinational prospective registry
- **999** patients with 24-hr fluid data; **957** with 6-hr data
- Measured at admission, 6 hr, 24 hr:
  - SIRS status
  - BUN change
  - Fluid rates/volumes
- Outcomes: severe AP, necrosis, organ failure

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Key Results and Conclusion

- **Persistent SIRS at 24 hours = much worse disease**
  - Severe pancreatitis: 18.4% vs 0.5% (no SIRS)
- **After adjustment (logistic regression):**
  - Higher fluid rate at 6 hours → higher odds of persistent SIRS (aOR 1.33, 95% CI 1.21–1.46)
  - Higher fluid rate at 24 hours → higher odds of persistent SIRS (aOR 1.29, 95% CI 1.09–1.54)
- **BUN rise at 24 hours = early warning signal**
  - Severe pancreatitis: 11.4% vs 3.8% (no BUN rise)
  - Each unit increase in BUN independently predicted SIRS (aOR 1.03, p=0.001)
- **Organ failure**
  - Out of the 25% of patients who developed (any) organ failure, the fluid rate was higher at 24 hours (p = 0.028) but not at 6 hours (p = 0.329)

Take-Home Message:
Even small increases in **BUN** independently predict worse outcomes.
Although sicker patients received more fluids, outcomes remained worse, suggesting early BUN trajectory may be a better risk marker than fixed fluid targets.

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Early versus Delayed Cholecystectomy in Patients Admitted for Choledocholithiasis: Impact on Biliary Complications and Role of Sphincterotomy or Stenting

Arpita Jajoo, MD, Yana Cai, MD, Aditya Chandrashekar, MBBS, Jianing Li, MD, Alistar Kent, MD, Venkata Akshintala, MD, PhD

Department of Gastroenterology, Johns Hopkins

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Background & Study Design

- Choledocholithiasis complicates up to 20% of symptomatic cholelithiasis and is typically managed with ERCP followed by cholecystectomy
- Guidelines (ASGE, European) recommend same-admission cholecystectomy, this occurs in only ~40% of cases

- **Retrospective** cohort study of adults hospitalized with choledocholithiasis undergoing ERCP at a tertiary center and affiliated hospitals (**2005–2023**)

Patients were stratified into:

- Concurrent (same-admission) cholecystectomy
- Deferred cholecystectomy
- Patients were followed for **12 months** for pancreatobiliary complications
- Assessed whether **ERCP with sphincterotomy or biliary stent placement** reduced subsequent biliary events

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Key Results and Conclusion

- **Biliary complications within 1 year**:
  Concurrent cholecystectomy: **~1.6%**
  Deferred cholecystectomy: **~23%**
- Highest incidence of recurrent events occurred within the first 3 months after index admission
- **ERCP adjuncts**:
  - Sphincterotomy and biliary stenting did not reduce the risk of future biliary complications
- Surgical delays were most commonly related to perceived operative risk, not improved outcomes with delay

Take-Home Message:

- Same-admission cholecystectomy is associated with the lowest risk of recurrent pancreatobiliary events after ERCP for choledocholithiasis.
- ERCP alone, even with sphincterotomy or stenting, does not provide definitive protection against recurrence.

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Feasibility of Targeted Pancreatic Cooling in Acute Pancreatitis: A Prospective, First-in-Human, Multi-Center, Single Arm Study

Bernardo Goecke, MD1 , Karina Carcamo, MD1 , Jose I. Vargas, MD2, Jan Cubilla, MD3, *Walter G. Park, MD4

1 Hospital Base Osorno, Osorno, Chile; 2 Hospital Católica, Santiago Chile; 3 Hospital Santo Tomás, Panama City, Panama; 4 Stanford University School of Medicine, Stanford, CA, USA

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Background & Study Design

- Acute pancreatitis is driven by local pancreatic inflammation, and current therapy is largely supportive
- Regional pancreatic cooling may reduce inflammatory injury without systemic hypothermia
- This was a prospective, first-in-human, multi-center, single-arm study evaluating a novel trans-gastric pancreatic cooling catheter
- 21 adult patients with acute pancreatitis treated within 72 hours of symptom onset; Device remained in place for up to 72 hours
- **Primary endpoints**:
  - Technical success of catheter placement
  - Device-related adverse events
- **Secondary endpoints**:
  - Change in PASS score (Pancreatitis Activity Scoring System)
  - Length of stay
  - Clinical follow-up at 14 days

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Key Results and Conclusion

- **Technical success**:
  - 100% successful placement (21/21 patients)
  - Target gastric temperature <29°C achieved, corresponding to pancreatic temperature <34°C
  - No systemic hypothermia observed
- **Safety**:
  - No unanticipated device-related serious adverse events
  - One possible aspiration pneumonia, resolved with antibiotics
- **Disease severity**:

PASS score improved from 151 ± 78 at baseline

  - To 70 ± 88 at **72** hours/discharge
  - To 8.8 ± 11.7 by day **14**, with full clinical recovery
  - Length of stay comparable or shorter than historical controls

Take-Home Message:

- Targeted pancreatic cooling is feasible and safe in early acute pancreatitis, achieving regional hypothermia without systemic effects.
- This represents a potential disease-modifying adjunct beyond fluids, warranting randomized trials to assess clinical efficacy.

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Best of ACG 2025 in General Gastroenterology

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Yield of Post-Polypectomy Interval Fecal Immunochemical Testing: Results from a Nationwide VA Database

Natalie Wilson, MD, Mohammad Bilal, MD, Anders Westanmo, PharmD, Amy Gravely, MA, Khalid Ishani, BS, Rahul Karna, MD, Aasma Shaukat, MD, MPH

University of Minnesota, University of Colorado Anschutz Medical Campus, Minneapolis VA Medical Center, NYU Langone Health

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Methods

Design:
- Retrospective cohort study
- Data collected from Veterans Health Administration Corporate Data Warehouse from 2000-2024

Population:
- Adults with colonoscopy performed for any indication followed by FIT within ≤10 years
- Stratified by polypectomy using CPT codes

Definitions:
- Advanced neoplasia: adenoma with HGD, TVA/villous adenoma, or CRC

Analysis:
- Descriptive statistics
- Multivariable logistic regression for predictors of advanced neoplasia and CRC

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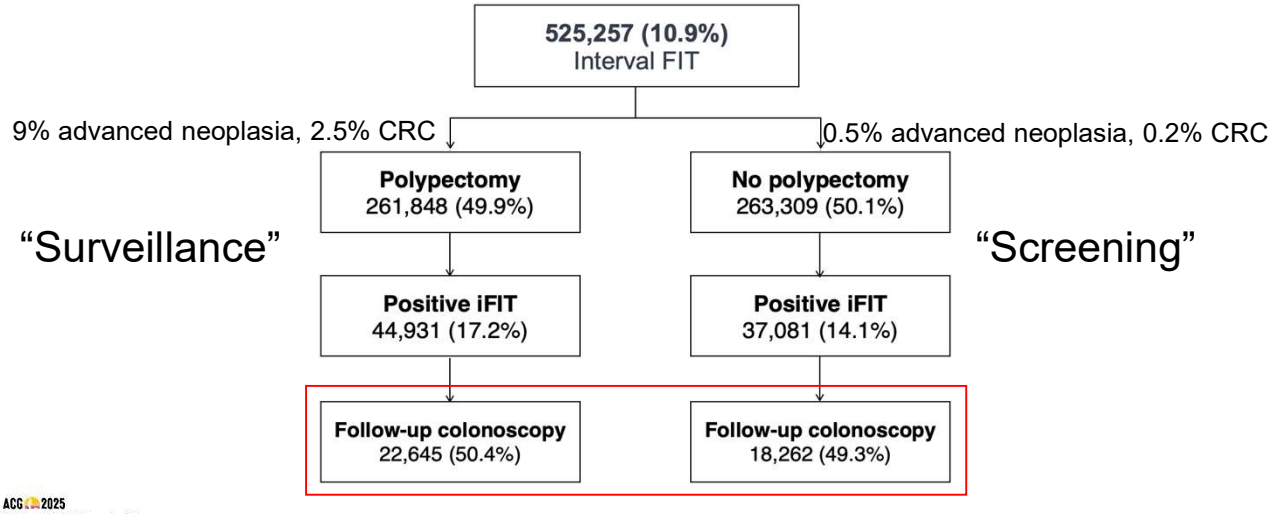
Rate of follow-up colonoscopy after positive interval FIT



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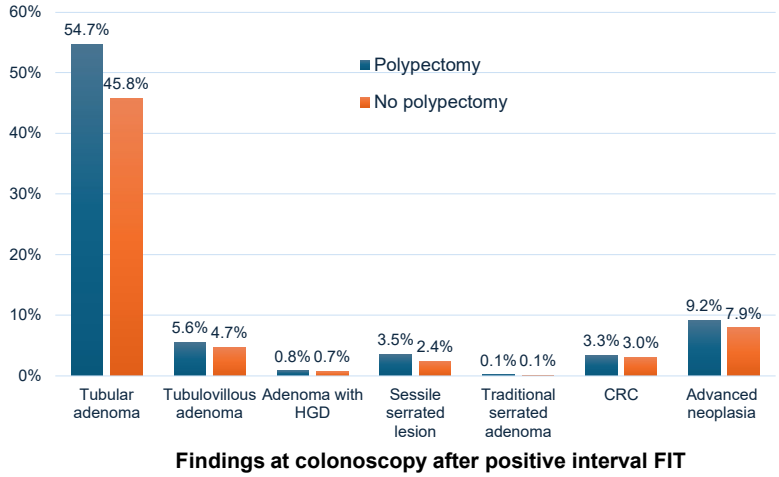
Findings at follow-up colonoscopy

- More tubular adenomas and SSLs in polypectomy group
- Advanced neoplasia: **9.2% vs 7.9%**
- CRC: **3.3% vs 3.0%**



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Impact of GLP-1RA Therapy on Esophageal Motility Patterns

Annie L. Wang, BS, BA[1], Laura Bach, DO[2], David A. Leiman, MD, MSHP[2,3]

[1]Duke University School of Medicine, Durham, NC, [2]Division of Gastroenterology, [3]Duke Clinical Research Institute

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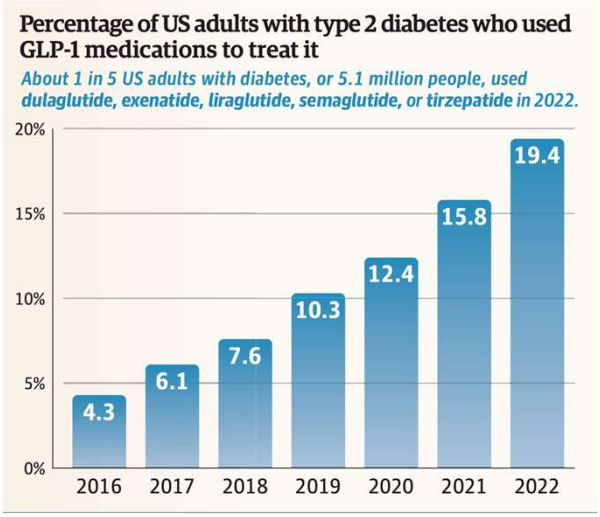
Background



- Glucagon-like peptide-1 receptor agonists (GLP-1RAs) impact gastrointestinal motility
  - Slow transit
  - Delayed gastric emptying

Hegland TA, et al. JAMA 2024.
Jalleh RJ, et al. J Clin Endocrinol Metab 2024.

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Methods

- Patients with type 2 diabetes (T2DM) who underwent high-resolution manometry (HRM) between 12/2022-10/2024
- Biodemographic data, glycemic control parameters, HRM diagnoses per Chicago Classification 4.0, and reflux testing results were extracted from the electronic health record
- Patient-reported outcomes were collected from the Brief Esophageal Disease Questionnaire (BEDQ), Eckardt, and Reflux Symptom Index (RSI)

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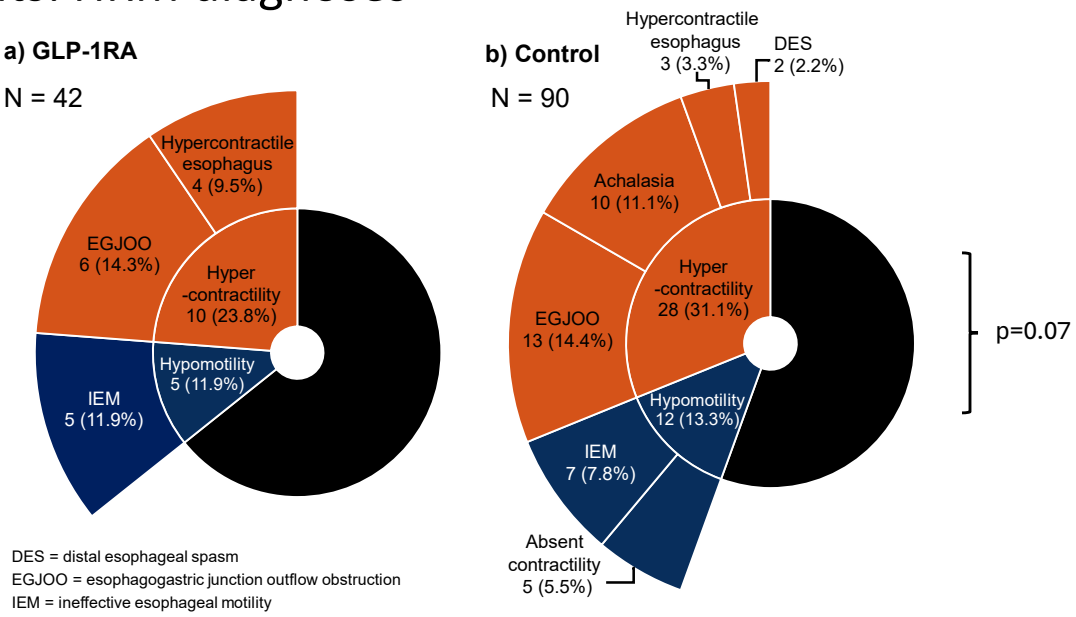
Results: HRM diagnoses



DES = distal esophageal spasm
EGJOO = esophagogastric junction outflow obstruction
IEM = ineffective esophageal motility

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Results: HRM indications & pH testing

	GLP-1RA (N=42)	Control (N=90)	P-value
HRM indications			0.82
Dysphagia	17 (40.5)	42 (46.7)	
GERD	24 (57.1)	45 (50.0)	
Other	1 (2.4)	3 (3.3)	

	GLP-1RA (N=42)	Control (N=90)	P-value
pH testing ordered	23 (52.4)	42 (46.7)	0.54
Pathologic GERD	9 (21.4)	13 (14.4)	0.51
Positive pH impedance testing	6 (14.3)	9 (10.0)	
Positive wireless pH testing	3 (7.1)	4 (4.4)	

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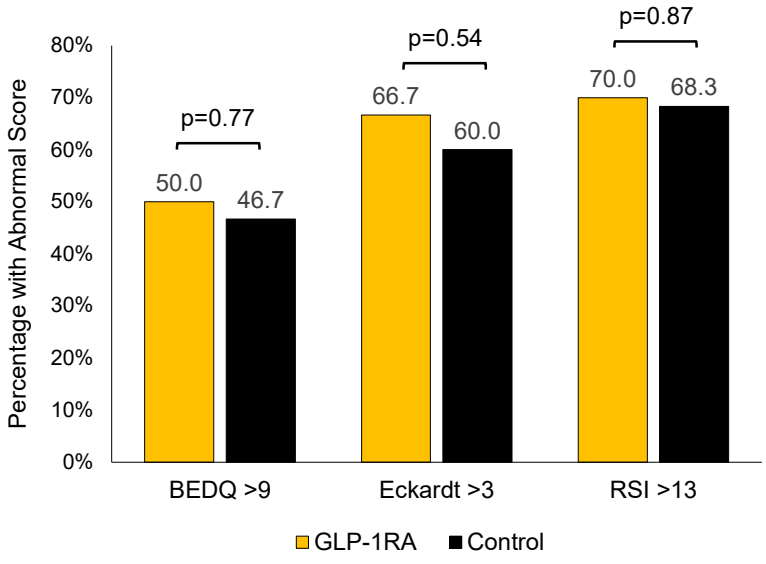
Results: Symptom scores



BEDQ = Brief Esophageal Disease Questionnaire
RSI = Reflux Symptom Index

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Best of ACG 2025!
Outstanding Science, Expert Discussions

Category : General GI
Ekta Gupta MD, FACG, AGAF
Associate Professor of Medicine
Chief of Gastroenterology, UMMC Midtown
Director Ambulatory Operations,
Division of Gastroenterology and Hepatology
University of Maryland.

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From ED to EoE: Improving Practices for Timely Diagnosis

Rosa L. Yu MD[1], Natalie Sanfratello MPH[2], Megan M. Leo MD[3], Frederic F. Little MD[4], Alison Li MPH[2], Christopher S. Huang MD[1]

[1]Boston Medical Center, Section of Gastroenterology, Boston, MA
[2]Boston University Chobanian & Avedisian School of Medicine, Center for Continuing Education, Quality Improvement Hub, Boston, MA
[3]Boston Medical Center, Department of Emergency Medicine, Boston, MA
[4]Boston Medical Center, Section of Pulmonary, Allergy, Sleep, and Critical Care, Boston, MA

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Introduction

- Early diagnosis of Eosinophilic Esophagitis (EoE) is critical for timely treatment and avoidance of complications
- With rising prevalence and frequent diagnostic delays, adults with undiagnosed EoE may present to the ED with esophageal food impaction (EFI) or dysphagia.
- Prompt EGD with biopsies, ideally concurrent with treatment of impaction, is essential to confirm diagnosis and prevent loss to follow-up, ensuring optimal care.

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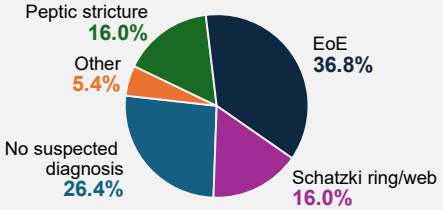
Post-endoscopy Care for Food Impaction

Alberta Health Services, Canada, 2016-2018

519 adults presenting with food impaction undergoing EGD from **4 tertiary care hospitals** in Calgary Health Zone (single payer, fully integrated, provincial health authority)

25% with inadequate follow-up and management

Associated with absence of a suspected esophageal diagnosis at presentation (aOR, 7.28; 95% CI, 4.49-11.78)



20% of patients had their diagnoses changed after follow-up evaluation

aOR, adjusted odds ratio

Guo H et al. *Am J Gastroenterol.* 2023;118(10):1787-1796

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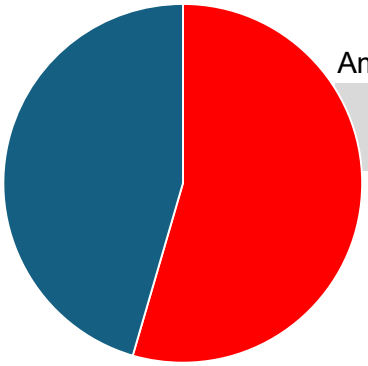
Patients are at a high risk of being lost

University of Michigan, 2000-2017



Among **220 patients** presenting to the ED with food impaction,

54.5% of patients were lost to follow up.

- Biopsies were obtained in **34.4%** of index endoscopies.
- Biopsies were eventually obtained in **71.8%** of cases.
  - Those with ≥15 eos/HPF were more likely to be LTFU than those with <15 eos/HPF (**52.8% vs. 34.8%, *P* < 0.05).**
- Of those never biopsied, **79.0%** were lost to follow-up.

Chang JW et al. *Dis Esophagus*. 2019 Dec 31;32(12)

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Core Goals of QI Project

- **Facilitate screening** of patients presenting to the ED with symptoms of EoE, including referral to appropriate specialists and/or endoscopy/biopsy
  - **AIM:** To improve the average time to diagnosis for patients with EoE after presentation to the ED for dysphagia or food impaction
- **Promote timely diagnosis** of patients with EoE by obtaining biopsies at the time of initial endoscopy, if feasible
- **Reduce the number of patients lost to follow-up** by providing additional supportive resources

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Interventions

Clinician Education	Patient Education	Operations
• **For ED:** recognition and triage of EoE • **For GI:** regarding importance and safety of biopsies during index endoscopy	• **Resources for patients** regarding EFI and importance of follow-up, translated into multiple languages	• Building a rapid referral process allowing ED providers to order expedited endoscopy

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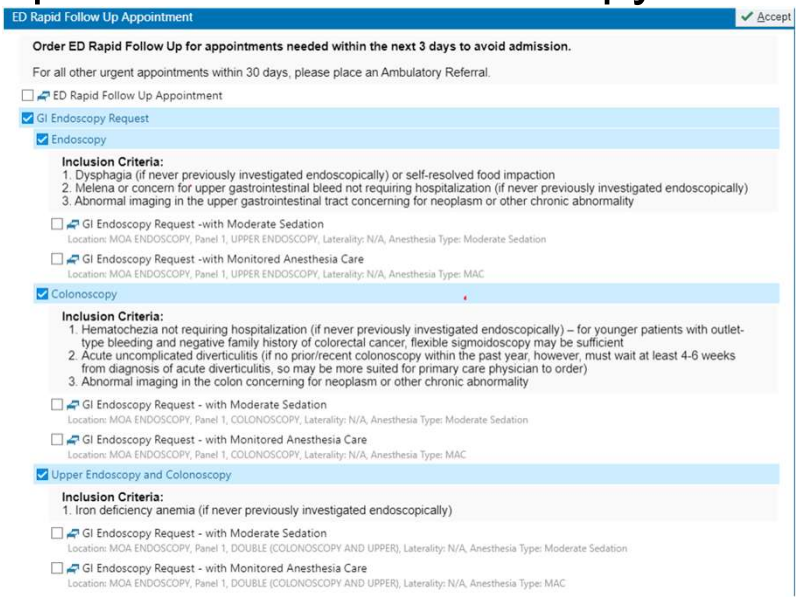
ED Rapid Referral for endoscopy



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Results

Pre-Intervention

44% of eligible patients (n=9) biopsied

1.2% of eligible ED patients(n=78) presenting with dysphagia were referred for EGD

Post-Intervention

100% of eligible patients (n=8) biopsied

16.2% of eligible ED patients(n=68) presenting with dysphagia were referred for EGD

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Conclusion

Through **targeted education** and **updated workflows** between the ED and GI, we were able to significantly improve biopsy rate during index EGDs for EFI **(44% to 100%)** and referrals to GI **(1.2% to 16.2%)** to expedite EoE diagnosis and care.

Take Home :Food impaction should trigger an automatic EoE diagnostic pathway with biopsies, even if mucosa appears normal.

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Reducing Inappropriate Proton Pump Inhibitor Prescribing in Non-Critically Ill Hospitalized Patients: A Single Center Quality Improvement Project

Matthew Ryan, MD[1], Christopher D. Ma, MD[1], Ami Panara Shukla, MD[2], Marlene Onaindia, PharmD, BCPS[3], Sebastian Suarez, MD, MPH[1,4]

[1]UM/JMH Internal Medicine Residency Program, University of Miami, Miami, FL
[2]Division of Digestive Health and Liver Diseases, University of Miami, Miami, FL
[3]Department of Pharmacy Services, University of Miami, Miami, FL, USA.
[4]Division of Hospital Medicine, University of Miami, Miami, FL

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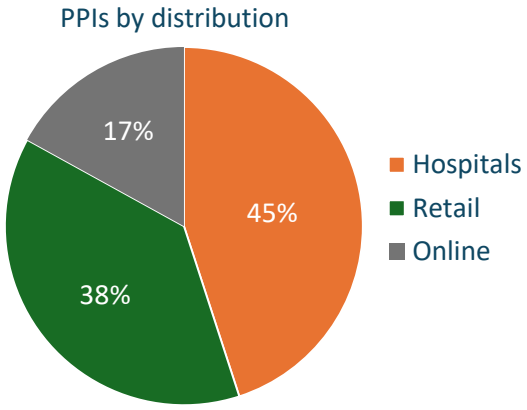
Overview of Proton Pump Inhibitors (PPIs)

- Prescribed to nearly 25% of adults worldwide
- $3.8 billion global market value **greater than GDP of Belize**
- Historically considered safe for various GI conditions
- Commonly used "off-label" for stress ulcer prophylaxis (SUP)



Krag M et al., N Engl J Med. 2018;379(23):2199-208.
Strand DS et al., Gut Liver. 2017;11(1):27-37.
Shanika LGT et al., Eur J Clin Pharmacol.
GDP (current US$). https://data.worldbank.org/indicator/NY.GDP.MKTP.C
Proton Pump Inhibitors Market. https://market.us/report/proton-pump-inhibitors-market/

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Adverse effects of PPIs within the hospital

Clostridium difficile (C. diff) infection

Hospital Acquired Pneumonia

Acute Interstitial Nephritis

Finke M et al., J Infect. 2025;90(5):106488.
Herzig SJ et al., JAMA. 2009;301(20):2120-8.
Geevasinga N et al., Clin Gastroenterol Hepatol. 2006;4(5):597-

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Aims and scope

- Goal: 20% reduction in inappropriate PPI admission orders
- Setting: Academic tertiary care hospital, Epic EMR
- Population: All patients admitted to hospital medicine
- Design: QI project using the PDSA model
- Root Cause Analysis performed prior to interventions

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PDSA Cycles

Intervention 1
5/1/24 – 7/30/24

Removal of PPI option on admission order set

Intervention 2
7/31/24 – 12/31/24

Implementation of a standardized H&P template for hospital medicine

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Methods and Data Analysis

- Appropriate PPI orders excluded via ICD-10
- Groups: Pre-intervention, Intervention 1, Intervention 2
- Primary measure: PPI orders on admission
- Secondary measures: *C. diff* diagnosis
- Sub-analysis: teaching vs. non-teaching teams
- Chi-square test performed

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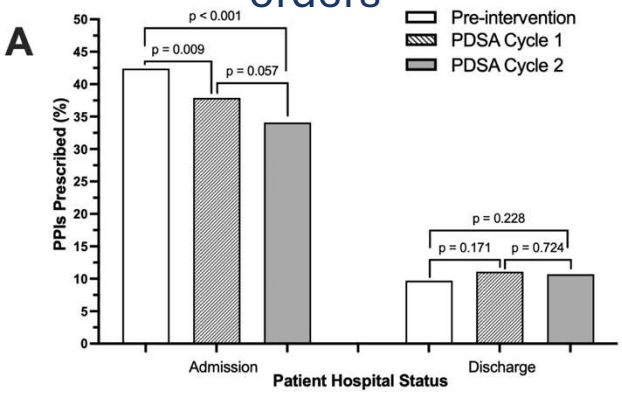
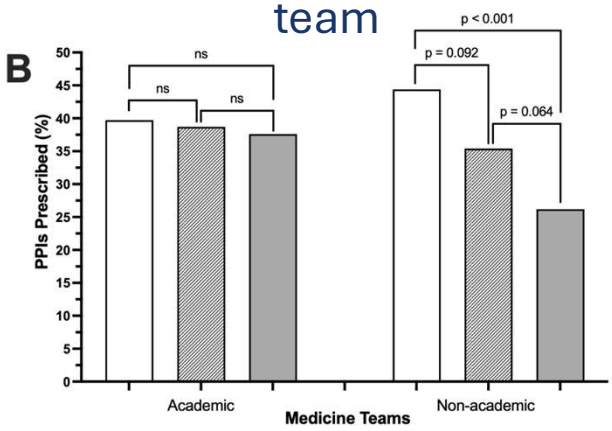
Rates of PPI orders



Stratified by medicine team



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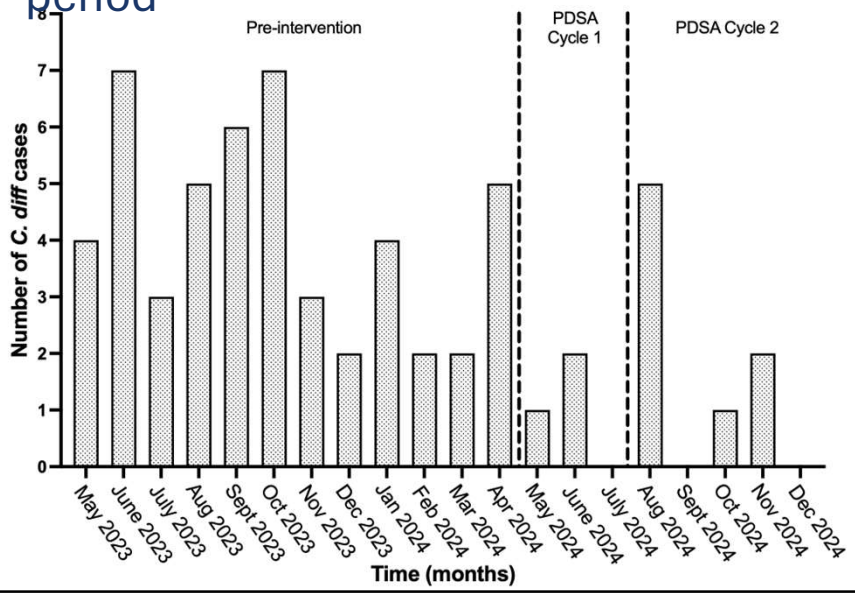
C. diff cases throughout the study period



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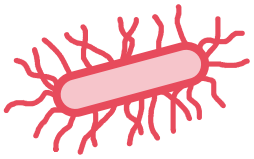
Results

19.6% reduction of inappropriate PPI admission orders



Associated 42% decrease in *C. diff* diagnoses

Hospitalist

41% decrease

V

S

Academic Teams

5.5% decrease

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Discussion

- The interventions increase cognitive effort of ordering PPIs
- Hospitalists likely to appreciate system changes, decreases workflow variability
- Residents work with 3 different EMRs
- Association of decreased *C. diff* infections
- Limitations: ICD-10 coding, OTC availability

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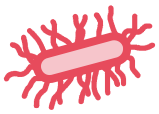
Summary

Systems-based interventions are effective for PPI stewardship



Lowering PPI orders on admission **may** decrease complications; more research needed

Other institutions can replicate EMR changes

Further studies needed for academic teams and impact of PPI prescriptions on discharge

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Take Home message

- Recommend multifaceted, workflow-level EMR changes are effective for PPI stewardship and may reduce inpatient complications.

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Thank You

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ACG 2025: Best of IBD Abstracts

Omer Shahab, MD

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Data in Action: Improved Patient Adherence Using a Novel IBD Dashboard. Results of a Multi-Site 6-Month Pilot.

Michael Mills, MD, MPH, FACG1, 3, Gena Ettinger, PA-C, MSHS1, Nicole Smith, MS2, Wanda Wilt, RN, BSN2, Paul Berggreen, MD1

1-GI Alliance, 2 – Cardinal Health, 3-Univ of Arizona College of Medicine

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Implementing a Novel IBD Dashboard to Improve Patient Adherence

- Community IBD practices face challenges with patient attrition, inconsistent monitoring, and adherence to care pathways
- A novel IBD clinical dashboard was developed to proactively identify patients needing intervention and track key care metrics
- KPIs were aligned with STRIDE-II treat-to-target recommendations, including:
  - Patient attrition
  - Lab monitoring adherence
  - Colonoscopy completion
  - Advanced therapy utilization
  - Chronic care enrollment

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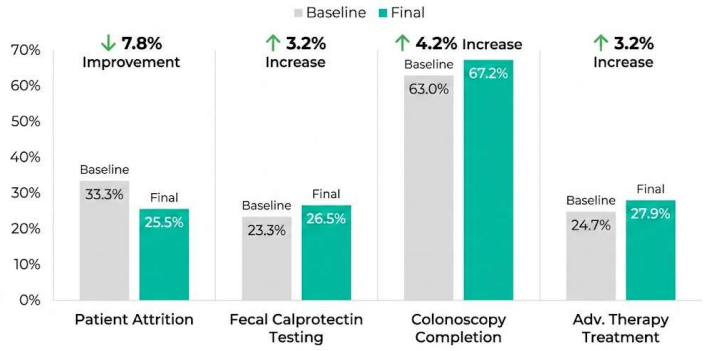
Results and Statistical Outcomes

- Patient Attrition: Decreased significantly from a baseline of 33.3% to 25.5% (P < 0.0001)
- Fecal Calprotectin Testing: Adherence rates increased from 23.3% to 26.5% (P < 0.0001)
- Colonoscopy Completion: Rates for patients on advanced therapy improved from 63.0% to 67.2% (P = 0.0034)
- Advanced Therapy Treatment: Treatment rates for high-risk patients rose from 24.7% to 27.9% (P = 0.0062)



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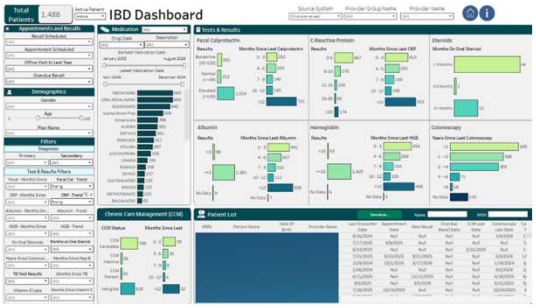
Clinical Impact and Future Directions

- The initiative identified over 900 potential care gaps, resulting in **407 patients** being "recovered" and re-engaged by the practices.
- The project establishes a national baseline for community-based GI practices, moving care processes from reactive to proactive
- Future: AI-enabled data curation, enhanced KPI tracking, expansion to other disease states



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Both Low (TECH) and High (TEAM) Touch Interventions Improve Behavioral Health, IBD Symptoms, and Quality of Life: A Randomized Control Trial

Laurie Keefer, PhD, FACG on behalf of:
Professor of Medicine and Psychiatry
Icahn School of Medicine at Mount Sinai, New York, NY USA
Benjamin L. Cohen, MD, Jeffrey M. Dueker, MD, MPH, Benjamin Click, MD, MS, Marla C. Dubinsky, MD, Miguel Regueiro, MD, Stephen E. Lupe, PhD, Ashley L. Taylor, MLIS, Jane Kogan, PhD, Cara Nikolajski, PhD, MPH, Nina Oryshkewych, MS, Meredith Wallace, PhD and
Eva Szigethy, MD, PhD, FACG

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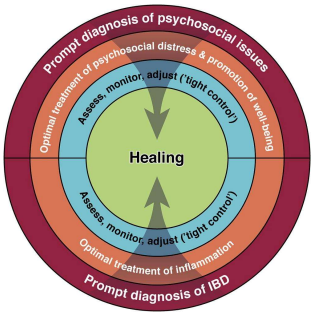
Both Low (TECH) and High (TEAM) Touch Interventions Improve Behavioral Health, IBD Symptoms, and Quality of Life: A Randomized Control Trial

- Objective: To compare the impact of two specialty medical home approaches on patient outcomes, specifically IBD symptoms, behavioral health (BH), and quality of life
- RCT involving **657 randomized patients** across three major sites: Mount Sinai (NY), UPMC (PA), and Cleveland Clinic (OH)
- Interventions compared:
  - (High Human Touch): Integrated behavioral care delivered by licensed therapists using a hybrid of telemedicine and face-to-face visits, with care coordination by the medical team
  - TECH (Low Human Touch): Digital tools serve as the first line of care. Digital coaches provide support via interactive text messaging, with a focus on telemedicine delivery



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Methodology and Study Population

- Patient Eligibility
  - Adults (18-60) with confirmed Crohn's disease or Ulcerative Colitis.
  - Must exhibit mild to severe behavioral health symptoms (PHQ-4 score >6).
- Demographics: The average age was ~34.8 years, predominantly female (64.5%), with 67% of participants having Crohn's Disease and 53.9% on advanced therapy.
- Key Outcome Measures (Tracked at Baseline, 6, & 12 Months):
  - Primary:
    - IBD symptom severity (Physical Health Composite Score)
    - BH symptom severity (PHQ-ADS) .
  - Secondary:
    - Functional impairment, healthcare utilization (ED visits/hospitalizations), self-efficacy, and IBD-related quality of life

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Results and Clinical Implications

- Both interventions worked effectively. There were no significant "group by time" interactions, meaning the TECH (Low Touch) and TEAM (High Touch) approaches produced similar positive trajectories
- Patients in both groups demonstrated significant improvement in:
  - Biopsychosocial Complexity (Combined IBD and BH severity). * Quality of Life and Self-Efficacy.
  - Anxiety and Depression scores (PHQ + GAD) decreased significantly from baseline to 6 and 12 months.
- Conclusion: This was the first large RCT of its kind, proving that integrated behavioral health interventions, whether delivered through licensed therapists or scalable digital tools, significantly improve outcomes for high-risk IBD patients

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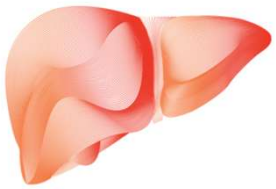
Best of ACG 2025

Innovations in Liver



By

Sangeeta Agrawal, MD, FACG, FASGE, AGAF

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Treatment with Resmetirom for Up to Two Years Led to Improvement in Liver Stiffness, Fibrosis Biomarkers, Fibrosis Scores and Portal Hypertension in 122 Patients with Compensated MASH Cirrhosis

N. Alkhouri,[1] R. Taub,[2] X. Lu,[2] R. Pushkin,[2] M. Charlton,[2] S. Moussa,[3] A. Kohli,[1] M. Noureddin,[4] J. M. Schattenberg[5]

1: Summit Clinical Research, San Antonio, TX, US; 2: Madrigal Pharmaceuticals, West Conshohocken, PA, US; 3: University of Arizona for Medical Sciences, Tucson, US; 4: Houston Research Institute, Houston, US; 5: Universitätsklinikum des Saarlandes, Homburg, Germany

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Unmet Need in MASH Cirrhosis

High Risk of Outcomes, No Approved Disease Modifying Therapies

Resmetirom, an oral, once-daily, liver-directed thyroid hormone receptor β (THR-β) agonist, was the first drug approved by FDA for MASH in March 2024

No approved therapies for patients with compensated cirrhosis due to MASH.

Cirrhosis (F4) is highly associated with clinical outcomes including hepatic decompensation events, liver failure, liver transplant and mortality

MASH: metabolic dysfunction-associated steatohepatitis
Harrison SA et al. N Engl J Med. 2024 Feb 8;390(6):497-509; Sanyal AJ et al. N Engl J Med. 2021 Oct 21;385(17):1559-1569;

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Trial Design – Open-Label (OL) 52-Week Cirrhosis Arm of MAESTRO-NAFLD-1 followed by an Extension Trial

Inclusion Criteria

≥3 metabolic risk factors
Well-compensated MASH cirrhosis - Child Pugh A:

- F4 fibrosis[1] OR
- Non-invasive clinical assessment (liver stiffness (VCTE, MRE), platelets, ELF)
- **Allowed platelet count ≥70,000**
- No history of decompensation

MAESTRO-NAFLD-1

OL cirrhosis cohort

Open Label

N=180

RESMETIROM 80 mg

52-week OL treatment

N=161 completed

Variable gap off treatment, 1 month up to 1 year

OL EXTENSION

RESMETIROM 80 mg

OL treatment- data analyzed after second 52-week treatment period

N=122
113 completed

Primary Endpoint

Safety and tolerability of resmetirom in cirrhosis patients

Secondary/Exploratory Endpoints

VCTE, MRE, MRI-PDFF, liver enzymes, biomarkers, lipids, liver and spleen volume

Liver biopsy was obtained 66% of patients; for patients with clinical progression from F3 on biopsy to F4, F4 was confirmed by platelets <LLN. (most) or MRE >4.2

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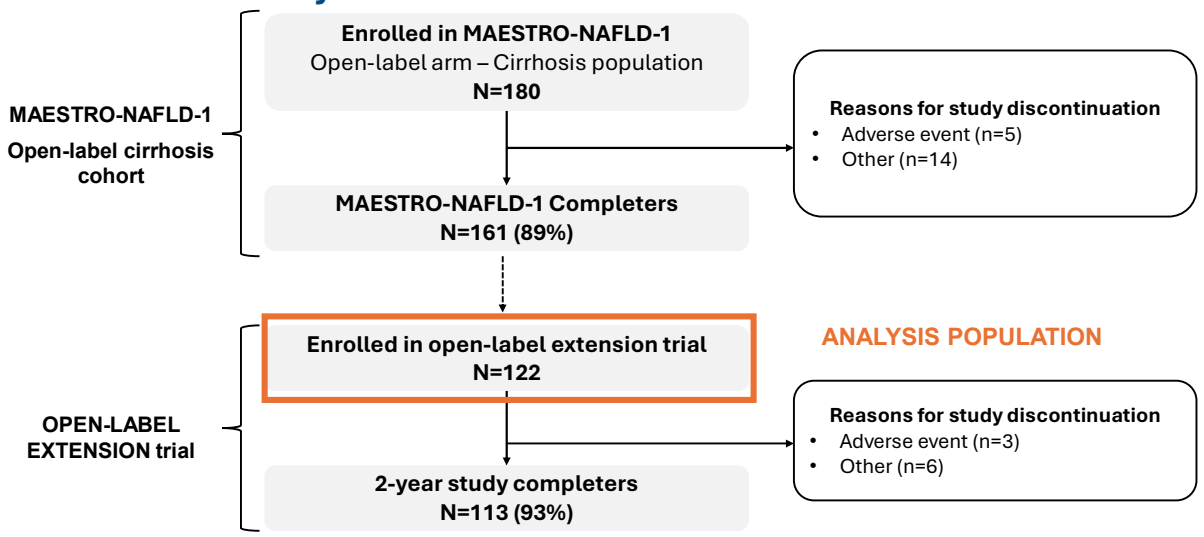
Trial flow – Open-Label Cirrhosis Arm (MAESTRO-NAFLD-1) followed by an Extension Trial



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Summary

Resmetirom was well tolerated over 2 years in patients with well-compensated cirrhosis.

>50% of patients achieved a sustained ≥25% reduction in LSM after 2 years

Lower VCTEs are associated with less progression to decompensation

Reduced clinically significant portal hypertension risk score based on Baveno and modified Baveno criteria

Clinically significant portal hypertension predicts progression to decompensation

Multiple biomarker and imaging evidence of improvement

Results support the potential clinical benefit of resmetirom in MASH cirrhosis that is being evaluated in the fully enrolled, ongoing 845 MASH cirrhosis MAESTRO-NASH-OUTCOMES trial

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Change in Pruritus in Patients With Primary Biliary Cholangitis and Moderate to Severe Pruritus: A Pooled Analysis From the RESPONSE and ENHANCE Studies

David E. J. Jones[1], Cynthia Levy[2], Andreas E. Kremer[3], Alma Ladron de Guevara Cetina[4], Alejandra M. Villamil[5], Ewa Janczewska[6], Mordechai Rabinovitz[7], Pietro Andreone[8], Xin Qi[9], Susheela Carroll[9], Timothy R. Watkins[9], Marlyn J. Mayo[10]*

[1]Translational and Clinical Research Institute and Centre for Rare Disease, Newcastle University, Newcastle upon Tyne, UK; [2]Division of Digestive Health and Liver Diseases, Miller School of Medicine, University of Miami, Miami, FL, USA; [3]Department of Gastroenterology and Hepatology, University Hospital Zürich, Zürich, Switzerland; [4]Centro de Investigación y Gastroenterología, Hospital Angeles Clinica Londres, Mexico City, Mexico; [5]The Liver Autoimmunity Unit, Hospital Italiano de Buenos Aires, Buenos Aires, Argentina; [6]Department of Basic Medical Sciences, Faculty of Public Health in Bytom, Medical University of Silesia, Bytom, Poland; [7]Division of Gastroenterology, Hepatology, and Nutrition, Department of Medicine, University of Pittsburgh, Pittsburgh, PA, USA; [8]Division of Internal Medicine, Università di Modena e Reggio Emilia, Modena, Italy; [9]Gilead Sciences, Inc., Foster City, CA, USA; [10]Division of Digestive and Liver Diseases, University of Texas Southwestern, Dallas, TX, USA

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Background

- Pruritus may occur in up to 70% of patients with PBC during the course of disease and can greatly reduce quality of life
- Seladelpar is a first-in-class delpar (selective PPARδ agonist) indicated for the treatment of PBC in combination with UDCA in adults who have an inadequate response to UDCA, or as monotherapy in patients who are unable to tolerate UDCA
- In two Phase 3, placebo-controlled trials—ENHANCE and RESPONSE —seladelpar significantly reduced pruritus among patients who had moderate to severe pruritus at baseline, defined as an NRS score ≥4

Objective: To explore pruritus outcomes in greater detail from the pooled dataset of patients with PBC and NRS ≥4 at baseline in ENHANCE and RESPONSE

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ENHANCE and RESPONSE Study Designs

Entry Criteria

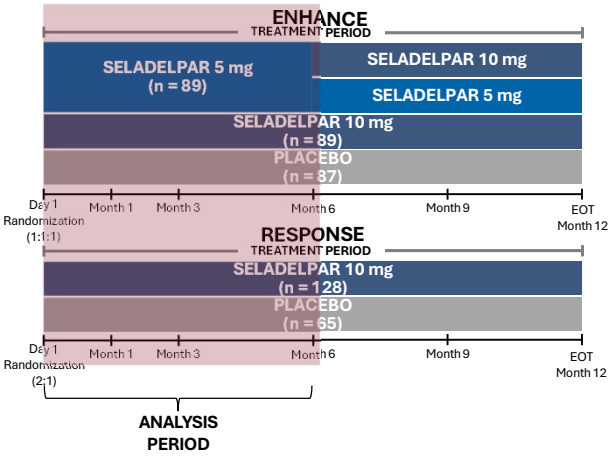
- PBC and UDCA for the past 12 months (stable dose) or intolerant to UDCA
- ALP ≥1.67 × ULN
- ALT and AST ≤3 × ULN
- TB ≤2 × ULN
- Compensated cirrhosis allowed

Stratification

- Pruritus NRS <4 vs NRS ≥4
- ALP <350 U/L vs ALP ≥350 U/L

Methods

- Patients were randomized to seladelpar 10 mg or placebo as add on therapy to UDCA (if tolerant of UDCA)
- Data up to month 6 were assessed in patients with moderate to severe pruritus at baseline (NRS score ≥4) change in daily NRS scores (range 0–10)[a]
- Change in PBC-40 itch domain scores (range 0–15)
- Change in 5-D Itch scale scores (range 5–25 for total score),
- Sleep disturbance item scores in both PBC-40 and 5-D Itch scale[b]



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Conclusions

- Consistent with previous studies, This pooled analysis demonstrated that seladelpar treatment for up to 6 months reduced pruritus to a greater extent vs placebo in patients with PBC who had moderate to severe pruritus at baseline
  - —Improvement vs placebo was evident at month 1 of treatment and was sustained through month 6 using 3 different measures of pruritus (NRS, 5-D Itch, PBC-40)
  - —Improvements in sleep disturbance were seen in patients receiving seladelpar vs placebo through month 6 using 2 different measures of (5-D itch and PBC-40)
  - —Seladelpar was overall safe and well tolerated regardless of baseline itch

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Outcomes of Liver and Cardiovascular Metabolic Diseases Among Lean vs. Non-Lean Individuals with Metabolic Dysfunction-Associated Steatotic Liver Disease —A Meta-analysis

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Background

- **MASLD (Metabolic dysfunction–associated steatotic liver disease)** is a leading cause of liver and cardiometabolic complications.
  - Traditionally associated with **overweight/obesity**, but…
  - **Lean individuals** (BMI < 25 kg/m^2, or < 23 kg/m^2 for Asian populations) can also develop MASLD.
  - Their **clinical profiles and outcomes are poorly defined** in comparison to non-lean MASLD.
- **Knowledge gap:**
  - Do lean MASLD patients experience different risks for fibrosis, cirrhosis, CVD, hypertension, or mortality?
  - Are current **screening strategies**, based on obesity alone, adequate?

Hoochuay K, Kunhapan P, Puangpetch A, et al. *World Journal of Hepatology*. 2024;16(3):452–464.

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Objectives

- **Primary Objective:**
  Compare **liver** and **cardiovascular outcomes** between **lean and non-lean individuals** with MASLD.
- **Outcomes analyzed**:
  - Liver fibrosis
  - Hepatic steatosis
  - Nonalcoholic steatohepatitis (NASH)
  - Cirrhosis
  - Hypertension
  - Cardiovascular disease (CVD)
  - Mortality

Database searched:
PubMed, Medline, Cochrane, Embase
Time frame: last 20 years (up to Feb 2025)
Final Inclusion

- 31 studies
- 10,735,550 participants

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Results (Summary)

Outcome	pOR (Lean vs Non-Lean)	95% CI	p-value	I^2 (%)	Interpretation
Liver fibrosis	2.0	1.0, 3.9	0.04	82	↑ Non-lean risk
Hepatic steatosis	2.1	1.5, 2.9	<0.001	78	↑ Non-lean risk
Hypertension	0.7	0.6, 0.9	0.002	64	↑ in non-lean (protective for lean)
Cirrhosis	0.7	0.5, 0.9	0.007	57	↑ in non-lean
NASH	1.2	0.7, 2.0	0.5	69	NS difference
Cardiovascular disease	0.9	0.7, 1.0	0.1	71	NS difference
Mortality	1.4	1.0, 2.0	0.06	84	Trend toward ↑ in non-lean

pOR = prevalence Odds Ratio
NS = non statistically significant difference

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Summary of Clinical Relevance

- Expand **screening and surveillance** for MASLD beyond BMI:
- Consider **body fat percentage**, **metabolic markers**, and **ethnicity-specific thresholds**
- Develop **risk stratification** models for *lean* individuals
- Raise awareness among:
  - Gastroenterologists
  - Primary care providers
  - Cardiologists

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Indwelling Pleural Catheters as a Safe and Convenient Alternative to Serial Thoracentesis for the Management of Hepatic Hydrothorax: A Retrospective Propensity-Matched Cohort Study

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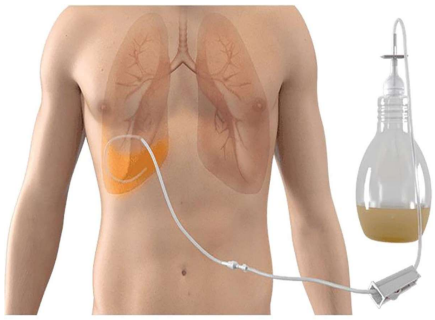
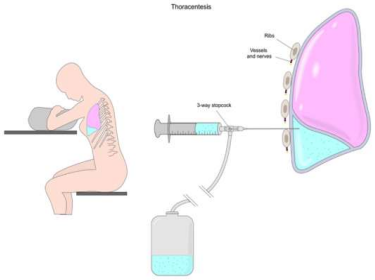
Objective of the Study

The aim of this study was to evaluate the impact of PleurX™ catheters versus serial thoracentesis in patients with HH.

IPCs[4]



Thoracentesis[5]



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Methods

- Study design: retrospective 1:1 propensity matched cohort study.
- Intervention: IPCs vs. serial thoracentesis.
- Study population: aged 18-89 years with hepatic hydrothorax secondary to liver cirrhosis of any etiology.
- Exclusion criteria: any malignancy, congestive heart failure, nephrotic syndrome, chronic kidney disease, prior TIPS placement, or pleural effusion from non-hepatic causes.
- Study cohorts:

IPCs cohort- Patients managed with IPCs placement.

Serial thoracentesis cohort- Patients undergoing ≥2 thoracentesis per month.

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Primary outcome:

All-cause mortality and healthcare utilization (emergency department and urgent care visits) within 18 months post-intervention.

Secondary outcomes

- Systemic complications: dehydration, sepsis, severe sepsis, and septic shock
- Hepatic and renal complications: hepatic encephalopathy and acute kidney injury
- Electrolyte abnormalities
- Pulmonary and infectious complications: empyema, pneumonia, and hemothorax
- Liver-related outcomes: spontaneous bacterial peritonitis, and liver transplant status

Conclusions

- IPCs placement was associated with a lower healthcare utilization (emergency room and urgent care visits), hepatic encephalopathy, pneumonia, hypokalemia, and reduced need for liver transplantation compared to serial thoracentesis in patients with HH.
- These findings suggest that IPCs may offer a safe and effective alternative for long-term effusion management in this population.
- However, prospective studies are warranted to confirm these results.

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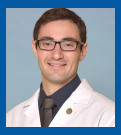
Questions



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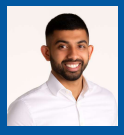

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