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**

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2026

ACG FUNCTIONAL GI & MOTILITY DISORDERS SCHOOL & MIDWEST REGIONAL POSTGRADUATE COURSE

DETROIT

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2026
ACG SUMMER SCHOOL SERIES:
WOMEN'S LEADERSHIP COURSE, IBD SCHOOL AND ESOPHAGUS SCHOOL
JUNE 5-7, 2026 | WASHINGTON MARRIOTT AT METRO CENTER WASHINGTON, DC
Register online: meetings.gi.org

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ACG 2026
OCTOBER 9-14, 2026 | NASHVILLE, TN
CALL FOR Abstracts
SUBMISSION SITE OPENS MARCH 2, 2026
SUBMISSION DATES: MARCH 2 - JUNE 1, 2026
The American College of Gastroenterology invites you to submit abstracts for presentation at the 2026 Annual Scientific Meeting and Postgraduate Course. Abstracts must be clinical or research-oriented, with a focus on gastroenterology or hepatology.
IMPORTANT DATES
MARCH 2
Submission Site OPENS
JUNE 1 | 11:59 PM ET
Submission Site CLOSES (No Exceptions!)
BY JULY 17
Notification of abstract ACCEPTANCE
SEPTEMBER 16
Presenting Authors MUST REGISTER as an attendee
ABSTRACT CATEGORIES
Biliary/Pancreas
Colon
Colorectal Cancer Prevention
Diet, Nutrition, and Obesity
Endoscopy Video
Esophagus
Functional Bowel Disease
General Endoscopy
GI Bleeding
IBD
Infections and Microbiome
Interventional Endoscopy
Liver
Pediatrics
Practice Management
Small Intestine
Stomach and Spleen
Clinical Vignettes/Case Reports
SCAN FOR THE SUBMISSION SITE
bit.ly/ACG2026_Abstracts

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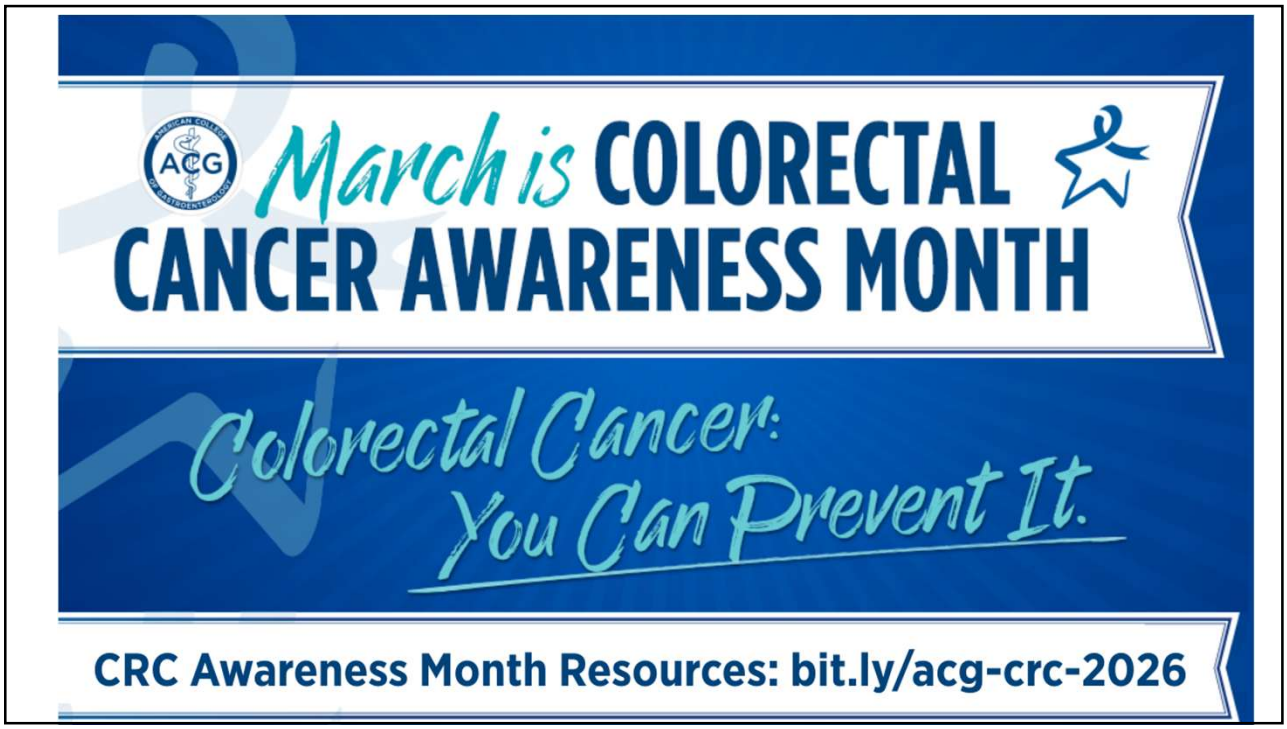
March is COLORECTAL CANCER AWARENESS MONTH
Colorectal Cancer: You Can Prevent It.
CRC Awareness Month Resources: bit.ly/acg-crc-2026

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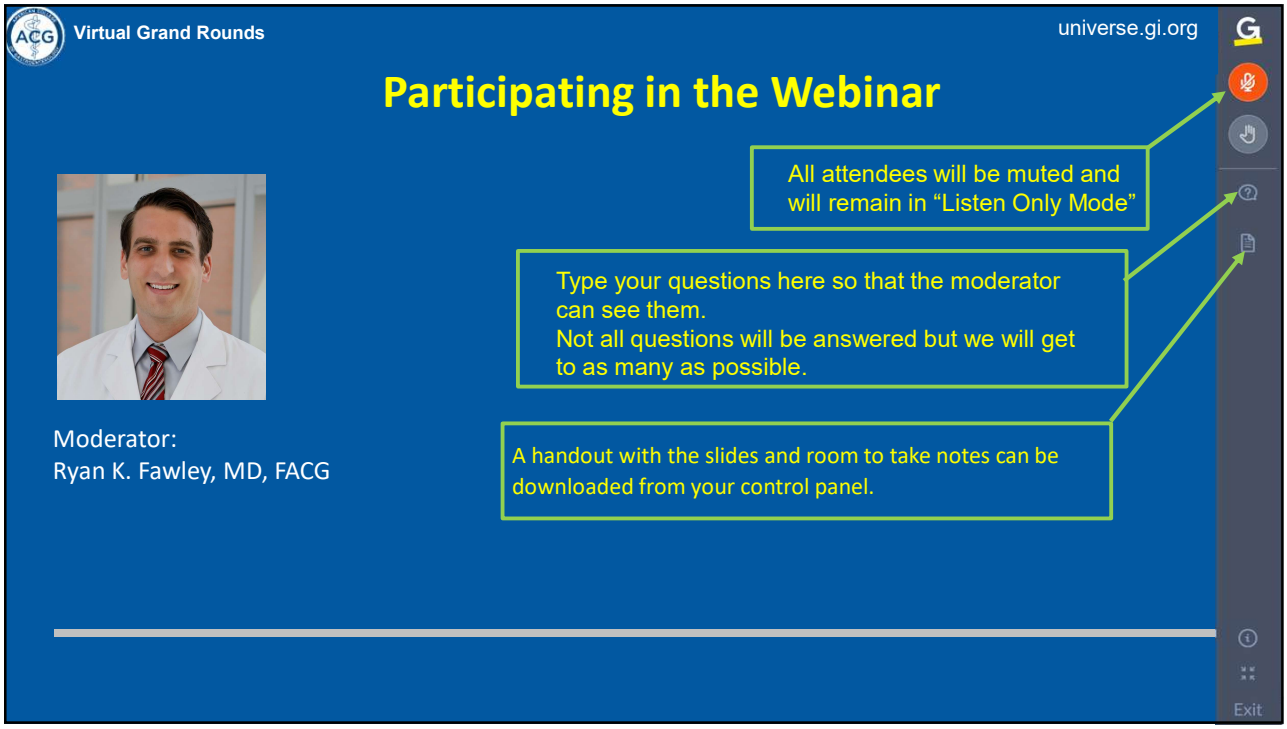
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universe.gi.org
Participating in the Webinar
All attendees will be muted and will remain in "Listen Only Mode"
Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.
A handout with the slides and room to take notes can be downloaded from your control panel.
Moderator:
Ryan K. Fawley, MD, FACG
Exit

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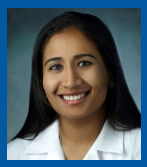
ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 12 – Thursday, March 19, 2026
AI in Colonoscopy and Beyond
Faculty: Seth A. Gross, MD, FACG
Moderator: Reezwana Chowdhury, MD, FACG
At Noon and 8pm Eastern


Week 13 – Thursday, March 26, 2026
Colon Cancer Screening and Polyp Surveillance: Considerations for the Older Adult
Faculty: Aasma Shaukat, MD, MPH, FACG, and Audrey H. Calderwood, MD, MS, FACG
At Noon and 8pm Eastern

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

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- Clinical Vignettes/Case Reports

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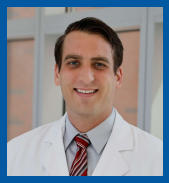
Disclosures

Carol A. Burke, MD, MACG:
AbbVie: Food and Drink; Almirall: Consult; Ambry: Other - Clarification Requested; Emtora Biosciences: Research; Ferring: Food and Drink; Freenome: Consultant; Genzyme: Food and Drink; Invitae: Other - Clarification Requested; Lumabridge: Consultant; Medtronic: Food and Drink; Merck: Food and Drink; Myriad: Food and Drink, Other - Clarification Requested; Natera: Other - Clarification Requested; Parabilis: Consultant; Salix: Food and Drink; Sebela: Consultant; US Multi-Society Task Force on Colorectal Cancer: Member



Ryan K. Fawley, MD, FACG:
No relevant financial relationships with ineligible companies.

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

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Update on Best Practices for Colonoscopy Bowel Preparation

Carol A. Burke, MD, MACG
Department of Gastroenterology, Hepatology, and Nutrition
Cleveland Clinic, OH

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MULTI-SOCIETY TASK FORCE

Optimizing bowel preparation quality for colonoscopy: consensus recommendations by the US Multi-Society Task Force on Colorectal Cancer

Brian C. Jacobson, MD, MPH,[1,2,*] Joseph C. Anderson, MD,[3,4,5,*] Carol A. Burke, MD,[6] Jason A. Dominitz, MD, MHS,[7,8] Seth A. Gross, MD,[9] Folasade P. May, MD, PhD, MPhil,[10,11] Swati G. Patel, MD, MS,[12,13] Aasma Shaukat, MD, MPH,[14] Douglas J. Robertson, MD, MPH[3,4]

Gastrointest Endosc 2025;101:702-32

CME

Optimizing Bowel Preparation Quality for Colonoscopy: Consensus Recommendations by the US Multi-Society Task Force on Colorectal Cancer

Brian C. Jacobson, MD, MPH, FACG[1,2,*], Joseph C. Anderson, MD, FACG[3,4,5,*], Carol A. Burke, MD, MACG[6], Jason A. Dominitz, MD, MHS, FACG[7,8], Seth A. Gross, MD, FACG[9], Folasade P. May, MD, PhD, MPhil[10,11], Swati G. Patel, MD, MS[12,13], Aasma Shaukat, MD, MPH, FACG[14] and Douglas J. Robertson, MD, MPH[3,4]

Gastroenterology 2025;168:798–829

Am J Gastroenterol. 2025;120:738-764

AGA SECTION

Optimizing Bowel Preparation Quality for Colonoscopy: Consensus Recommendations by the US Multi-Society Task Force on Colorectal Cancer

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Discussion Topics

*MSTF focus: ambulatory patients at low risk of inadequate bowel preparation

- Implications of bowel preparation quality
- Pre-colonoscopy considerations
- Bowel preparation regimens
- Approach to Improving inadequate bowel preparation
- Other interesting things

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Impact of Bowel Prep on Colonoscopy Metrics

	Adequate Prep	Poor Prep	p value
Exam complete	90.4%	71.1%	< 0.001
Insertion time	11.9 mins	16.1 mins	< 0.001
Withdrawal time	9.8 mins	11.3 mins	< 0.001
ADR	29.4%	23.9%	0.007
Adenoma > 10 mm	6.4%	4.3%	0.016

Gastrointest Endosc 2005;61:278-84

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Select Quality Indicators for Colonoscopy Impacted by Bowel Preparation

Measure: % examinations	Target
Bowel prep adequate	≥ 90%
Complete to cecum with photography of landmarks	≥ 95%
Adenoma Detection Rate*	≥ 35%

*≥ 45 yrs; excludes exams for follow up of non-invasive screening test

Am J Gastroenterol. 2024;119:1754-1780

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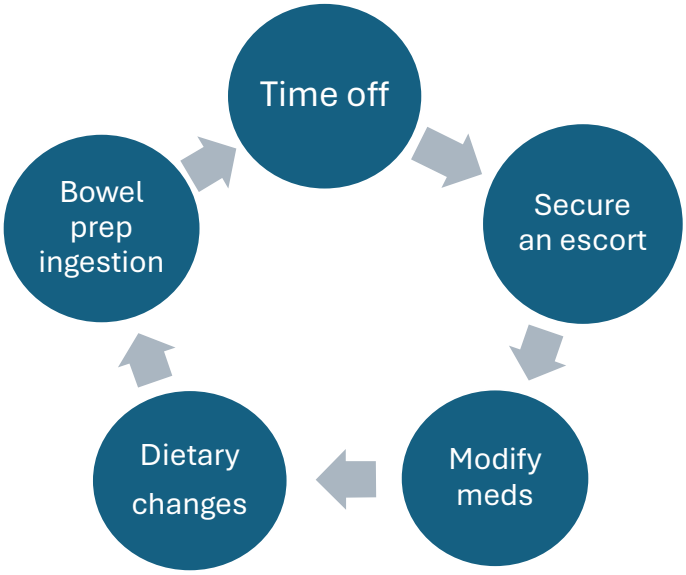
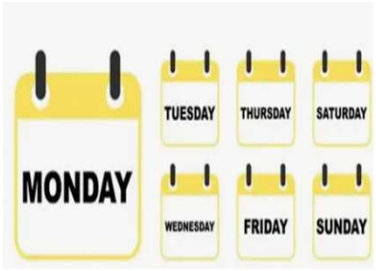
Colonoscopy is not for the faint of heart!





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Pre-colonoscopy Patient Education

- Verbal and written instructions should be provided (*strong recommendation, high-quality evidence*)

- Use patient navigation with telephone or virtual messaging reminders *(weak recommendation, moderate quality evidence)*

GOAL: increase bowel prep adequacy, decrease no show rate, enhance safety and colonoscopy completion

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Enhanced Instructions Beats Standard Instructions

Visual aids, phone calls, text messages, group discussion, smartphone apps

- Improved cleansing
  - (OR 2.35, 95 %CI 1.65 – 3.35)
- Higher cecal intubation rate
  - (OR 2.77, 95 %CI 1.73 – 4.42)
- More willingness to repeat preparation
  - (OR 1.91, 95% CI 1.20 – 3.04)

Gastrointest Endosc 2017;85:90-97
PLoS One. 2022 Apr 21;17(4):e0266780

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Pre-colonoscopy Dietary Changes

- Limit dietary modifications to day prior to colonoscopy
  (strong recommendation, high-quality evidence)

- Use low-residue, low-fiber foods or full liquids for early and midday meals day before exam when using a split-dose bowel preparation regimen
  (strong recommendation, high-quality evidence)

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Low Residue vs Clear Liquid Diet

Systematic Review and Meta-analysis

- 13 RCTs; 2587 patients

- Adequacy of prep similar: (RR 1.02; 0.99–1.05)
- Tolerability improved: (RR 1.17; 1.12–1.23)
- Adverse effects fewer: (RR 0.89; 0.84–0.94)

Not affected by volume of bowel prep!

Surgical Endosc 2022:36:3858-3875

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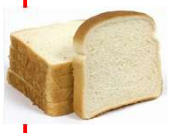
Example of Low Residue Diet

	Breakfast	Snack	Lunch	Snack	Dinner
Carbohydrate	80 g of white bread or 3 slices of white toast	1 low-fat yogurt without fruits or cereals	White rice (130 g) or plain white pasta (200 g) or peeled potatoes baked, or boiled) (300 g)	1 low-fat yogurt without fruits or cereals	White rice (130 g) or plain white pasta (200 g) or peeled potatoes baked, or boiled) (300 g
Protein	Poultry (120 g) or ham (120 g)		Lean meat: poultry (160 g) or fish (200 g) or eggs (2 units)		Lean meat: poultry (160 g) or fish (200 g) or eggs (2 units)
Dairy products	1 glass (250 ml) skim milk (coffee allowed at will)				

The LFD provide up to 2000 kcal/day with a mean dietary fibre content < 10 g





Surgical Endosc 2022:36:3858-3875

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Choice of Bowel Preparation

- No purgative superior to others regarding bowel prep adequacy *(strong recommendation, high-quality evidence)*
- Suggest 2-liter over 4-liter regimen *(weak recommendation, moderate-quality evidence)*
- 2014 guideline: In healthy, non-constipated individuals 4L PEG-ELS procedures cleansing quality that is not superior to a lower-volume PEG formulation *(strong recommendation, high-quality evidence)*

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Meta-analysis: 17 studies; 2L vs 4L split-dosing

- Low and high-volume regimens similar in efficacy
- Tolerability was superior for low volume groups
- Findings similar for PEG and non-PEG based regimens
- Non-FDA approved regimens excluded

Clin Gastroenterol Hepatol 2020;18:1454-1465

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Commonly Used Bowel Preparations

FDA Approved	MOA/Tonicity	Total Laxative/ H_2O Volume
1 L PEG/Ascorbate (PLENVU)	Osmotic/Isotonic	1 L + 2L
2 L PEG/Ascorbate (MoviPrep)	Osmotic/Isotonic	2L + 2L
Sodium Sulfate solution (Suprep)	Osmotic/Hypertonic	12 oz + 2.5L
Sodium sulfate tablets (Sutab)	Osmotic/Hypertonic	24 tabs + 2L
Sodium picosulfate/Magnesium Oxide and Citric Acid (CLENPIQ)	Osmotic/Hypertonic	10 oz + 2L
PEG-ELS (Golytely, CoLyte, NuLytely, TriLyte)	Isosmotic/Isotonic	4L
Over the Counter		
PEG 3350 + sports drink +2 tablets of bisacodyl	Hypotonic	2L
Magnesium Citrate	Osmotic/Hypertonic	24 oz + 2L

* Ascorbate is osmotically active

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Special Considerations

- Avoid hyperosmotic regimens in individuals at risk for volume overload or electrolyte disturbances
  (strong recommendation, high-quality evidence)

- Select a prep regimen that considers the individual's medical history, medications, prior bowel prep adequacy
  (strong recommendation, moderate-quality evidence)

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Choice of Bowel Preparation

Safety

Cost

Tolerability

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Select Factors Associated with Inadequate Bowel Prep

Comorbidities

- Diabetes, Cirrhosis
- Dementia, Parkinsonism, Stroke
- Gastroparesis, Constipation
- Hypertension
- Male sex, Age > 65
- Obesity
- Medicare, Medicaid vs Private Insurance
- Lower Education Level
- Inpatient status

Medications

- ACE/ARB
- Ca channel blockers
- Statins
- Aspirin
- Calcium
- Vitamin D
- Estrogen
- Opiates
- GLP1 RA?

Dig Dis Sci. 2021 June;66(6):2059-2068; MSTF2025

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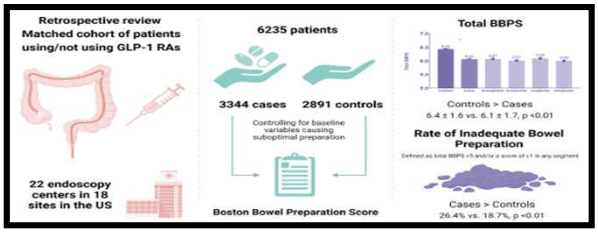
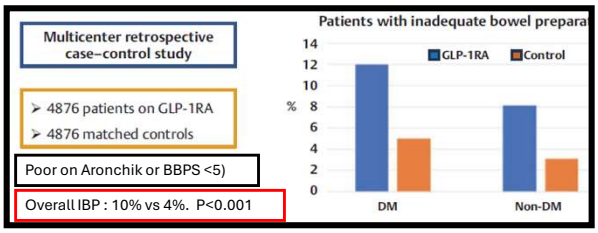
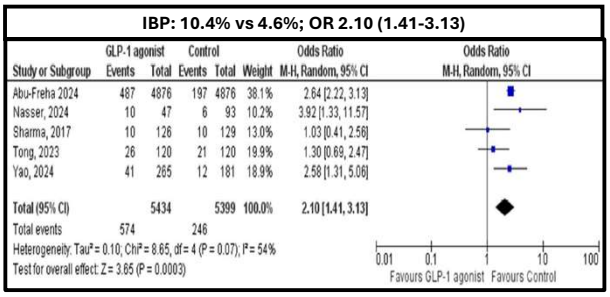
GLP1-RA and Bowel Preparation



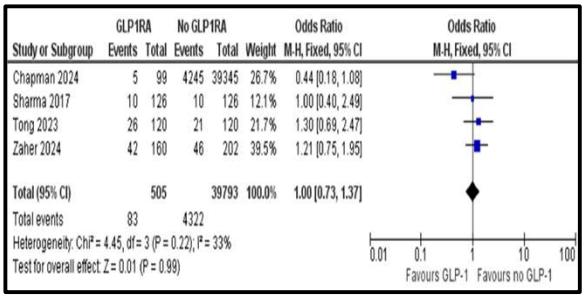
BPPS: < 5 (14.5% vs 10%) /< 1 any segment (26.5% vs 19.1%), P < .01
ADR: 48.8% vs 42.3%, P < .01. GIE 2025;101:1068-72



Excluded: CVA, Parkinson, motility d/o, opioids, anticholingergics
Endoscopy 2025; 57: 126–133



BBPS: mean difference – 0.34 (-0.51 to -0.17); **DM:** OR 1.89 (1.20-2.98)
AJG 2025;120:1653-1656



Mean difference BBPS: ; 0.36; (- 0.44 to - 0.28; P < .001);Ahmed, GIE 2025;101:343-9

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Dosing Schema for Bowel Preparation

- Use split-dosing for all patients, regardless of volume used (*strong recommendation, high-quality evidence*)
- Same-day prep acceptable alternative to split dosing for PM colonoscopy (*strong recommendation, high-quality evidence*)
- Same-day regimen is inferior to split dosing for AM colonoscopy (*weak recommendation, low-quality evidence*)

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Split Dosing

- Split dosing = at least 50 % of prep consumed day of exam
  - Increases ADR and SSP detection
  - Increases bowel preparation adequacy
  - Increases patient willingness to repeat preparation
  - Decreases nausea
- Same-day dosing for PM exams similar to split dosing
  - Adequacy of prep
  - ADR
  - Patient willingness to repeat the purgative

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Runway Time and Preparation Adequacy

- Begin 2nd dose of prep 4–6 hours before colonoscopy and complete at least 2 hours before procedure (*strong recommendation, moderate-quality evidence*)

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Measuring Bowel Prep Adequacy

Bowel Preparation Scales

- Aronchik
- Boston
- Chicago
- Ottowa
- Harefield

Assessed after cleaning

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Tactics for History of Inadequate Bowel Prep

- Use ≥ 1 of the following:
  - Limit vegetables and legumes 2-3 days before exam;
  - Ingest only clear liquids day before exam
  - Add promotility agents
  - Treat constipation, cease anti-cholinergic, opioid, or constipating meds
  - Use high-volume bowel preparation
    (*strong recommendation, moderate-quality evidence*)

- Split dose 4L PEG with 15 mg bisacodyl afternoon before exam, low residue diet 3 and 2 days before exam, clear liquid diet day before exam
  (weak recommendation, low-quality evidence)

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Tactics for History of Inadequate Bowel Prep

- 196 pts with IBP, RCT
  - 4L split dose PEG vs 6 L split dose (4L/2L)
- All: low-fiber diet 3 & 2 days before exam, CLD + 15 mg bisacodyl day before exam
- **Outcome: BPPS ≥ 6 with all segment ≥ 2: 91.2% vs 87.6% (p= .44)**
  - 4L had higher willingness to repeat prep: 91.2% vs 66.2%; (P < .001)

Clin Gastroenterol Hepatol 2022; 20(6):e1283–e1291.

- 256 pts with IBP, RCT
  - 4 L split dose PEG vs 2L split dose PEG + ascorbic acid
- All: 3-day low fiber diet, 10 mg bisacodyl day before exam
- **Outcome BBPS ≥ 6: 81.1% vs 67.4%; OR 2.07 (1.16-3.69)**
  - No difference in lesion detection, willingness to repeat, tolerability

Am J Gastro 2017;112:951–958

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Bubble Management

Preprocedural Simethicone

- Evidence inconclusive on purgative + simethicone on ADR and prep quality but decrease intraprocedural use of simethicone
  - (49% to 2%)
- A dose of at least 320 mg, if used
- Out of pocket patient cost needs consideration

Intraprocedural Simethicone

- Use lowest dilution and administer through instrument channel only
  - e.g.: 0.5 ml /99.5 ml water
- Consider endoscopic manufacturer warranty limitation

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Quality Metric Considerations

- Track rate of bowel prep adequacy
  - Endoscopy unit level
  - Endoscopist level

(strong recommendation, moderate quality evidence)

- Significant variability in bowel prep adequacy between endoscopists with shared prep process suggests endoscopists' intraprocedural efforts to enhance prep quality or assessment of adequacy may be a factor

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Intraprocedural Efforts Pay Off

- Prep quality ratings during insertion and after intraprocedural cleansing
- Prospective, single center study in 525 patients
- Outcome: Rates of adequate prep and time required to improve cleansing quality

Aronchick Scale score	Aronchick Scale scores on insertion no. (%)	Time spent washing and suctioning (minutes)	Fluid volume used (mL)	Final Aronchick Scale score after cleansing, no (%)
1, Excellent	227 (43.2)	2.77	167.8	481 (91.6)
2, Good	249 (47.4)	4.64	315.2	28 (5.3)
3, Fair	33 (6.3)	8.72	807.3	7 (1.3)
4, Poor	11 (2.1)	9.27	40.0	4 (0.8)
Procedure aborted	5 (1)	6.70	71.2	5 (1)

- Mean time: 4.1 ± 3.1 mins; was 17% of total procedure time
- Mean volume of fluid used 272 ± 273 mls (range 0-2100 mL)

Gastrointest Endosc 2015;81:525-30

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Patient Perception of Prep Adequacy

- When patients report incomplete adherence to bowel prep or suggest prep may not be adequate, we suggest inserting scope to sigmoid to confirm inadequate bowel prep before aborting procedure *(weak recommendation, low quality evidence)*

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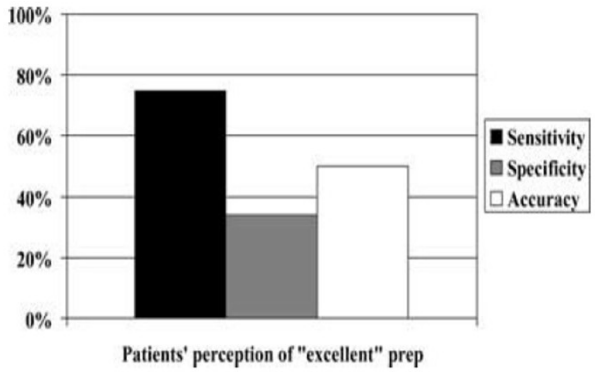
Patient Perception of Prep Adequacy

N = 474 outpatients

Global quality of preparation	Patient	MD
Excellent	69.4% (329)	38.4% (182)
Good	30.2% (143)	36.5% (173)
Fair	0.4% (2)	18.4% (87)
Poor	0	6.8% (32)

r = 0.08



Factors Associated with Accurate Patient Assessment

Variables	Odds Ratio (95% CI)
Age (≥61 yr *vs* <61 yr (median age))	0.57 (0.39–0.83)*
Gender (male *vs* female)	0.95 (0.66–1.38)
Medication (narcotics, TCADs *vs* none)	0.77 (0.35–1.67)
Prep agent (PEG *vs* sodium phosphate)	0.92 (0.62–1.35)
% prep taken (>90% *vs* ≤90%)	0.71 (0.48–1.11)

Am J Gastroenterol 2004;99(5):839–843.

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Patient Perception of Prep Adequacy

- Prospective, 429 outpatients
- Agreement between patient rectal effluent description vs endoscopist

What did you last BM look like?

- Brown liquid, Clear, water like, Brown with solid pieces, Semi-clear liquid, yellow flecks

	Endoscopist rating			$K = 0.067$, $p = 0.032$
Patient response	**Excellent**	**Good**	**Fair**	**Poor**
Clear	58 (13.5%)	80 (18.7%)	31 (7.2%)	13 (3.0%)
Semiclear	50 (11.7%)	92 (21.5%)	43 (10.0%)	10 (2.3%)
Brown liquid	7 (1.6%)	13 (3.0%)	12 (2.8%)	15 (3.5%)
Brown solid	0 (0.0%)	2 (0.5%)	2 (0.5%)	1 (0.2%)

When patients reported effluent clear or semiclear, 74%were excellent or good
When patients reported effluent brown liquid or brown with solid pieces, 42% were excellent or good

Gastrointest Endosc 2010;71:1244-52

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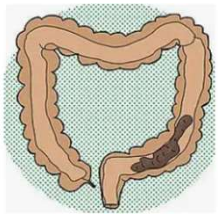
Quality Considerations Aborted Exams



If colonoscopy aborted due to inadequate prep, photos of segments causing procedure cessation should be obtained

This will aid in quality assurance efforts in setting of variability in cancellation rates among endoscopy unit's endoscopists

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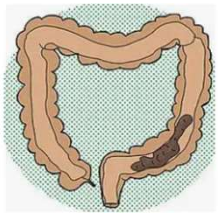
Practical Considerations Aborted Exams



If left colon (rectum through descending) is well visualized during screening colonoscopy with otherwise more proximal IBP, reasonable to consider screening options with patient and referring provider

Rationale: The limited colonoscopy can be considered adequately screened and should repeat sigmoidoscopy or colonoscopy in 5 yrs or use of non-endoscopic CRC screening tests as per MSTF and USPSTF

MSTF 2025

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Follow up for Inadequate Bowel Preparation

- If bowel prep deemed inadequate to allow standard screening or surveillance intervals, recommend rescheduling a colonoscopy within 12 months and as soon as possible (generally within 3 mos.) for exams done for abnormal non-colonoscopy CRC screening test follow up

  (strong recommendation, moderate quality evidence)

If colonoscopy indication was for alarm symptoms, repeat ASAP

MSTF 2014, MSTF 2025; ESGE 2019 Endoscopy2019;51:775–794

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Adherence to FU for Inadequate Bowel Preparation

- 373 average risk outpatients with IBP between 2004-2009
- Assessed adherence to recommendation FU interval within 10% of time specified in colonoscopy report

Recommended Interval	Number Patients	% Pts Recommended Interval	% Adherent
Next day	17	6.3%	47.1%
2 days-6 mos.	37	13.8%	18.9%
7 mos. – 1 yr	127	47.2%	15.0%
> 1 yr	192	32.7%	19.3%

Next day exam vs > 1 day (OR 4.4, 1.6–12.3)

- MDs more likely to recommend repeat within 1 yr if polyps detected (OR = 2.2, 1.4–3.5)

Dig Dis Sci 2013; 58(8):2151–2155.

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Take Home Points

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- Tailor approach to your patient- communicate rational and importance of prep process
  - Instructional materials, navigation
  - Comorbidities, Medications, Cost, Safety
  - Previous results of bowel preparation
- Use low residue diet, split prep, last dose 4-6 hrs. before exam
- Understand special circumstances
- Track quality: unit level and endoscopist level

Thank you!

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Questions

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