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**

1

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**

2


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

3

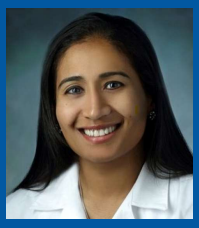

2026
ACG FUNCTIONAL GI & MOTILITY DISORDERS SCHOOL & MIDWEST
REGIONAL POSTGRADUATE COURSE
DETROIT

4

Virtual Grand Rounds

universe.gi.org

Participating in the Webinar



Moderator:
Reezwana Chowdhury, 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

5

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

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

Week 14 – Thursday, April 2, 2026
There will be no ACG Virtual Grand Rounds presentation on Thursday, April 2, 2026.

Week 15 – Thursday, April 9, 2026
Parkinson's Disease and the Gut
Faculty: Amol Sharma, MD, MSc, FACG
Moderator: Ali Keshavarzian, MD, MACG
At Noon and 8pm Eastern

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

6

7

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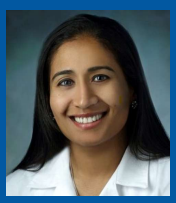
Disclosures

universe.gi.org

Seth A. Gross, MD, FACG:
Colowrap: Consultant; Cook: Consultant; Medtronic: Consultant; Microtech: Consultant; Olympus: Consultant.



Reezwana Chowdhury, MD, FACG:
Celltrion: Advisory Board.

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

8

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NYU Langone Health

AI IN COLONOSCOPY AND BEYOND

Seth A. Gross, MD, FACG
Clinical Chief of Gastroenterology and Hepatology
NYU Langone Health
Professor of Medicine
NYU Grossman School of Medicine

9

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Objectives

- Review AI applications available today
- Discuss the focus on CADq
- Highlight what is on the AI horizon
- Discuss AI for training

10

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Where We Are…

11

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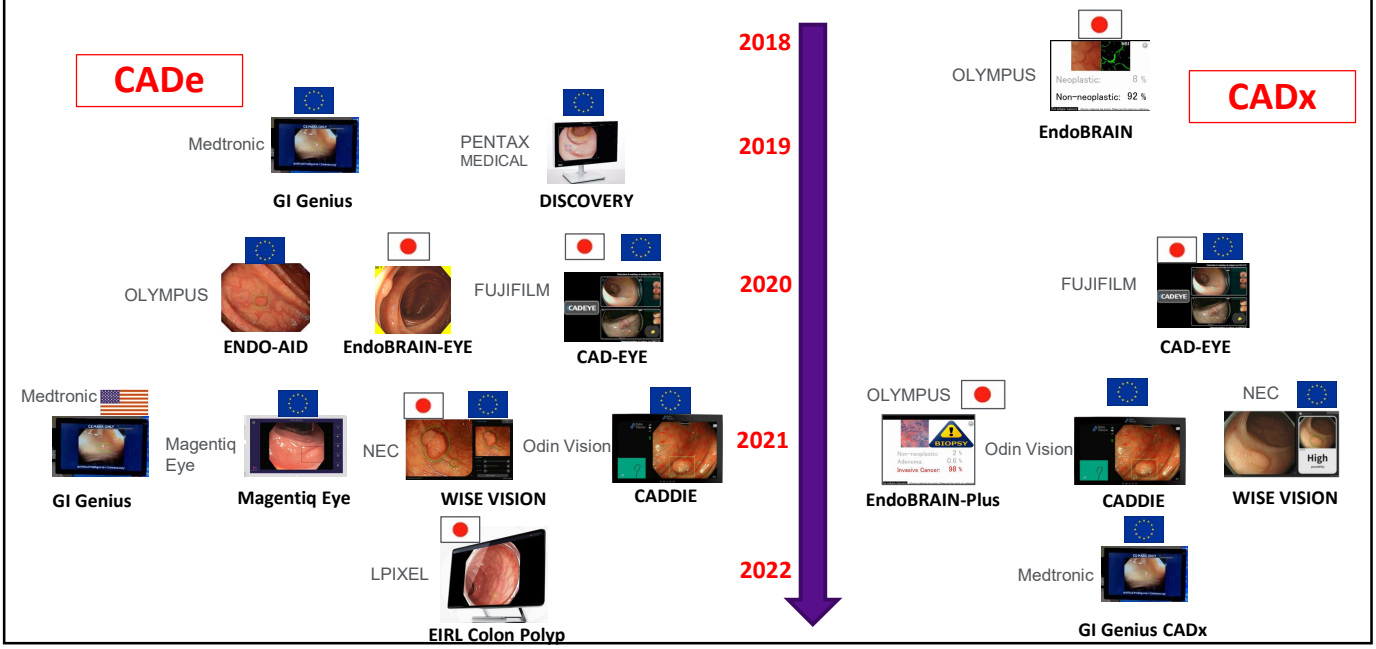
Regulatory Approval of AI in Colonoscopy



12

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Beyond Colonoscopy

- **Upper GI & Barrett's Esophagus**
- **CADU® (Odin Vision/Olympus)** — AI for Barrett's esophagus (dysplasia detection/characterization); CE-marked (also UKCA).
- **IBD Endoscopy (activity scoring/quality)**
- **SMARTIBD® (Odin Vision/Olympus)** — Cloud-AI for objective inflammatory activity scoring and reporting; CE-marked 2024.
- **Capsule Endoscopy (AI-assisted reading)**
- **NaviCam® ProScan™ (AnX Robotica)** — AI-assisted reading tool for small-bowel capsule; vendor states FDA clearance and CE mark for EU

13

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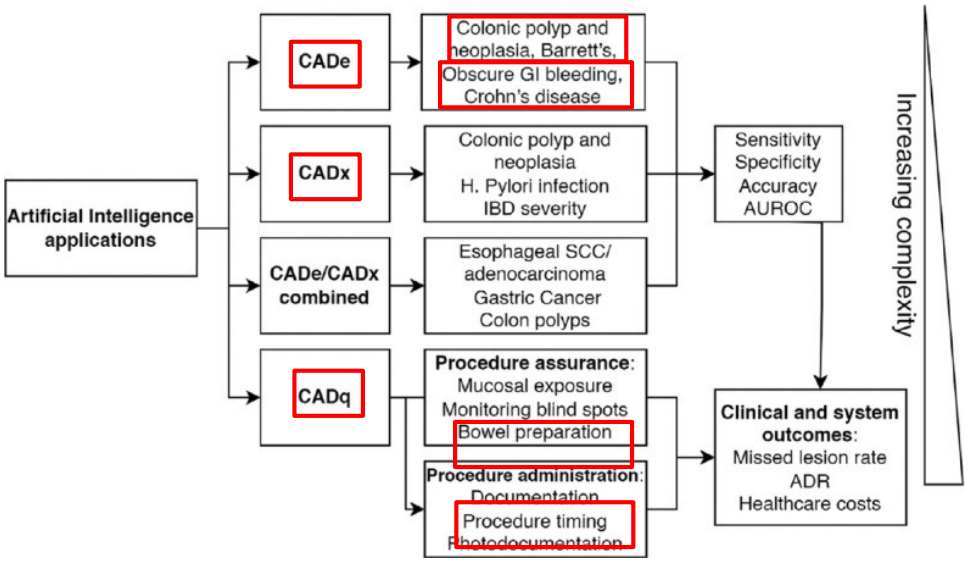
The Dream: Complete AI Story



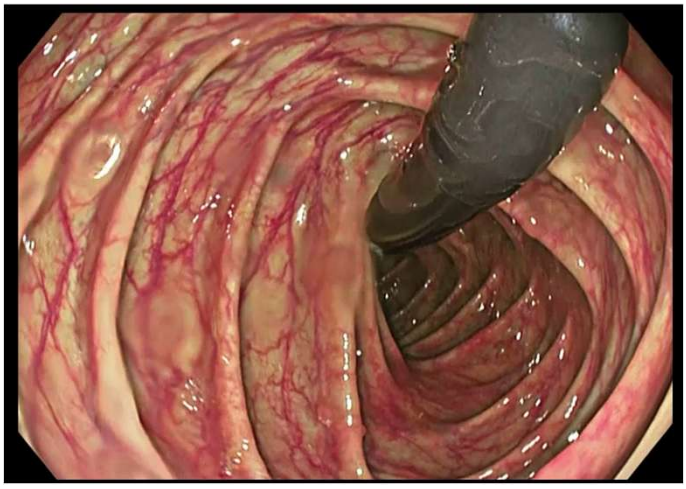
Arif AA et al. Saudi J of Gastro 2023; 29:269

14

Detection = CADe

15

Easy and Fast



16

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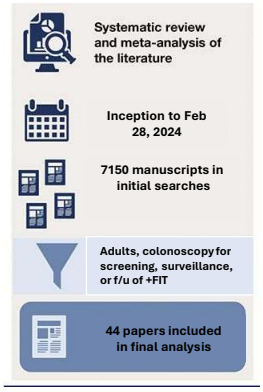
Annals of Internal Medicine REVIEW

Artificial Intelligence–Assisted Colonoscopy for Polyp Detection

A Systematic Review and Meta-analysis

Saeed Soleymanjahi, MD, MPH; Jack Huebner, MD; Lina Elmansy, BS; Niroop Rajashekar, BS; Nando Lüdtke, BS; Rumzah Paracha, MD; Rachel Thompson, MD; Alyssa A. Grimshaw, MBA, MSLIS, MPH; Farid Foroutan, PhD; Shahnaz Sultan, MD, MHSc; and Dennis L. Shung, MD, MHS, PhD

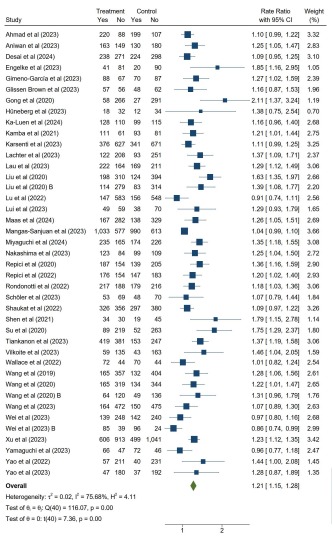


44,000 patients

Benefit
- ADR 44.4% versus 36.7%
- APC 0.98 versus 0.78
- Adv. neopl. detection rate 12.7% versus 11.5%

Harm
- Non-neoplastic polyps 53% versus 33%
- Resected polyps are non-neoplastic rate: 34% versus 29%

Burden
- Withdrawal time 10.33 versus 9.68 min.



17

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Variable	Pre-CADe Deployment		Post-CADe Deployment	
	Control Sites (N=97)	CADe Sites (N=42)	Control Sites (N=97)	CADe Sites (N=42)
Number of Colonoscopies	**151,792**	**71,594**	**75,415**	**35,399**
Adenoma Detection Rate*	51.8%	**50.7%**	51.1%	**54.9%**
Withdrawal Time	10.2 (7.7-13.7)	10.6 (8.2-14.3)	9.8 (7.4-13.0)	10.9 (8.2-14.8)
Provider Characteristics				
Gastroenterology	53.0%	**51.4%**	52.0%	**55.5%**
Surgeon	42.7%	**43.9%**	43.2%	**47.9%**
Provider Years Since Medical Degree				
<5	55.4%	**53.5%**	53.5%	53.2%
5-9	58.1%	**55.3%**	57.7%	57.6%
10-14	55.8%	**56.3%**	53.7%	58.5%
15-19	54.6%	**54.8%**	55.7%	59.3%
20-29	51.2%	**51.4%**	50.2%	55.2%
30-39	48.3%	**47.7%**	48.5%	51.8%
40+	47.1%	**42.2%**	45.8%	50.4%

Jason A. Dominitz, MD, et al. DDW 2024

18

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AI Impact in Patients with Positive FIT

- FIT-based CRC screening programs reduce mortality - colonoscopy after + FIT is standard
- RCT (*n* = 1009), CADe did not improve advanced adenoma detection rate (AADR).
- CADe significantly increased overall ADR and APC

Spada C, et al. United European Gastroenterol J. 2026 Feb;14(1):e70176.

19

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	CADe colonoscopy $n = 506$	Standard colonoscopy $n = 503$	95% CI %difference or Cohen's d effect size[a]	*p* value
AADR *n* (%)	108 (21.3%)	103 (20.5%)	[−4.3%, 6.1%]	0.794
ADR *n* (%)	342 (67.6%)	301 (59.8%)	[1.6%, 13.9%]	0.012
PDR *n* (%)	401 (79.2%)	350 (69.6%)	[4.1%, 15.2%]	< 0.001
PPC mean ± SD	2.62 ± 2.65	2.04 ± 2.47	$d = 0.23$	< 0.001
APC mean ± SD	1.82 ± 2.12	1.34 ± 1.81	$d = 0.24$	< 0.001
ASPC mean ± SD	2.09 ± 2.27	1.63 ± 2.05	$d = 0.21$	< 0.001
SSLDR *n* (%)	91 (18.2%)	91 (18.3%)	[−4.9%, 4.7%]	1000
Withdrawal time min (SD)	17:10 ± 8:28	16:13 ± 8:28	$d = 0.09$	0.016
(S)AE *n* (%)	0	0	—	—

Spada C, et al. United European Gastroenterol J. 2026 Feb;14(1):e70176.

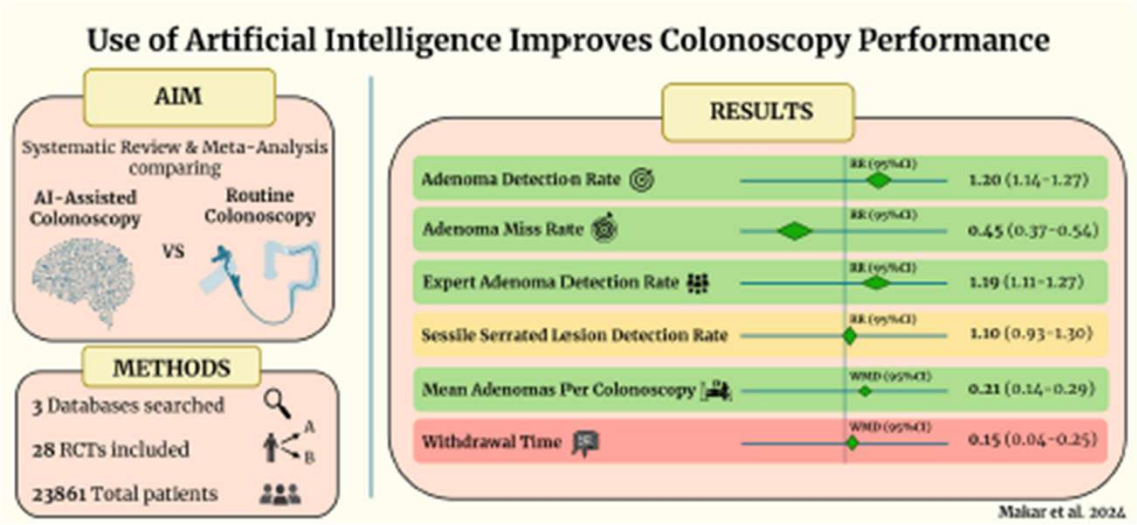
20

	Proximal colon[a]				Distal colon[b]			
Size, *n* (%)	CADe (*n* = 840)	SC (*n* = 636)	95% CI % difference[c]	*p* value	CADe (*n* = 485)	SC (*n* = 390)	95% CI %difference[£]	*p* value
Adenoma								
≤ 5 mm	493 (58.7%)	315 (49.5%)	[−0.9%, 14.4%]	0.150	182 (37.5%)	122 (31.3%)	[−0.3%, 12.7%]	0.988
6–9 mm	69 (8.2%)	67 (10.5%)	[−5.4%, 0.8%]	0.944	71 (14.6%)	65 (16.7%)	[−7.1%, 3.1%]	0.340
≥ 10 mm	49 (5.8%)	44 (6.9%)	[−3.7%, 1.5%]	0.383	55 (11.3%)	62 (15.8%)	[−9.4%, 0.3%]	0.758
Sessile serrated lesion								
≤ 5 mm	53 (6.3%)	72 (11.3%)	[−8.1%, 1.9%]	0.801	16 (3.3%)	12 (3.1%)	[−2.3%, 2.7%]	0.999
6–9 mm	42 (5.0%)	33 (5.2%)	[−2.6%, 2.2%]	1000	6 (1.2%)	5 (1.3%)	[−1.6%, 1.5%]	1000
≥ 10 mm	13 (1.5%)	19 (2.9%)	[−3.1%, 2.9%]	0.961	1 (0.0%)	2 (0.0%)	[−1.4%, 0.5%]	0.999

[a]Located in the cecum, ascending colon, right colic flexure, or transverse colon.
[b]Located in the left colic flexure, descending colon, sigmoid colon, or rectum. *p*-values were carried out by test for proportion.
[c]95% CI of the percentage differences were performed for differences in proportions between the two study groups.

Spada C, et al. United European Gastroenterol J. 2026 Feb;14(1):e70176.

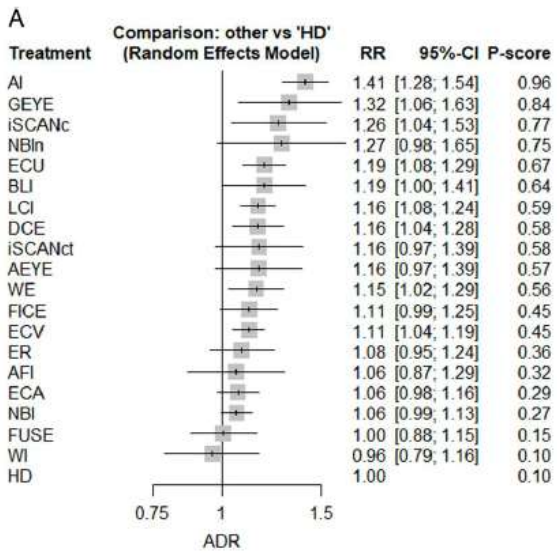
21



Abdelmalak MJ et al. Gastrointest Endosc. 2025 Jan;101(1):68-81

22

Colonoscopy Enhancements



Aziz, M. , Haghbin, H. , Sayeh, W. et al. *Journal of Clinical Gastroenterology, 58* (2), 143-155.

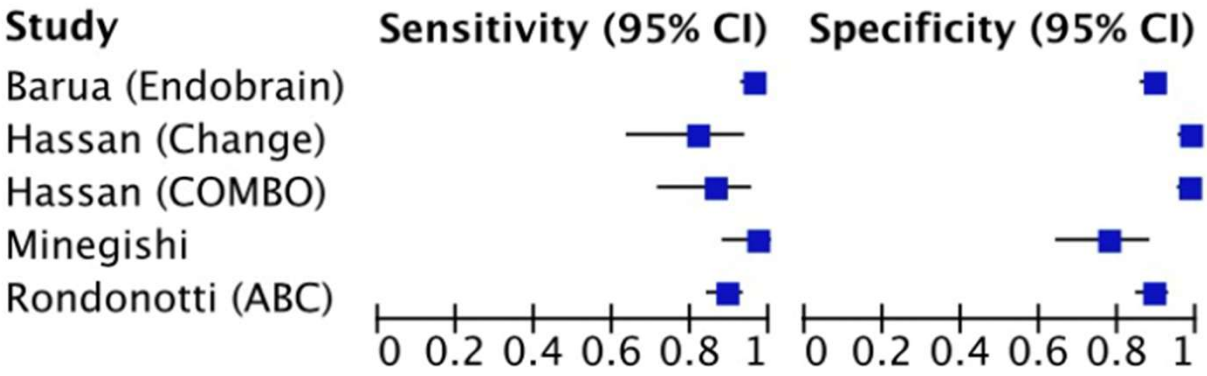
23

Easy and Fast - CADx

Hassan C et al. Clin Gastroenterol Hepatol (in press), 2022

24

META-ANALYSIS CADx: Accuracy



25

Accuracy of Computer-aided Diagnosis in Colonoscopy Varies according to Polyp Location. A Systematic Review and Meta-analysis.

CADx-Alone Diagnostic performance: Data based on 7,782 ≤ 5mm polyps from 11 diagnostic accuracy studies. * Results based on a bivariate model ** Results based on a univariate model	Proximal colon (cecum + ascending colon + transverse colon + descending colon) Pooled data [95% CI]	Risk Ratio [95% CI]	Distal colon (Rectum + sigmoid colon) Pooled data [95% CI]
Sensitivity*	0.89 [0.83, 0.93]	1.00 [0.97, 1.03]	0.87 [0.80, 0.92]
Specificity*	0.62 [0.52, 0.71]	0.74 [0.72, 0.84]	0.85 [0.75, 0.92]
Negative Predictive Value**	0.64 [0.55, 0.72]	0.71 [0.64, 0.79]	0.93 [0.90, 0.95]
Positive Predictive Value**	0.87 [0.84, 0.91]	1.11 [1.06, 1.17]	0.76 [0.70, 0.82]
Accuracy**	0.81 [0.77, 0.85]	0.95 [0.91, 0.99]	0.86 [0.83, 0.90]

Highlights

CADx alone diagnostic performance is lower in the proximal colon versus the distal colon, mainly due to lower specificity

Due to the higher prevalence of neoplastic polyps in the proximal colon, a lower negative predictive value was observed in the proximal colon.

Clinical Gastroenterology and Hepatology

Fugazza A et al. Clin Gastroenterol Hepatol. 2025 Mar;23(4):531-541.

26

Computer Aided Quality (CADq)

27

Quality Colonoscopy Metrics

Metric	Current	Updates
Adequate Bowel Prep	≥ 85%	≥ 90%
Withdrawal Rate	≥ 6mins	≥ 8mins
Cecum Intubation	>90%	>90%
Adherence to Surveillance Guidelines	≥ 90%	≥ 90%
Resection Method *4-9mm*	Not Mentioned	Cold Snare ≥90%
Resection Documentation *(Size, Location, Shape, Tooling)*	Not Mentioned	Complete documentation in ≥98% of resections

Courtesy of Dr. Aasma Shaukat

28

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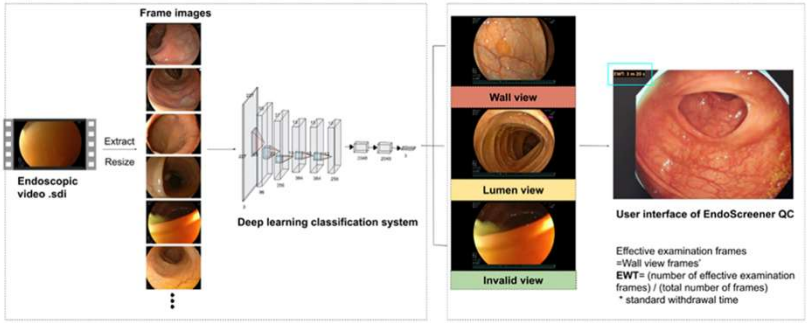
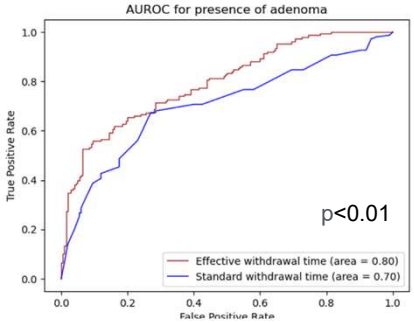
Computer Aided Quality (CADq)

Effective Withdrawal Time (EWT)





Each minute increase in EWT was associated with a 49% increase in ADR

Gastrointest Endosc. 2024 Mar;99(3):419-427.e6. .

29

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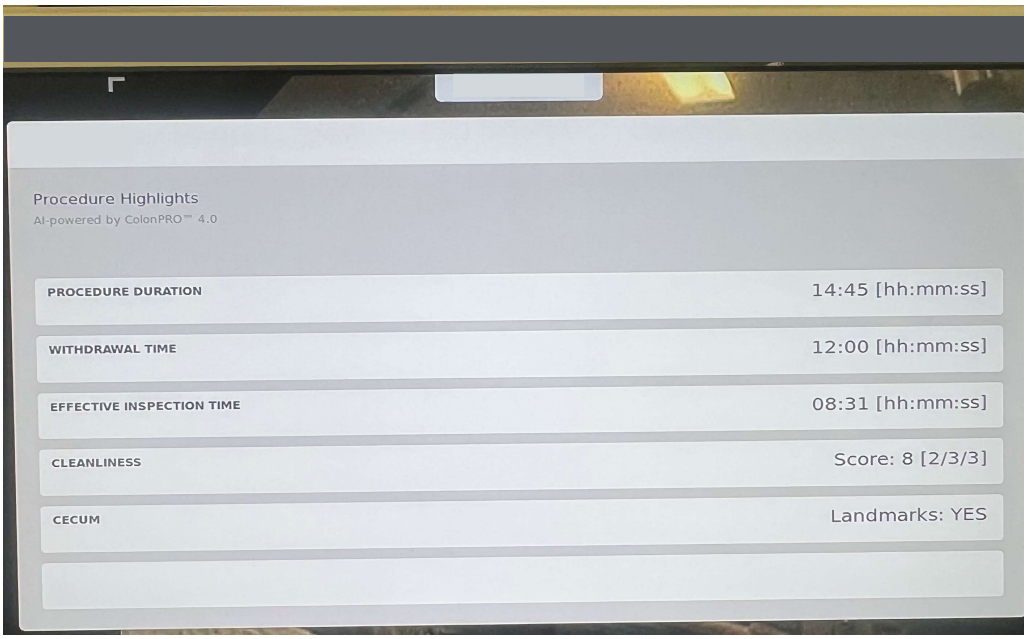
CADq is Now



30

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Monitoring Blind-Spots in Upper Endoscopy

	ENDOANGEL (n=498)	CONTROL (n=504)	p-value
# blind spots	5.38 (4.32)	9.82 (4.98)	<0.01
inspection time	5.40 (3.82)	4.38 (3.91)	<0.01

Endoscopy. 2021 Dec;53(12):1199-1207.

31

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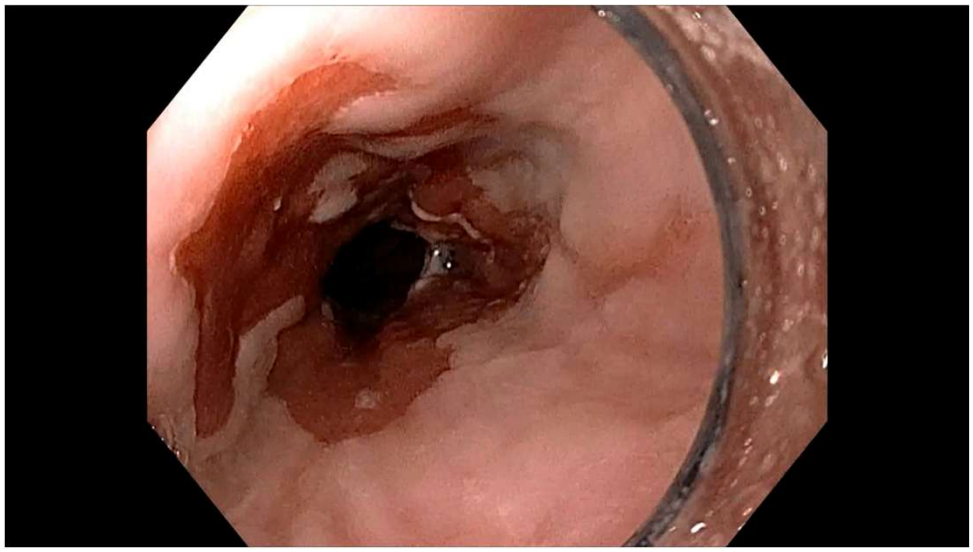
AI Assisted Barrett's Surveillance Procedure



32

32

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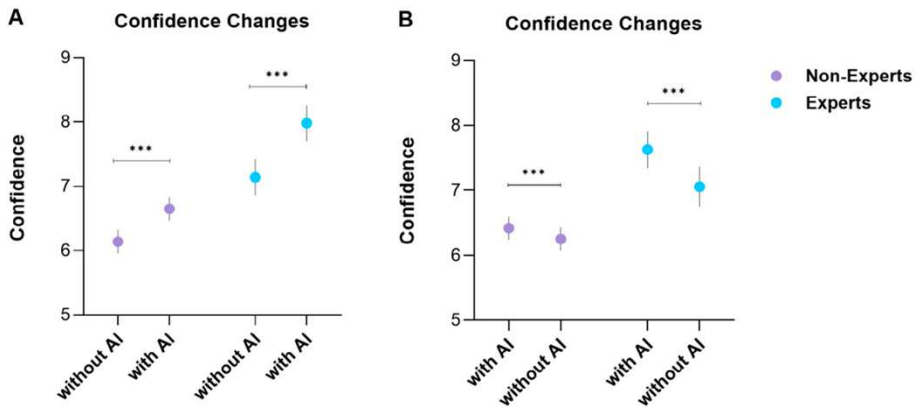
Improved Confidence BE-related neoplasia (BERN)



Rose D. et al. DEN Open 2026

33

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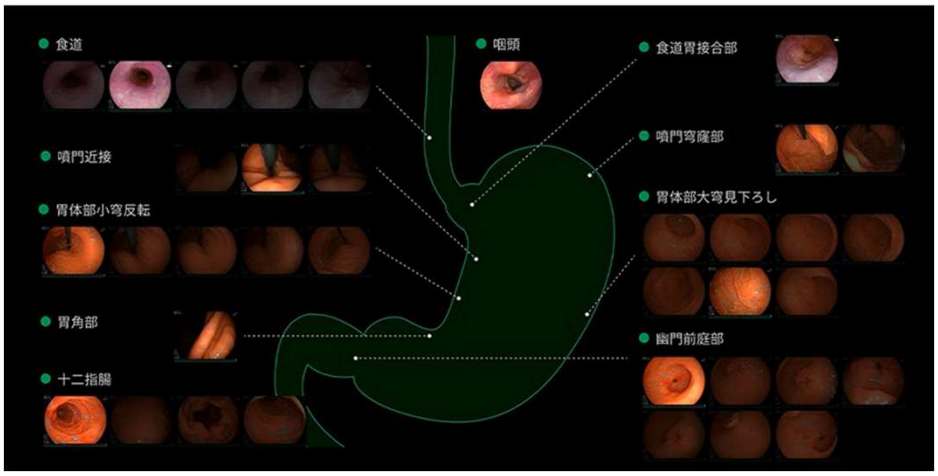
Improve Endoscopy Reporting

Upper GI



Sekiguchi et al. Digestive endoscopy 2026

34

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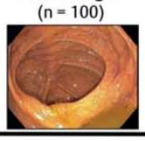
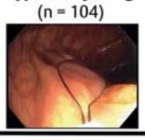
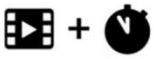
Lower GI

Artificial intelligence (AI)-assisted reporting – precise and efficient

AI improves:	Image reporting		Withdrawal time reporting
Ground truth Videos of 100 colonoscopies from 5 centers	Cecal images (n = 100) 	Polypectomy images (n = 104) 	Median Δt (n = 98) 
Examiners' reports	88 (88%)	38 (36.5%)	120 seconds
AI reports	**98 (98%)**	**68 (65.4%)**	**24 seconds**

Endoscopy

Endoscopy. 2023 Dec;55(12):1118-1123.

35

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Capsule Endoscopy AI

Ready for Primetime

ANX ROBOTICA ANNOUNCES FDA CLEARANCE FOR PROSCAN™: A GROUNDBREAKING AI ASSISTED READING TOOL FOR SMALL BOWEL VIDEO CAPSULE ENDOSCOPY

Press Releases

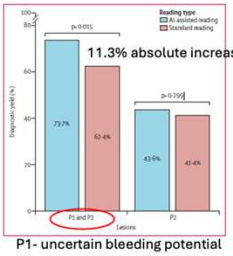
FLOW DIAGRAM

133 patients
↓
Standard CE read (enrollment center)
↓
AI CE read (blinded center)
↓
Central Review of Videos

DEMOGRAPHIC DATA

	N=133
Female	73 (55%)
Bowel cleansing Good-excellent	98 (74%)
Main Diagnosis	
Negative	28 (21%)
Vascular lesion	86 (65%)
Mucosal lesion	16 (12%)
Protruding lesion	2 (2.3%)

RESULTS



P1- uncertain bleeding potential
P2- high bleeding potential

Sensitivity 79.0% ; Specificity 100%
Sensitivity 93.3% ; Specificity 100%

33.7 ±22.9 vs 3.8 ±3.3 min

Lancet Digit Health 2024 May;6(5):e345-e353.

36

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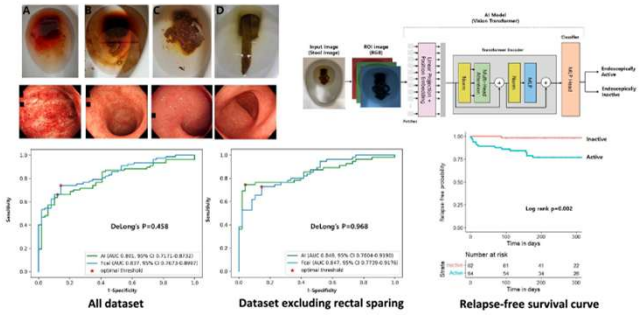
Patient-Centered AI

Wait…don't flush

AI model of stool pictures to predict endoscopy UC activity



Am J Gastroenterol. 2024 Jul 25.

accuracy 85%, sensitivity 75%, specificity 96% in patients without rectal sparing

AI model to predict bowel preparation before colonoscopy

Dig Endosc. 2024 Jun 21.

prospective study (n=106) 99.0% achieved a BBPS ≥6

37

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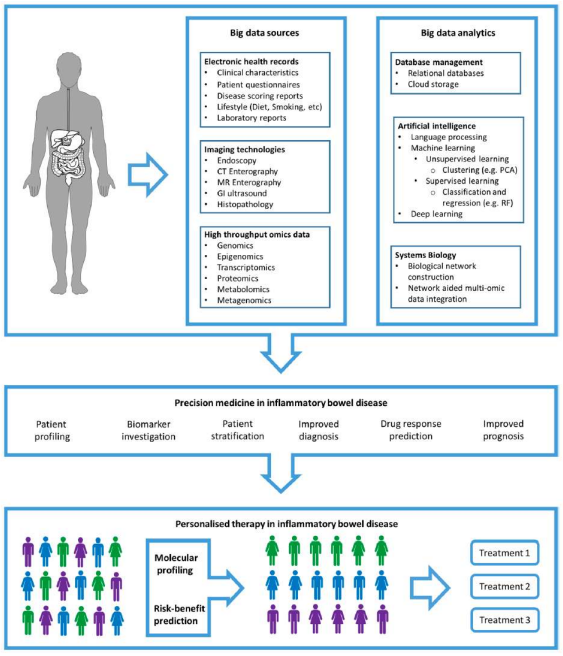
AI for IBD



Seyed Tabib NS, *et al*. *Gut* 2020;**69**:1520–1532. doi:10.1136/gutjnl-2019-320065

38

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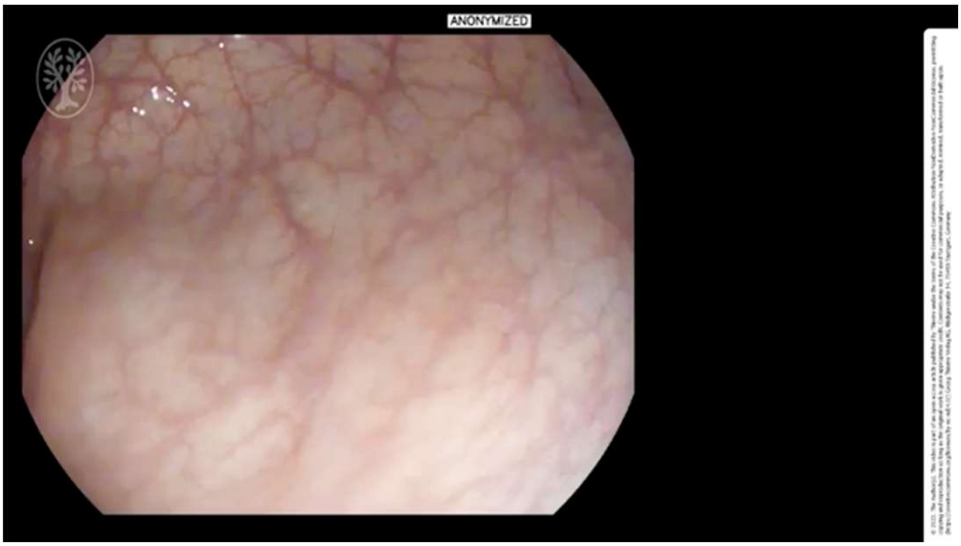

Iacucci Marietta et al. A virtual chromoendoscopy… Endoscopy 2023; 55: 332–341

39

Virtual Grand Rounds

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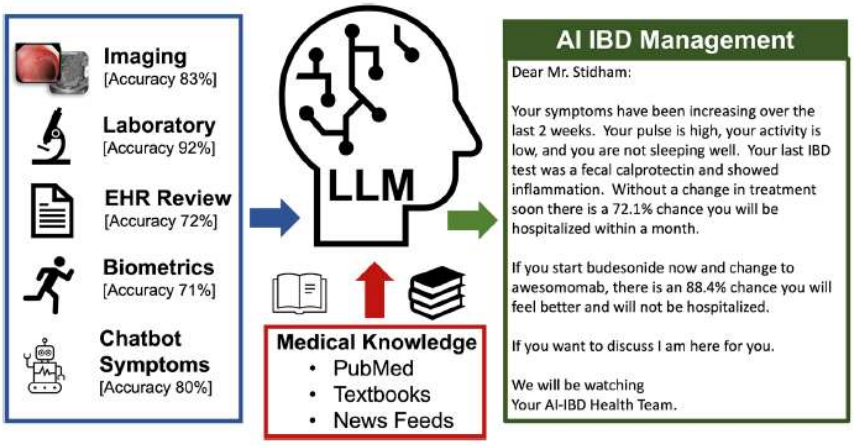
Automated IBD Care



Current Gastroenterology Reports
https://doi.org/10.1007/s11894-024-00918-8

40

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AI and Physician Training in GI

41

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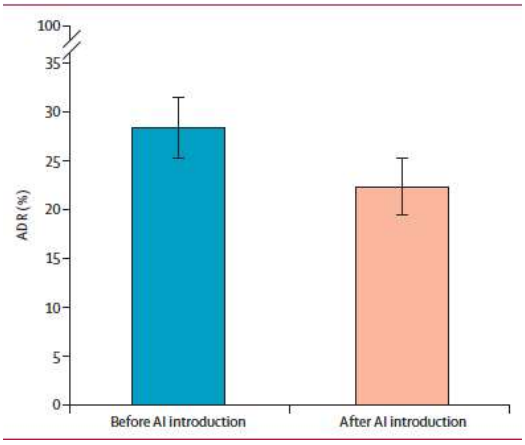
Deskilling in Colonoscopy

	Before AI implementation (n=795)	After AI implementation (n=648)	Difference (95% CI)	p value
ADR	226 (28·4%)	145 (22·4%)	−6·0 (−10·5 to −1·6)	0·0089*
Adenomas per colonoscopy	0·54 (1·23)	0·43 (1·13)	0·11 (−0·01 to 0·24)	0·071†
Advanced adenomas per colonoscopy	0·062 (0·27)	0·063 (0·33)	−0·002 (−0·03 to 0·03)	0·92†

Data are n (%) or mean (SD). AI=artificial intelligence. ADR=adenoma detection rate. *χ^2 test. †t test.

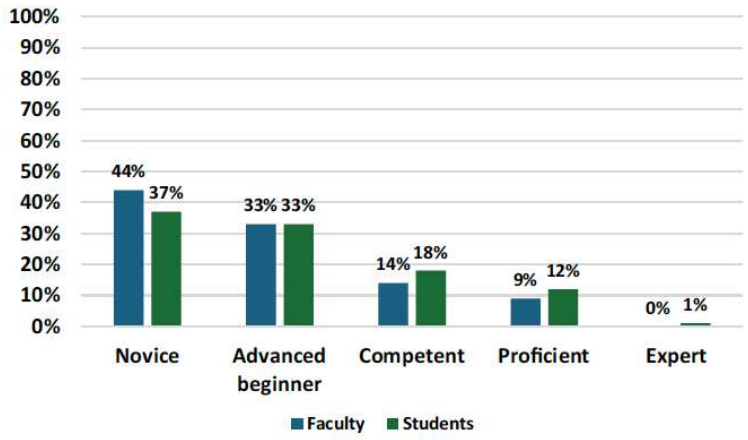
Table 2: **Quality indicators of standard, non-AI assisted colonoscopy before and after AI introduction**



Budzyń K, et al. Lancet Gastroenterol Hepatol. 2025 Oct;10(10):896-903.

42

AI Knowledge Level



Blanco MA, Med Educ Online. 2025 Dec;30.

43

Positive:

- **Use of AI during endoscopy training can serve as an on-demand ‘instructor’ for trainees**

Negative:

- **Adding AI to an already demanding task accelerates acquisition of these skills or results in cognitive overload**

44

AI in Endoscopy Impact on Trainees

- Computer-aided detection is at the forefront of AI in endoscopy
- A recent meta-analysis adenoma miss rate 17% and serrated polyp miss rate 27%
- Trainees have difficulties with polyp detection.
  - Proximal colon adenoma miss rate (pAMR) and proximal colon sessile serrated polyp miss rate (pSMR) were high (41% and 56%, respectively
  - Both these rates decreased as trainees advanced in training

Zhao S, Gastroenterology. 2019 May;156(6):1661-1674
Lalehzari M, Gastrointestinal Endoscopy, Volume 95, Issue 6, AB54

45

Lesion Interpretation:

- Trainees have trouble differentiating neoplastic and non-neoplastic polyps
- CADx, similar to CADe, offers the opportunity to utilize artificial intelligence to identify abnormalities
- Yoshida et al found that CADx detection rates for differentiating neoplastic and hyperplastic lesions with blue-laser imaging/blue-light imaging was 87.8%, which was significantly higher than trainees (79.0%)

Small Bowel Capsule:

- AI is also commonly used in small bowel capsule endoscopy (SBCE), which is inherently difficult to interpret, especially for trainees.
- By assisting with this complex, high-volume reading process, AI can help trainees learn to interpret SBCE more effectively.

Yoshida N. Int J Colorectal Dis. 2021 Oct;36(10):2237-2245
Nielsen AB, Endosc Int Open. 2024 May 29;12(5):E697-E703..

46

Beyond Endoscopy

- Medical management of complex GI conditions
- Interpretation of motility tests
  - Trainee could first interpret a motility study and, after independent interpretation, utilize AI to "check" their work

47

The Clinical Expert

- Trainees often struggle with rapid decisions for medically complex patients in short 15–30 minute visits
- Generative AI can quickly read and synthesize unstructured data (history, risk factors, imaging, endoscopy reports)
- Summarizes complex charts so clinicians can focus on key management decisions
- May help reduce redundant tests and interventions by highlighting what has already been done

48

- When linked to risk scores, AI can:
  - Flag when screening colonoscopy is due
  - Suggest next-line treatments to consider
- Future tools may help manage complex diseases (eg, IBD, autoimmune hepatitis) that require detailed histories
- LLMs integrated with the EHR can act as an “expert colleague” for:
  - Summarizing prior colonoscopy findings
  - Checking mechanisms of action and drug interactions in real time

49

In Research

- Can streamline research tasks (eg, grant applications, IRB forms, and other paperwork)
- Trainees must follow institutional/funder rules on AI use and disclosure; some journals may restrict AI-generated content
- Current LLMs can help organize ideas but may:
  - Produce unoriginal research questions
  - Generate fake citations or papers, risking scientific accuracy
- More accurate, customized outputs

50

Table 1. Summary of Generative AI Applications in Gastroenterology

Areas of application	LLM capabilities	Examples	Limitations
Documentation	• Summarize complex medical records and data. • Generate documentation for providers and patients.	• Drafting clinical notes or discharge summaries. • Generating jargon-free patient instructions.	• LLMs may fabricate aspects of clinical data, which are not accurate.
Clinical decision making	• Suggest diagnostic steps or treatment options based on clinical data and published evidence.	• Individualized risk assessment for CRC screening. • Personalized treatment algorithms for IBD. • Generation of differential diagnoses.	• AI tools may replicate biases that exist in available datasets. • Diagnostic blind spots, which vary between AI models.
Research	• Assist in completing academic writing tasks. • Support data analysis, literature exploration, and idea generation for research projects.	• Drafting sections of an IRB application. • Writing a jargon-free consent form for study participants. • Generating a preliminary literature search/analysis.	• Risk of fabricating or replicating research concepts. • Confidential data cannot be entered into public LLM tools. • Strict transparency requirements when using LLM tools for research output of any type (grants, articles etc).

Ahmed, et al.Clinical Gastroenterology and Hepatology, Volume 22, Issue 10, 1975 - 1978

51

52

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Trainee Challenge

Balancing its use as a resource, but avoiding overreliance

53

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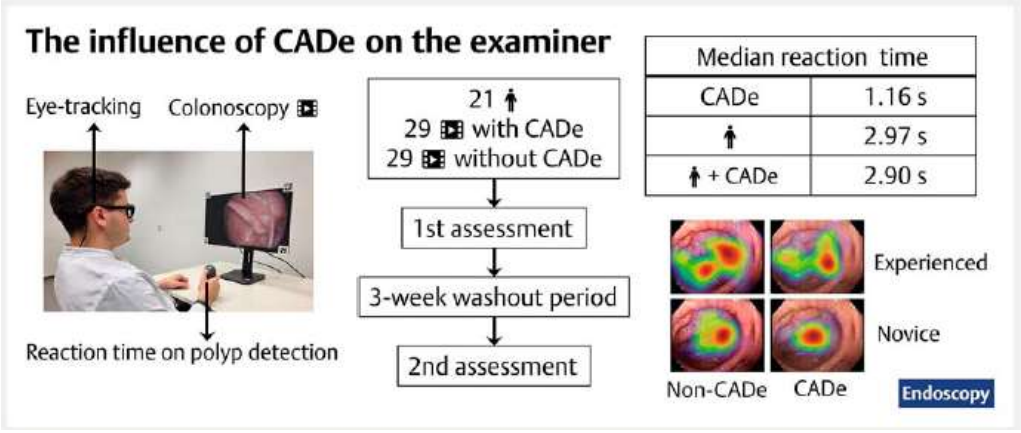
AI A Negative Influence?



Troya J. Endoscopy. 2022 Oct;54(10):1009-1014.

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How Do We Integrate?

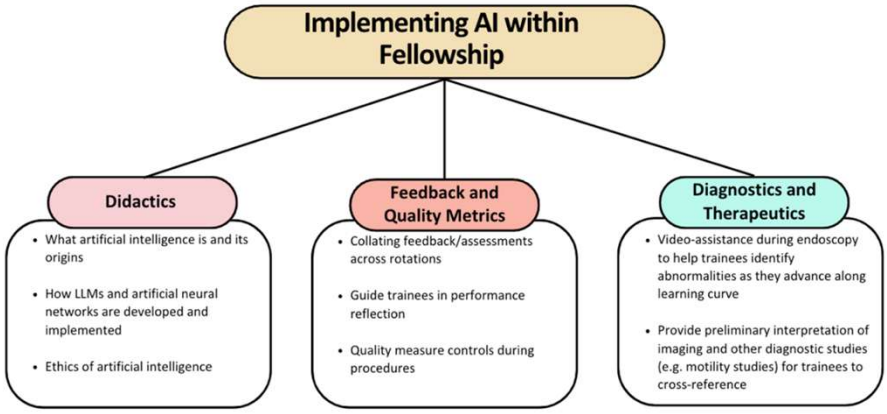

Figure 3. How AI could be implemented into a trainee's education

Kang AJ. Gastrointest Endosc Clin N Am. 2025 Apr;35(2):457-467.

55

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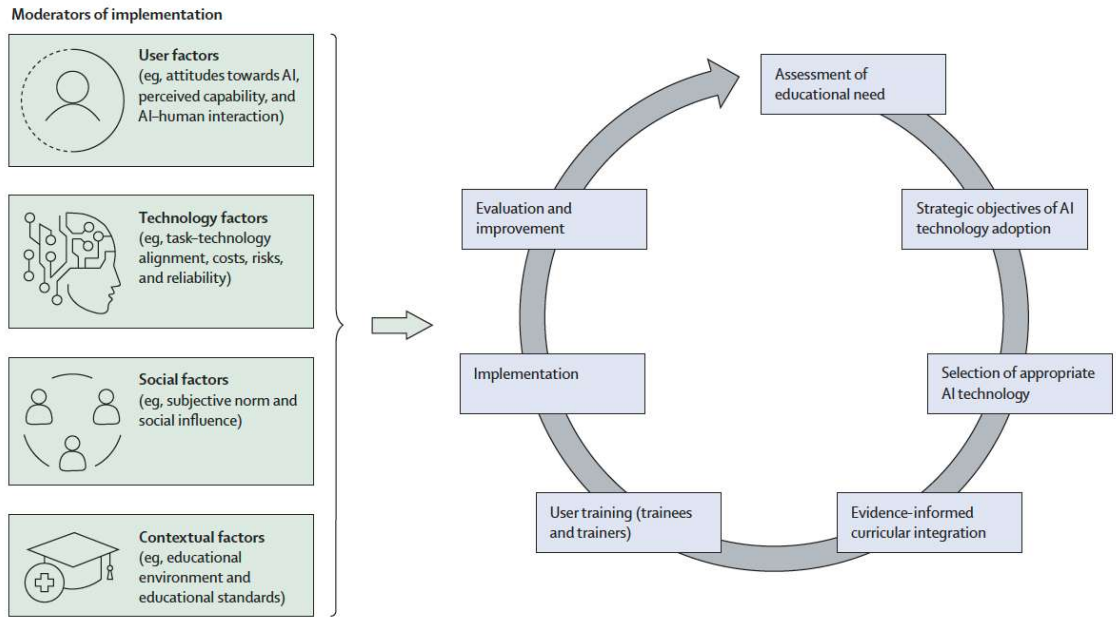

Grover. *The lancet.* 9.1 (2024): 11–13

56

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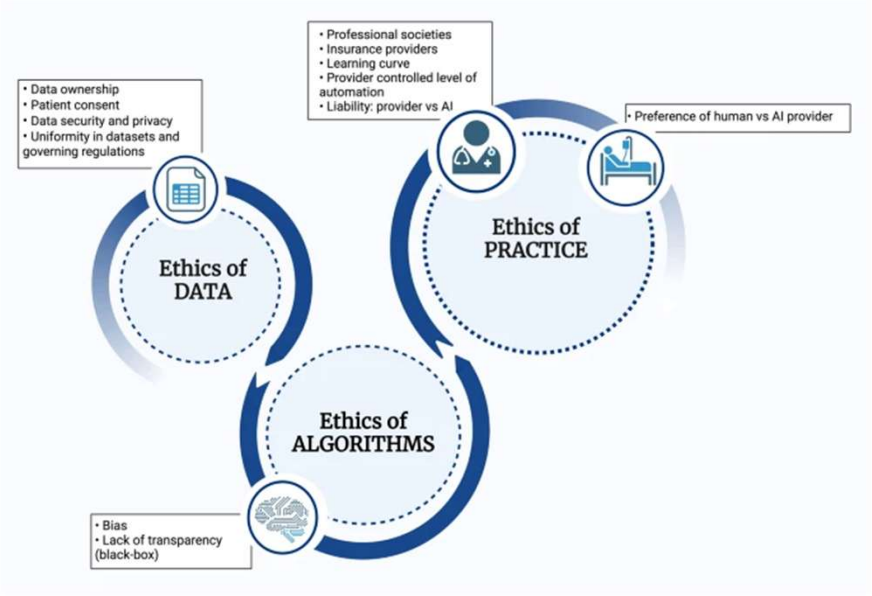
Ethical implications of AI in GI



Aggarwal N et al. DDS 2024;69:2727-2733

57

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Rose D. et al. DEN Open 2026

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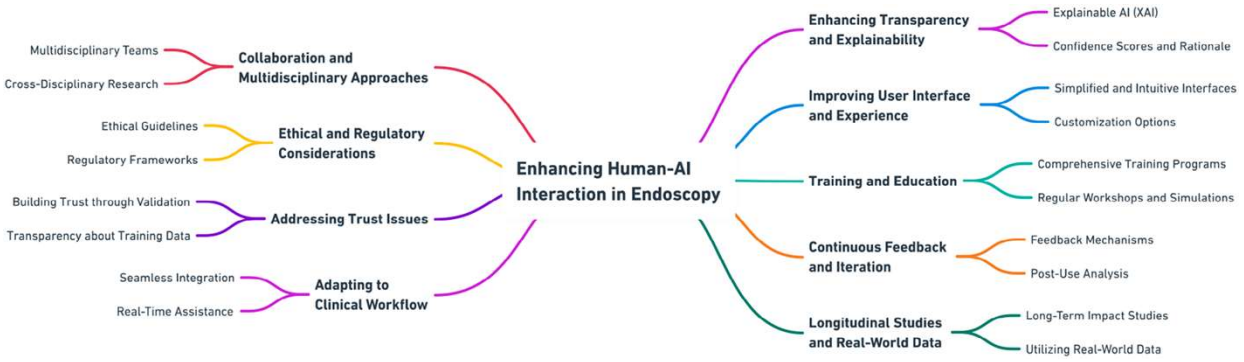
Improvement of Human-Artificial Intelligence Interaction



Rose D. et al. DEN Open 2026

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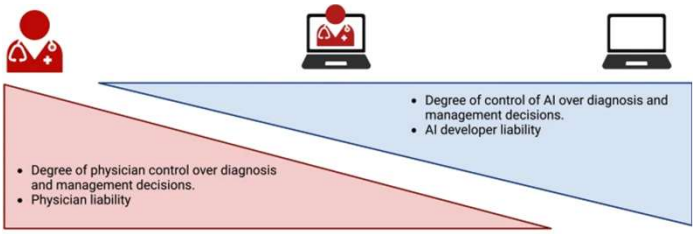
Levels of Automation in AI



Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
No automation	◄----- Assistive AI algorithms -----►		◄---------- Autonomous AI algorithms ----------►		
	AI-assisted diagnoses	AI-assisted management	Conditional partial automation	High automation	Full automation
Conventional physician-patient interaction	AI retrieves relevant findings for further review by physician (e.g. sepsis alerts)	AI suggests potential diagnoses which can be accepted/ rejected by the physician	AI generates a preliminary diagnosis and treatment plan which can be adjusted by physician before final decision	AI generates a diagnoses and signs prescriptions with optional physician review for high-risk patients	Autonomous AI provider with no physician intervention
Conventional endoscopy	Computer-aided detection (CADe)	Computer-aided diagnosis of lesions (CADx) including "resect and discard" and "diagnose and leave" strategies	Capsule endoscopy with automated preliminary report requiring physician review before approval	Capsule endoscopy with automated report with optional physician review for high-risk findings	Capsule endoscopy with automated report without physician review

Aggarwal N et al. DDS 2024;69:2727-2733

60

Final Thoughts

AI
AUGMENTATION VS. AUTOMATION

61

THANK YOU

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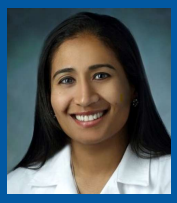
Questions

Seth A. Gross, MD, FACG



Reezwana Chowdhury, MD, FACG

63

64