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ACG 2023
OCTOBER 20-25, 2023 | VANCOUVER, CANADA

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Participating in the Webinar

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Moderator:
Miguel A. Valdovinos, MD

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.

The slide is a blue presentation slide with a white header and footer. It includes a photo of the moderator, Miguel A. Valdovinos, MD. Three yellow callout boxes with arrows point to specific controls in the webinar interface on the right side of the slide. The interface includes icons for mute, chat, and a handout icon.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!




Week 34 – Thursday, August 24, 2023
 Management of Patients With Acute Lower Gastrointestinal Bleeding: An Updated ACG Guideline
 Faculty: Neil Sengupta, MD
 Moderator: Lisa L. Strate, MD, MPH, FACC
At Noon and 8pm Eastern




Week 35 – Thursday, August 31, 2023
 ACG Clinical Guideline: Diagnosis and Management of Biliary Strictures
 Faculty: Jennifer L. Maranki, MD, MSc
 Moderator: Anna Tavakkoli, MD
At Noon and 8pm Eastern

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Oradores



Sarah K. McGill, MD, MSc, FACP



Sergio A. Sánchez-Luna, MD

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

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La Gastroparesia: Guía para los Gastroenterólogos del ACG

Sarah McGill, MD, MSc
Associate Professor of Medicine
University of North Carolina at Chapel Hill



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CLINICAL GUIDELINES

CME

ACG Clinical Guideline: Gastroparesis

Michael Camilleri, MD, DSc, MRCP (UK), MACG, AGAF¹, Braden Kuo, MD, MSc, FACP², Linda Nguyen, MD³,
Vida M. Vaughn, MLIS, MBA⁴, Jessica Petrey, MSLS⁴, Katarina Greer, MD, MS⁵, Rena Yadlapati, MD, MSHS, FACP⁶ and
Thomas L. Abell, MD⁴



Aug 2022 Journal of American Gastroenterology

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Se realiza endoscopia superior en una mujer de 55 años con diabetes que tiene síntomas de náusea y vómitos frecuentes. En el estómago, hay una gran cantidad de comida, aunque no comió nada desde la noche anterior. No hay obstrucción ni H pylori. ¿Qué haría después?

a) Se diagnostica gastroparesia
b) Se prescribe un estudio de vaciamiento gástrico de 4 horas
c) Se prescribe una prueba de aliento ¹³C-spirulina

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Se realiza endoscopía superior en una mujer de 55 años con diabetes que tiene síntomas de náusea y vómitos frecuentes. En el estómago, hay una gran cantidad de comida, aunque no comió nada desde la noche anterior. No hay obstrucción ni H pylori. ¿Qué hace Ud. después?



e.gi.org

- a) Se diagnostica gastroparesia
- b) Se prescribe un estudio de vaciamento gástrico de 4 horas
- c) Se prescribe una prueba de aliento 13C-spirulina



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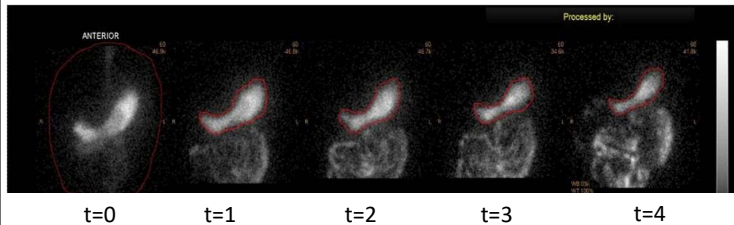
Sólo la mitad de las personas con remanentes de comida en el estómago tienen –tras un diagnóstico formal- la gastroparesia

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Diagnóstico de la Gastroparesia

- Estudio de vaciamiento gástrico de 3 o 4 horas
- Estudio de aliento 13-Spirulina

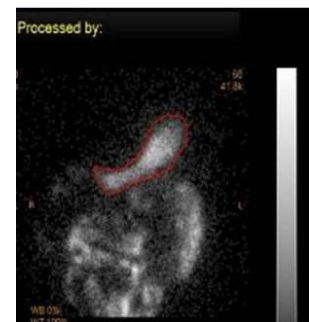


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Se realiza estudio de vaciamiento gástrico y es demorado, con 15% de la comida retenida a las 4 horas. La más reciente HbA1c fue 10% y toma bebidas gaseosas con la comida. ¿Qué le recomienda hacer?

- tomar únicamente agua con las comidas
- hablar con su médico de cabecera o endocrinólogo sobre cómo controlar mejor su diabetes
- comer comida en “partículas pequeñas”
- poner un estimulador eléctrico gástrico



t=4

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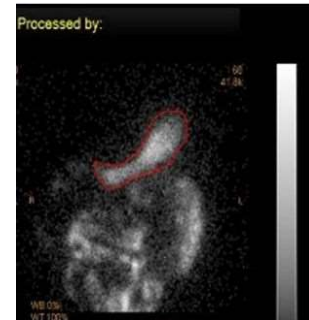


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Se realiza estudio de vaciamiento gástrico y es demorado, con 15% de la comida retenida a las 4 horas. La más reciente HbA1c fue 10% y toma bebidas gaseosas con la comida. ¿Qué le recomienda hacer?

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- b) hablar con su médico de cabecera o endocrinólogo sobre cómo controlar mejor su diabetes
- c) comer comida de “partículas pequeñas”
- d) poner estimulador eléctrico gástrico

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t=4

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La Comida en la Gastroparesia es la base de la terapia

- Comida baja en grasa y de partículas pequeñas que puedan ser machucados por un tenedor



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Ejemplos de comidas con partículas pequeñas

NO

- zanahorias crudas
- filete de carne
- naranja



SÍ

- zanahorias cocidas
- hamburguesa
- plátano

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La paciente regresa a la clínica tres meses después. Su HbA1c es ahora 9% y con el cambio de dieta se siente algo mejor. Toma ondansetron tres veces al día para la náusea y vómitos que aún no están controlados. ¿Cuál medicamento recetaría?

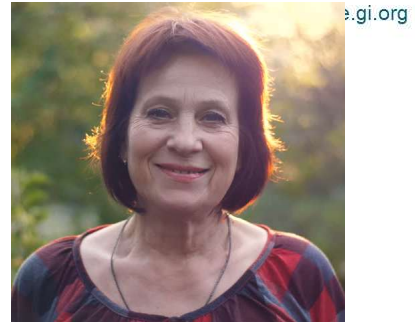


- a) nortriptilina en la noche
- b) metoclopramida 10 mg media hora antes de las comidas
- c) Domperidona 10-20mg tres veces al día

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La paciente regresa a la clínica tres meses después. Su HbA1c es ahora 9 y con el cambio de dieta se siente algo mejor. Toma ondansetron tres veces al día para la nausea y vómitos que aún no están controlados. ¿Cuál medicamento recetarías?



- a) nortriptilina en la noche
- b) metoclopramida 10 mg media hora antes de las comidas**
- c) Domperidona 10-20mg tres veces al día

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Medicinas para la gastroparesia:
el gabinete vacío



Metoclopramida

- líquida o tableta
- advertencia "black box" por efectos secundarios
- discinesia tardia MUY poco frecuente (<1 en 1000)

Domperidona

- sólo disponible en programa especial en EEUU
- cambios endocrinológicos (++)prolactina)
- Muerte cardíaca en pacientes de cáncer

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Paciente ha tenido gastroparesia desde una cirugía para la hernia hiatal hace 5 años. No tolera mucha comida y ha perdido 10 libras en el último año. Ya toma metoclopramida y ondansetron. Quiere saber si hay alguna nueva terapia. ¿Qué puede recomendar?

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- a) pilorotomía endoscópica
- b) inyección de toxina de botulínica
- c) estimulación eléctrica gástrica

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International Virtual Grand Rounds

Paciente ha tenido gastroparesia desde una cirugía para la hernia hiatal hace 5 años. No tolera mucha comida y ha perdido 10 libras en el último año. Ya toma metoclopramida y ondansetron. Quiere saber si hay alguna nueva terapia. ¿Qué puede recomendar?

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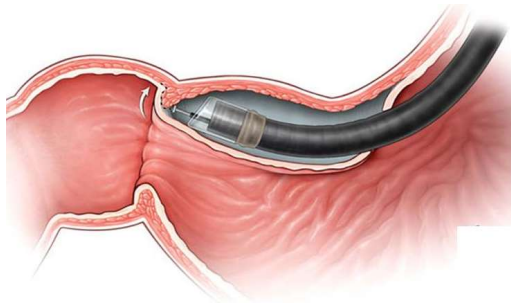
- a) pilorotomía endoscópica
- b) inyección de toxina de botulínica
- c) estimulación eléctrica gástrica

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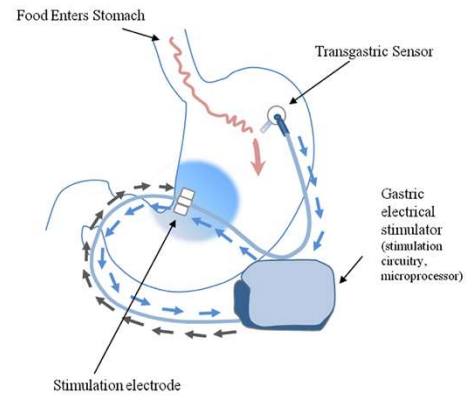


Procedimientos recomendados para la gastroparesia

Pilorotomía



Estimulación eléctrica gástrica



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El paciente no tiene acceso a la estimulación eléctrica gástrica, pero va al hospital Universitario y recibe pilorotomía endoscópica gástrica (G-POEM) sin ningún efecto. Sigue bajando de peso. ¿Qué recomienda?

- a) alimentación enteral por el yeyuno
- b) gastrectomía
- c) alimentación parenteral



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El paciente no tiene acceso a la estimulación eléctrica gástrica, pero va al hospital Universitario y recibe pilorotomía endoscópica gástrica (G-POEM) sin ningún efecto. Sigue bajando de peso. ¿Qué recomienda?

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- a) alimentación enteral por el yeyuno
- b) gastrectomía
- c) alimentación parenteral

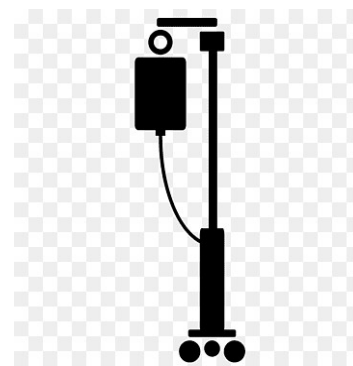
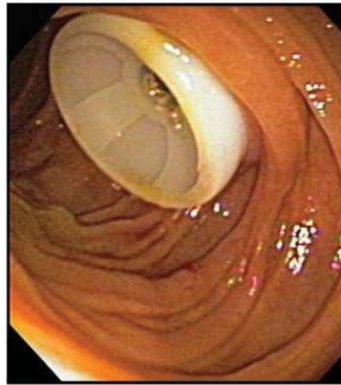
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Cuando no funcionen los medicamentos ni los cambios de dieta....

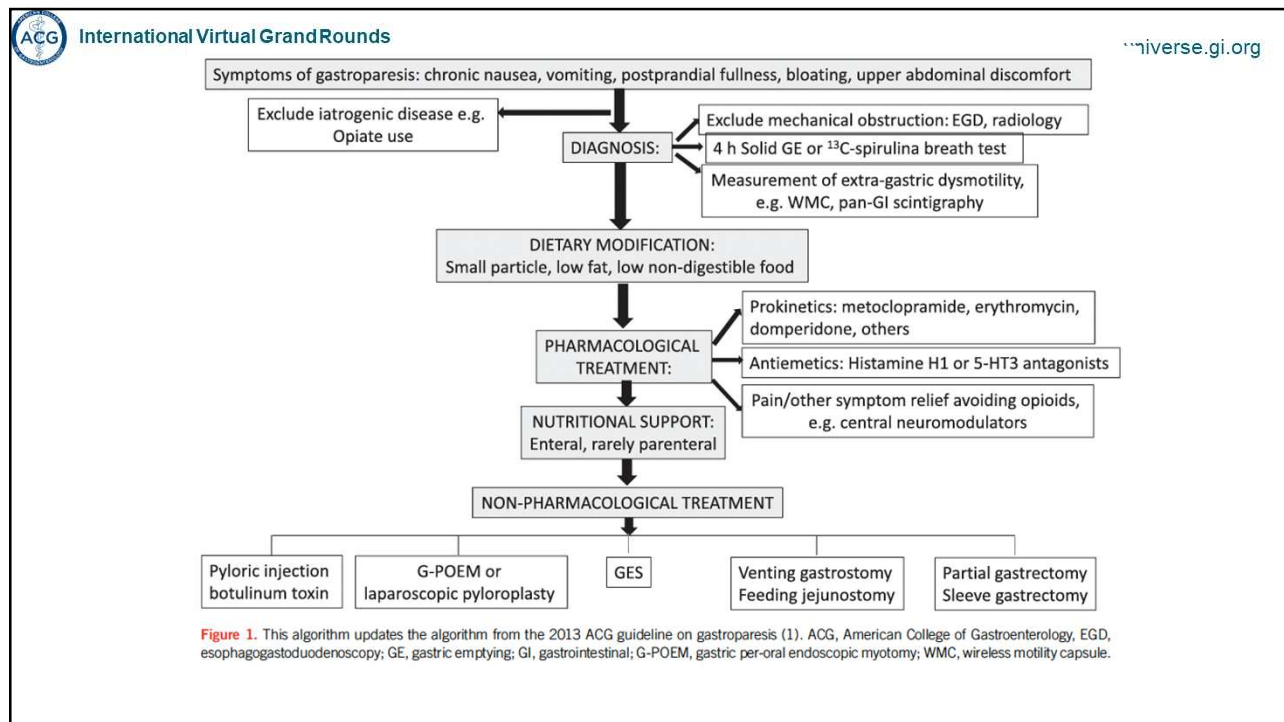
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Alimentación enteral al yeyuno

Alimentación parenteral por la vena

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¡Gracias!

Sarah McGill, MD, MSc
Associate Professor of Medicine
University of North Carolina at Chapel Hill




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ACG Guidelines – G-POEM for Gastroparesis

ACG International Grand Rounds



Sergio A. Sánchez-Luna, M.D., ABOM-D
Bariatric & Surgical Endoscopy Program
Basil I. Hirschowitz Endoscopic Center of Excellence
The University of Alabama at Birmingham Heersink School of Medicine

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Conflict of Interest

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- Recipient of the 2021 American Society for Gastrointestinal Endoscopy (ASGE) Endoscopic Training Award by the ASGE and Fujifilm.
 - Research grant award.

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Introduction

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- Patient selection for G-POEM.
- Role of G-POEM on the treatment of refractory gastroparesis.
- Best practices for G-POEM.
- Role of EndoFlip for predicting outcomes of G-POEM.

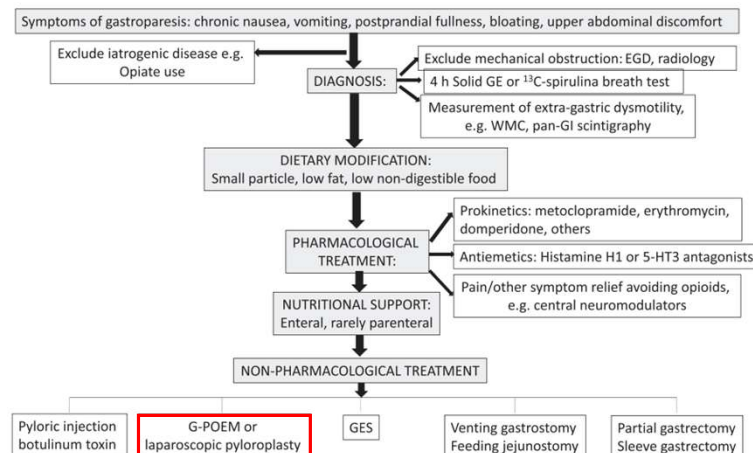
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ACG Clinical Guideline: Gastroparesis

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Michael Camilleri, MD, DSc, MRCP (UK), MACG, AGAF¹, Braden Kuo, MD, MSc, FACG², Linda Nguyen, MD³,
Vida M. Vaughn, MLIS, MBA⁴, Jessica Petrey, MSLS⁴, Katarina Greer, MD, MS⁵, Rena Yadlapati, MD, MSHS, FACG⁶ and
Thomas L. Abell, MD⁴

Camilleri M et al. *Am J Gastroenterol.* 2022.

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ACG Clinical Guideline: Gastroparesis

Michael Camilleri, MD, DSc, MRCP (UK), MACG, AGAF¹, Braden Kuo, MD, MSc, FACP², Linda Nguyen, MD³,
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Thomas L. Abell, MD⁴

Recommendation	GRADE level of evidence	Strength of recommendation
18. In patients with GP, EndoFLIP evaluation may have a role in characterizing pyloric function and predicting treatment outcomes after peroral pyloromyotomy.	Very low	Conditional
19. Intrapyloric injection of botulinum toxin is not recommended for patients with GP based on randomized, controlled trials.	Moderate	Strong
20. In patients with GP with symptoms refractory to medical therapy, we suggest pyloromyotomy over no treatment for symptom control.	Low	Conditional

Camilleri M et. al. Am J Gastroenterol. 2022.

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When? Who?

- “Ideally performed up to 4 hours unless it is documented that more than 90% of the solid meal has emptied at 3 hours.”
- How do we define refractory symptoms?
• Is the patient “truly” refractory?
- **Setting up realistic expectations is key!**

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When? Who?

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- GCSI >2.
- Patient has a contraindications for G-POEM.
- **Clinical success:** decreasing the total average score with 25% decrease in at least 2 subsets.

	None	Very mild	Mild	Moderate	Severe	Very severe
1. nausea (feeling sick to your stomach as if you were going to vomit or throw up)	0	1	2	3	4	5
2. retching (heaving as if to vomit, but nothing comes up)	0	1	2	3	4	5
3. vomiting	0	1	2	3	4	5
4. stomach fullness	0	1	2	3	4	5
5. not able to finish a normal-sized meal	0	1	2	3	4	5
6. feeling excessively full after meals	0	1	2	3	4	5
7. loss of appetite	0	1	2	3	4	5
8. bloating (feeling like you need to loosen your clothes)	0	1	2	3	4	5
9. stomach or belly visibly larger	0	1	2	3	4	5

} Nausea / vomiting
} Fullness / Early Satiety
} Bloating / Distention

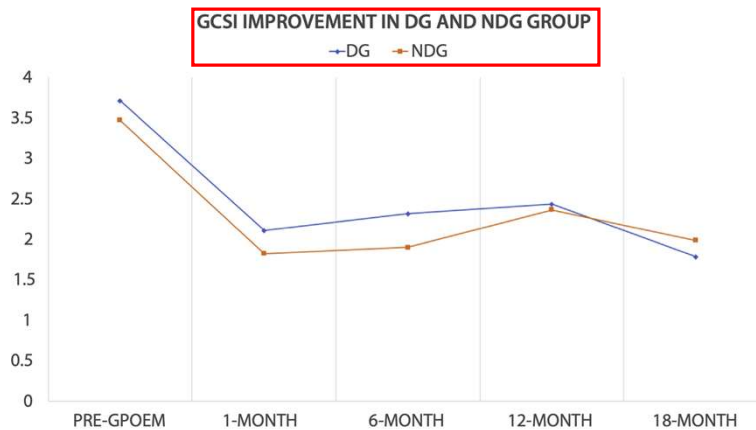
Revicki DA et. al. Qual Life Res. 2004.
Dacha N et al. Gastrointest Endosc. 2017.

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When? Who?

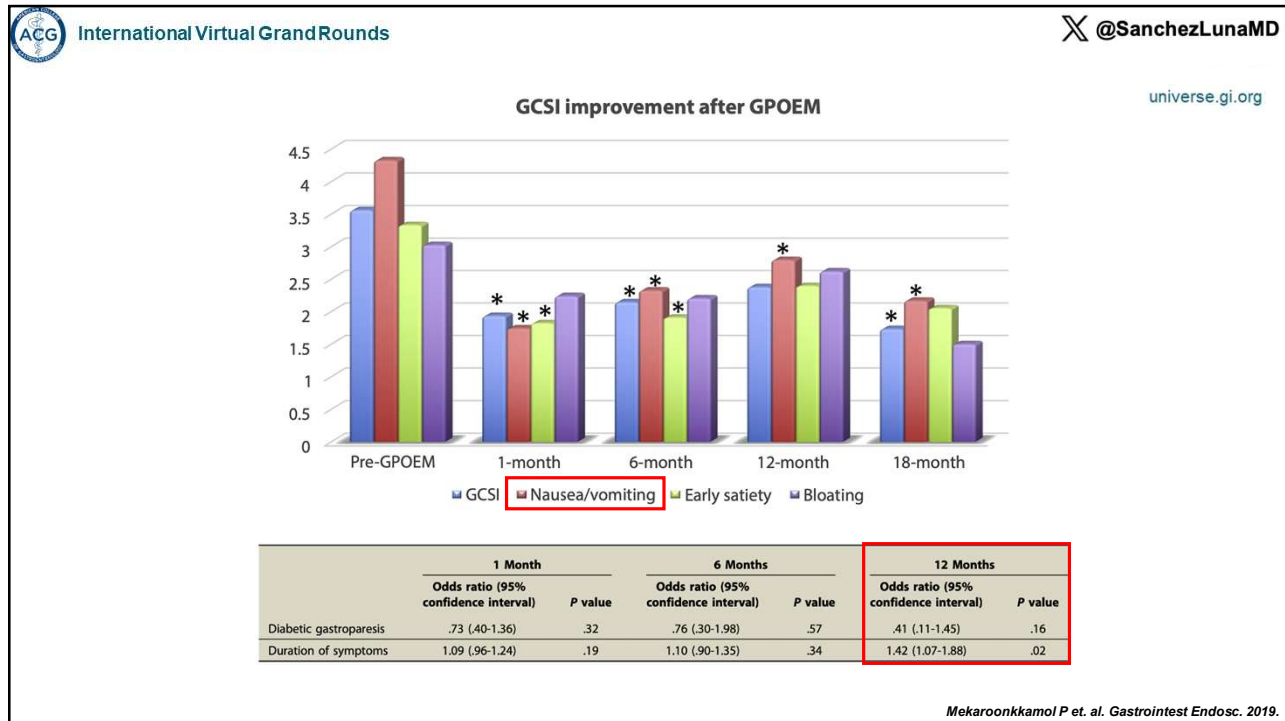
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Association between duration or etiology of gastroparesis and clinical response after gastric per-oral endoscopic pyloromyotomy



Mekaroonkamol P et. al. Gastrointest Endosc. 2019.

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Does it last?

Long-term Outcome of Gastric Per-Oral Endoscopic Pyloromyotomy in Treatment of Gastroparesis
 Mohamed M. Abdelfatah, Alan Noll, Neil Kapil, Rushikesh Shah, Lianyong Li, Rosemary Nustas, Baiwen Li, Hui Luo, Huimin Chen, Liang Xia, Parit Mekaroonkamol, Nikrad Shahnava, Steven Keilin, Field Willingham, Jennifer Christie, and Qiang Cai

Systematic review with meta-analysis: one-year outcomes of gastric peroral endoscopic myotomy for refractory gastroparesis
 Faisal Kamal¹, Muhammad Ali Khan², Wade Lee-Smith³, Sachit Sharma⁴, Ashu Acharya⁴, Dawit Jowhar⁵, Umer Farooq⁷, Muhammad Aziz⁸, Abdul Kouanda¹, Sun-Chuan Dai¹, Colin W Howden⁹, Craig A Munroe³

Gastric per-oral endoscopic myotomy (G-POEM) for refractory gastroparesis: results from an international prospective trial
 Kia Vosoughi¹, Yervant Ichkhanian,^{1,2} Petros Benias,³ Larry Miller,³ A Aziz Aadam,⁴ Joseph R Triggs,⁴ Ryan Law,⁵ William Hasler,⁶ Nicole Bowers,⁶ Dalton Chaves,⁶ Alberto M Ponte-Neto,⁶ Peter Draganov,⁷ Dennis Yang,⁷ Maan El Halabi,⁸ Omid Sanaei^{1,9}, Olaya Isabella Brewer Gutierrez¹⁰, Robert Stephen Bulat,¹ John Pandolfino,⁴ Mouen Khashab¹

Gastric peroral endoscopic myotomy outcomes after 4 years of follow-up in a large cohort of patients with refractory gastroparesis (with video)
 Oscar Victor Hernández Mondragón, MD, MBS, Luis Fernando García Contreras, MD, Gerardo Blanco Velasco, MD, MBS, Omar Michel Solórzano Pineda, MD, MBS, Daniel Mitchell Castillo Carrillo, MD, Enrique Murcio Perez, MD, MBS

Clinical response of 69% at 1 year
 (only 12.9% of initial responders lost that response per year up to 36 months post-procedurally)

Pooled rate (95%CI) of clinical success at 1 year of 61% and 8% of AEs

Clinical success of 56% at 12 months

At 48 months clinical success was 77%

Abdelfatah M et al. Clin Gastroenterol Hepatol. 2021.
 Kamal F et al. Aliment Pharmacol Ther. 2022.
 Vosoughi K et al. Gut. 2022.
 Hernández Mondragón et al. Gastrointest Endosc. 2022.

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What is new since last ACG guidelines?

Endoscopic pyloromyotomy for the treatment of severe and refractory gastroparesis: a pilot, randomised, sham-controlled trial

Jan Martinek¹, Rastislav Hustak^{2,3}, Jan Mares⁴, Zuzana Vackova⁵, Julius Spicak¹, Eva Kieslichova⁵, Marie Buncova⁶, Daniel Pohl⁷, Sunil Amin⁸, Jan Tack⁹

89% success rate in diabetic GP at 6-months

71% success rate in treatment group at 6-months

Martinek J et al. Gut. 2022.

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How to predict success?

Table 6 Univariable analysis of predictors of G-POEM clinical success at 12 months

	OR	95% CI	P value
Baseline characteristics			
Age	1.02	(0.99 to 1.05)	0.293
Female versus male	1.41	(0.52 to 3.83)	0.501
BMI	0.96	(0.88 to 1.04)	0.272
Aetiology			
Idiopathic			
Diabetes*	0.93	(0.28 to 3.03)	0.9
Postsurgical*	1.2	(0.42 to 3.4)	0.735
Duration of gastroparesis	1	(0.99 to 1.02)	0.551
Upper abdominal pain before G-POEM	1.27	(0.95 to 1.69)	0.11
Baseline GCSI Score higher than 2.6†	3.84	(1.43 to 10.30)	0.008
Baseline average GCSI Score	1.94	(1.19 to 3.17)	0.008
Baseline nausea/vomiting score	1.38	(0.97 to 1.96)	0.077
Baseline Fullness/early satiety score	1.68	(1.12 to 2.54)	0.013
Baseline bloating score	1.41	(1.02 to 1.95)	0.036
GES results			
Gastric retention >20% at 4 hours before G-POEM	3.24	(1.07 to 9.78)	0.037
Early response to G-POEM			
Clinical success at 1 month	8.75	(2.9 to 26.38)	<0.001
Medication use after the G-POEM			
Prescribed opioids	0.4	(0.14 to 1.19)	0.099
Cannabinoid	0.59	(0.15 to 2.4)	0.46
Prokinetics at 12 months	0.5	(0.1 to 2.42)	0.389
Prokinetics at any of the follow-up time points	0.83	(0.29 to 2.37)	0.732

Table 2 Primary treatment success comparison G-POEM versus sham at 6 months and predictors of treatment success at 6 months

Variable	OR*	95% CI for OR*	P value
Allocation G-POEM	9.0	2.0 to 40.2	0.005
Gender male	4.0	1.0 to 15.8	
Age >47 years	0.69	0.19 to 2.52	
Baseline GCSI >2.6	2.6	0.4 to 16.4	
Baseline GES 4 hours >20 %	0.24	0.06 to 0.93	
Baseline distensibility (DI) >8 mm ² /mm Hg†	3.6	0.5 to 33.6	
Post G-POEM distensibility (DI) >13 mm ² /mm Hg‡	6.0	0.66 to 136.8	

Table 3. Factors Predicting Failure of GPOEM

Variables	Univariate				Multivariate			
	OR	Lower	Upper	P value	OR	Lower	Upper	P value
Body mass index	1.070	1.000	1.130	.04	1.097	1.022	1.176	.010
Duration of GP	1.143	1.023	1.278	.019	1.4	1.07	1.8	.002
Psych medications	1.434	0.165	1.144	.091	.052	1.33	0.110	1.008
Pain medication	3.9	1.2	12.6	.02	.469	0.703	0.271	1.825

Abdefatah M et al. Clin Gastroenterol Hepatol. 2021. Vosoughi K et al. Gut. 2022. Martinek J et al. Gut. 2022.

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How to predict success?

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TABLE 4. Multiple logistic regression model for long-term clinical success (48 months) after G-POEM

Characteristic	Univariate			Multivariate		
	Odds ratio	95% Confidence interval	P value	Odds ratio	95% Confidence interval	P value
Age	1.241	.617-1.241	.421			
Gender (female)	2.531	.883-3.439	.132			
Gastroparesis etiology						
Diabetic	6.841	1.532-7.569	.021	5.113	1.643-5.981	.035
Idiopathic	1.452	1.121-2.454	.044			
Postsurgical	1.885	.988-2.155	.081			
Other	1.944	.644-3.540	.153			
Time before diagnosis						
<24 mo	2.934	1.568-3.923	.021	2.455	1.129-3.522	.042
≥24 mo	.845	.234-1.342	.244			
Body mass index	1.567	.713-2.435	.512			
Predominant symptoms						
Satiety/gastric fullness	2.132	1.122-2.431	.041			
Nausea/vomiting	4.312	2.451-6.342	.029	3.541	1.881-5.511	.012
Bloating/abdominal pain	1.121	.536-1.341	.323			

Hernández Mondragón et al. *Gastrointest Endosc.* 2022.

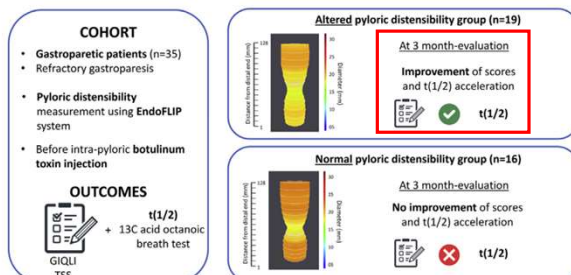
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The Reality of FLIP

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Pyloric distensibility measurement predicts symptomatic response to intrapyloric botulinum toxin injection

Charlotte Desprez, MD,^{1,2} Chloé Melchior, MD, PhD,^{2,3} Fabien Wuestenberghs, MD,^{1,2} Alberto Zalar, MD,³ Jérémie Jacques, MD, PhD,⁴ Anne-Marie Leroi, MD, PhD,^{1,5} Guillaume Gourcerol, MD, PhD^{1,5,6}

Peroral endoscopic pyloromyotomy is efficacious and safe for refractory gastroparesis: prospective trial with assessment of pyloric function

Jérémie Jacques^{1,2}, Lauriane Pagnon¹, Florent Hure³, Romain Legros⁴, Sabrina Crepin⁴, Anne-Laure Fauchais⁵, Sylvain Palat⁶, Philippe Ducrotte⁶, Benoit Marin⁷, Sebastien Fontaine⁷, Nour Edine Boubaddi⁸, Marie-Pierre Clement⁹, Denis Sautereau⁹, Veronique Loustaud-Ratti¹, Guillaume Gourcerol¹, Jacques Montell¹⁰

A pyloric 50-mL DI < 9.2 mm²/mmHg was associated with a clinical efficacy of G-POEM with 100% specificity and 72.2 % sensitivity (P = 0.04; 95 % CI 0.51 – 0.94).

The PPV was 100%, but the NPV was only 28.5 %.

Desprez C et al. *Gastrointest Endosc.* 2019.
Jacques J et al. *Endoscopy.* 2019.

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The reality of FLIP

universe.gi.org

Role of endoscopic functional luminal imaging probe in predicting the outcome of gastric peroral endoscopic pyloromyotomy (with video)

Kia Vosoughi, MD, MPH,^{1,2} Yervant Ichkhanian, MD,^{1,2} Jérémie Jacques, MD,² A. Aziz Adam, MD,³ Petros C. Benias, MD,³ Ryan Law, MD,³ William L. Hasler, MD,³ Andrew Canakis, MD,³ Olivier Ragi, MD,³ Joseph Triggs, MD, PhD,³ Nicole Bowers, BA,³ Olaya I. Brewer Gutierrez, MD,³ Vivek Kumbhari, MD,³ Anthony N. Kalloo, MBS, MD,³ Robert S. Balur, MD, MSc, PhD,³ John E. Pandolfino, MD,³ Mouen A. Khashab, MD³

TABLE 5. Performance of post-G-POEM CSA at 40-mL and 50-mL distention volumes in predicting 1-year clinical success

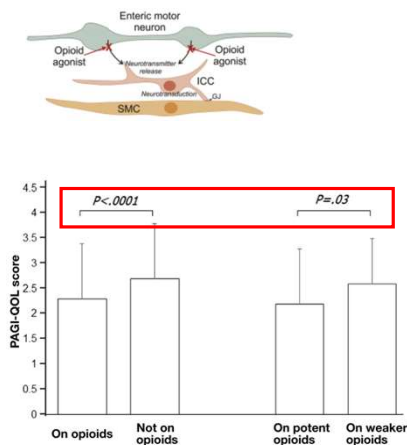
	Cutoff value (mm ²)	Accuracy, %	Sensitivity, %	Specificity, %
Post-G-POEM CSA at 40-mL volume	154*,†	77.1	70.8	90.9
	123.5	77.1	79.2	72.7
	77.9	77.1	87.5	54.5
Post-G-POEM CSA at 50-mL volume	247.5*	71.4	58.3	100
	238†	71.4	62.5	90.9
	219.2	68.6	66.7	63.6

Vosoughi K et al. *Gastrointest Endosc.* 2020.

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Opiates in GP

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Variable	Diabetic gastroparesis			Idiopathic gastroparesis			P value, diabetic vs idiopathic
	On opioids	Not on opioids	P value	On opioids	Not on opioids	P value	
4-hour scintigraphic gastric retention, means ± SD	40% ± 25%	41% ± 25%	.81	34% ± 20%	27% ± 16%	.91	.008
Symptoms							
Overall GCSI score	3.1 ± 1.0	2.8 ± 1.1	.02	3.2 ± 1.1	2.8 ± 1.0	.002	.91
Nausea/vomiting subscore	3.0 ± 1.4	2.5 ± 1.5	.01	2.6 ± 1.5	2.1 ± 1.3	.001	.96
Bloating/distention subscore	3.1 ± 1.5	2.7 ± 1.7	.07	3.3 ± 1.4	3.0 ± 1.6	.01	.95
Upper abdominal pain score	3.3 ± 1.7	2.6 ± 1.7	.002	3.4 ± 1.5	2.8 ± 1.7	<.0001	.93
Lower abdominal pain score	2.2 ± 1.6	2.0 ± 1.7	.41	2.6 ± 1.6	1.8 ± 1.5	<.0001	.02
Constipation score	2.7 ± 1.7	2.3 ± 1.7	.12	2.7 ± 1.9	2.4 ± 1.7	.19	.31
PGI-QOL, means ± SD	2.2 ± 1.2	2.9 ± 1.2	.0003	2.3 ± 1.0	2.6 ± 1.1	.006	.31
Hospitalized for gastroparesis in past year	59/91 (65%)	54/109 (50%)	.03	72/149 (48%)	69/234 (29%)	.0002	.65
Hospitalizations per year, means ± SD	5.3 ± 7.3	2.8 ± 6.3	.01	2.1 ± 3.6	0.9 ± 2.5	.0005	.09
Medication use							
Antiemetics	70/91 (77%)	53/109 (49%)	<.0001	103/149 (69%)	119/234 (51%)	.0004	.18
Nonopiate analgesics	48/91 (53%)	62/109 (57%)	.56	97/149 (65%)	142/234 (61%)	.38	.29
Pain modulators	48/91 (53%)	30/109 (30%)	.0003	53/149 (36%)	47/234 (20%)	.0008	.44
Laxatives	13/27 (48%)	12/40 (30%)	.02	23/48 (48%)	39/100 (39%)	.28	.55

Hassler WL et al. *Clin Gastroenterol Hepatol.* 2019. Camilleri M et al. *Gastroenterology.* 2020.

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Laparoscopic pyloroplasty vs. G-POEM universe.gi.org

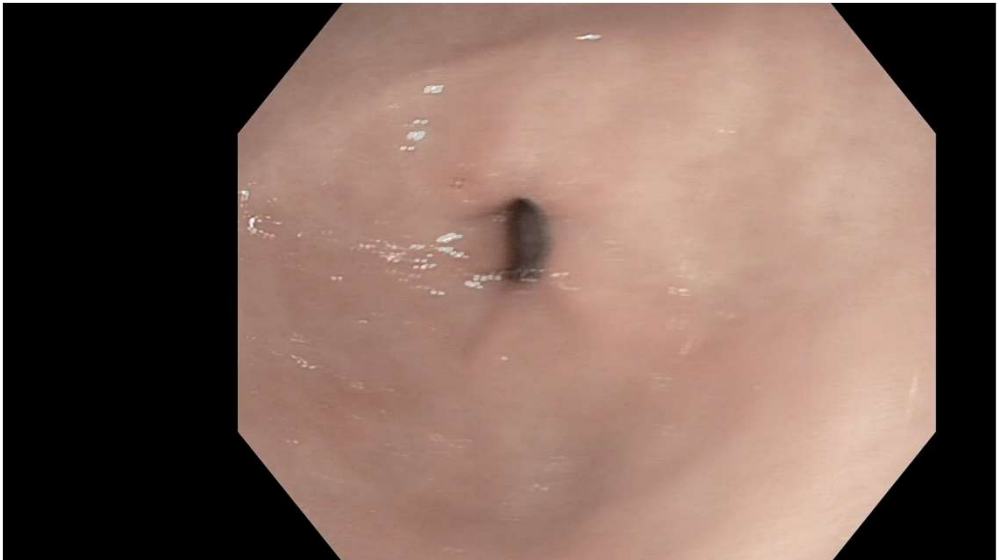
Retrospective comparison lap pyloroplasty (LP) vs G-POEM, single-center, 30 per group (19 IG, 6 PSG, 5 DG), matched by propensity scoring	LP and G-POEM both resulted in similar, significant improvements in GCSI scores (overall and each of 3 subscales) with no differences between treatment groups	LP and G-POEM both resulted in similar, significant improvements in objective GE with no differences between treatment groups	1-mo outcome (28 G-POEM, 22 LP) 3-mo outcome (25 G-POEM, 21 LP)	Longer length of stay, operative time, more estimated blood loss, and complications in the LP group (surgical site infection, pneumonia, and unplanned ICU admission)	Landreneau 2019, Ref. 180
G-POEM (332 in 11 studies) vs surgical pyloroplasty (375 in 7 studies)	4-h GE scintigraphy success results: G-POEM 85.1% (95% CI 68.9–93.7) and surgical pyloroplasty 84% (95% CI 64.4–93.8) with no significant difference	Clinical success, based on the GCSI score: G-POEM 75.8% (95% CI 68.1–82.1) and surgical pyloroplasty 77.3% (95% CI 66.4–85.4), with no significant difference		Overall adverse events were comparable	Mohan 2020, Ref. 181

Camilleri M et. al. Am J Gastroenterol. 2022.

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G-POEM - Video universe.gi.org



Courtesy of Sánchez-Luna, MD

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¡Gracias!

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

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The banner features a large, stylized blue and white graphic on the left with the text "REGISTRATION IS OPEN!". Below this is a white box with a blue border containing the registration link. To the right, the word "VANCOUVER" is written vertically in blue. Further right is a circular aerial photograph of Vancouver, Canada, showing the city skyline, water, and mountains. Below the photo is the ACG logo and the text "ACG 2023" with a stylized leaf icon, followed by "OCTOBER 20-25, 2023 | VANCOUVER, CANADA". A small circular ACG logo is also visible in the bottom right corner of the photo area.

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