


10 • GI ONCOLOGY
New Study Adds Data to Statins' Protective Effects on Liver.

14 • PERSPECTIVES
EMR and ESD Compared For Barrett's Esophagus.

20 • MEMBER SPOTLIGHT
Detroit GI Brings Cancer Patients Hope Through Trials, Treatments.

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GI&Hepatology News

May 2025 Volume 19 / Number 5

Better Prep, Better Scope

Task Force Updates Colonoscopy Preparation Advice

PHANIE / GARO / MEDICAL IMAGES

BY MEGAN BROOKS

FROM GASTROENTEROLOGY

The United States multi-society task force on colorectal cancer (CRC) has updated its 2014 guidance for optimizing the adequacy of bowel preparation for colonoscopy.

The latest consensus recommendations emphasize the importance of verbal and written patient education, refine diet restrictions, update optimal purgative regimens, and advise tracking bowel prep adequacy rates at both the individual endoscopist and unit levels.

"Colorectal cancer remains the second most common cause of cancer death in the United States, and colonoscopy is considered the gold standard for evaluating the colon, including assessing causes of colon-related signs or symptoms and the detection of precancerous lesions. It is well recognized that the adequacy of bowel preparation is essential for optimal colonoscopy performance," the task force wrote.

Choice of Prep, Dosing and Timing, and Dietary Restrictions

When choosing bowel preparation regimens,

See **Prep** · *page 22*

Wearable Devices May Predict IBD Flares Weeks in Advance

BY WILL PASS
MDedge News

FROM GASTROENTEROLOGY

Wearable devices like the Apple Watch and Fitbit may help identify and predict inflammatory bowel disease (IBD) flares, and even distinguish between inflammatory and purely symptomatic episodes, according to investigators.

These findings suggest that widely used consumer wearables could support long-term monitoring of IBD and other chronic inflammatory conditions, lead author Robert P. Hirten, MD, of Icahn School of Medicine at Mount Sinai, New York, and colleagues reported.

"Wearable devices are an increasingly accepted tool for monitoring health and disease," the investigators wrote in *Gastroenterology* (2025 Jan. doi: 10.1053/j.gastro.2024.12.024). "They are frequently used in non–inflammatory-based diseases for remote patient monitoring, allowing individuals to be monitored outside of the clinical setting, which has resulted in improved outcomes in multiple disease states."

Progress has been slower for inflammatory conditions, the investigators noted, despite interest from both providers and patients. Prior studies have explored activity and sleep tracking, or sweat-based biomarkers, as potential tools for monitoring IBD.

Hirten and colleagues took a novel approach, focusing on physiologic changes driven by autonomic nervous system dysfunction — a hallmark of chronic inflammation. Conditions like IBD are associated with reduced parasympathetic activity and increased

See **Wearable** · *page 18*

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LETTER FROM THE EDITOR

Gastroenterology Knows No Country


Dr. Katzka

The United States boasts one of the premier health care systems for medical education in the world. Indeed, institutions such as Johns Hopkins, Harvard, and the Mayo Clinic have storied reputations and are recognized names the world over. The United States also stands as a country of remarkable discovery in medicine with an abundance of enormously talented and productive medical scientists. This reputation draws physicians from every corner of the world who dream of studying medicine in our country.

Unfortunately, many US medical institutions, particularly the most prestigious medical centers, lean heavily toward preferential acceptance of US medical school graduates as an indicator of the highest-quality trainees. This historical bias is being further compounded by our current government's pejorative view of immigrants in general. Will this affect the pool of tomorrow's stars who will change the course of American medicine?

A glance at the list of recent AGA Presidents may yield some insight; over the past 10 years, three of our presidents trained internationally at universities in Malta, Libya, and Germany. This is a small snapshot of the multitude of international graduates in gastroenterology and hepatology who have served as division chiefs, AGA award winners, and journal editors, all now US citizens. This is not to mention the influence of varied insights and talents native to international study and culture that enhance our practice of medicine and biomedical research.

'Now, more than ever, is a time to attract the best and brightest international graduates not to compete with but to complement our remarkable US students. American medicine benefits from their talent and they inspire us to ... care for diseases in our field that affect the world's population, not just ours.'

We live in time when "immigrant" has been assigned a negative and almost subhuman connotation, and diversity has become something to be demonized rather than celebrated. Yet, intuitively, should a top US medical graduate be any more intelligent or driven than a top graduate from the United Kingdom, India, China, or Syria?

As American medical physicians, we place the utmost value on our traditions and high standards. We boast an unmatched depth of medical talent spread across our GI divisions and practices and take pride in the way we teach medicine, like no other nation. Now, more than ever, is a time to attract the best and brightest international graduates not to compete with but to complement our remarkable US students. American medicine benefits from their talent and they inspire us to remember and care for diseases in our field that affect the world's population, not just ours.

Over 100 years ago, Dr. William Mayo stated "American practice is too broad to be national. It had the scientific spirit, and science knows no country." Dr. Mayo also said, "Democracy is safe only so long as culture is in the ascendancy." These lessons apply more than ever today. ■

David Katzka, MD
Associate Editor

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GI&Hepatology News

GI & Hepatology News is the official newspaper of the American Gastroenterological Association (AGA) Institute and provides the gastroenterologist with timely and relevant news and commentary about clinical developments and about the impact of healthcare policy. Content for **GI & Hepatology News** is developed through a partnership of the newspaper's medical board of editors (Editor in Chief and Associate Editors), Frontline Medical Communications Inc. and the AGA Institute Staff. "News from the AGA" is provided exclusively by the AGA, AGA Institute, and AGA Research Foundation. All content is reviewed by the medical board of editors for accuracy, timeliness, and pertinence. To add clarity and context to important developments in the field, select content is reviewed by and commented on by external experts selected by the board of editors.

POSTMASTER Send changes of address (with old mailing label) to GI & Hepatology News, Subscription Service, 17550 N Perimeter Drive, Suite 110, Scottsdale, AZ 85255-7829.

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The AGA Institute headquarters is located at 4930 Del Ray Avenue, Bethesda, MD 20814, ginews@gastro.org.

GI & Hepatology News (ISSN 1934-3450) is published monthly for $230.00 per year by Frontline Medical Communications Inc., 283-299 Market Street (2 Gateway Building), 4th Floor, Newark, NJ 07102. Phone 973-206-3434

MDedge

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Navigating Esophageal Dysfunction in Immune and Infectious Disorders: AGA Clinical Practice Update

BY MEGAN BROOKS

FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

AGA has released an expert review and clinical practice update focusing on esophageal dysfunction caused by immune-mediated and infectious diseases.

"Many different disorders can lead to esophageal dysfunction, which is characterized by symptoms including dysphagia, odynophagia, chest pain, and heartburn. These symptoms can be caused either by immune or infectious conditions and can either be localized to the esophagus or part of a larger systemic process," co–first author Emily McGowan, MD, PhD, with the division of allergy and immunology, University of Virginia School of Medicine, Charlottesville, said in an AGA podcast.

However, without a "high index of suspicion," these conditions can be overlooked, leading to delays in diagnosis and unnecessary procedures. "With this clinical practice update, we wanted to help providers more readily recognize these conditions so that patients can be diagnosed and treated earlier in the course of their disease," McGowan explained.

Dr. Gabbard

"This is a fantastic review that highlights how many different systemic disorders can affect the esophagus," Scott Gabbard, MD, gastroenterologist and section head at the Center for Neurogastroenterology and Motility, Cleveland Clinic, Ohio, who wasn't involved in the review, said in an interview.

"Honestly, for the practicing gastroenterologist, this is one of those reviews that I could envision someone either saving to his or her desktop for reference or printing it and pinning it next to his or her desk," Gabbard said.

KAZUMA SEKI/ISTOCK/GETTY IMAGES

Best Practice Advice

The clinical practice update is published in *Clinical Gastroenterology and Hepatology* (2024 Dec. doi: 10.1016/j.cgh.2024.08.027). It includes 10 "best practice advice" statements and a table highlighting "important" considerations when evaluating patients with esophageal dysfunction.

The review authors note that esophageal dysfunction may result from localized infections — most commonly *Candida*, herpes simplex virus, and cytomegalovirus — or systemic immune-mediated diseases, such as systemic sclerosis (SSc), mixed connective tissue disease (MCTD), and eosinophilic esophagitis (EoE).

They advise clinicians to identify if there are risks for inflammatory or infectious possibilities for a patient's esophageal symptoms and investigate for these disorders as a potential cause of esophageal dysfunction.

Once esophageal infection is identified, it's important to identify whether accompanying signs and symptoms point to immunocompromise leading to a more systemic infection. Consultation with an infectious disease expert is recommended to guide appropriate treatment, the authors said.

If symptoms fail to improve after therapy for infectious esophagitis, the patient should be evaluated for refractory infection or additional underlying sources of esophageal and immunologic dysfunction is advised.

It's also important to recognize that patients with EoE who continue to have symptoms of esophageal dysfunction despite histologic and endoscopic disease remission, may develop a motility disorder and evaluation of esophageal motility may be warranted, the authors said.

In patients with histologic and endoscopic features of lymphocytic esophagitis, treatment of lymphocytic-related inflammation with proton-pump inhibitor (PPI) therapy or swallowed topical corticosteroids and esophageal dilation as needed should be considered.

In patients who present with esophageal symptoms in the setting of hypereosinophilia (absolute eosinophil count > 1500 cells/μL), the authors advise further workup of non-EoE eosinophilic gastrointestinal disease, hypereosinophilic syndrome, and eosinophilic granulomatosis with polyangiitis, with consultation with an allergy/immunology specialist if helpful.

In patients with rheumatologic diseases, especially SSc and MCTD, it's important to be aware that esophageal symptoms can occur because of involvement of the esophageal muscle layer, resulting in dysmotility and/or incompetence of the lower esophageal sphincter, they said.

In the setting of Crohn's disease, some patients can develop esophageal involvement from inflammatory, stricturing, or fistulizing changes with granulomas seen histologically. Esophageal manifestations of Crohn's disease tend to occur in patients with active intestinal disease.

In patients with dermatologic diseases of lichen planus or bullous disorders, dysphagia can occur because of endoscopically visible esophageal mucosal involvement. Esophageal lichen planus, in particular, can occur without skin involvement and can be difficult to define on esophageal histopathology.

The authors also advise clinicians to consider infectious and inflammatory causes of secondary achalasia during initial evaluation.

"Achalasia and EoE might coexist more commonly than what gastroenterologists think, especially in younger patients," co–first author Chanakyaram Reddy, MD, a gastroenterologist with Baylor University Medical Center, Dallas, Texas, said in the AGA podcast.

He noted that in a recent population-based study (*Clin Gastroenterol Hepatol*. 2024 Jan. doi: 10.1016/j.cgh.2023.06.013), the estimated relative risk of EoE was over 30-fold higher in patients with achalasia aged ≤ 40 years.

"In any suspected achalasia case, it would be wise to obtain biopsies throughout the entire esophagus when the patient is off confounding medications such as PPI therapy to establish if significant esophageal eosinophilia is coexistent," Reddy said.

"If EoE-level eosinophilia is found, it would be reasonable to consider treating medically for EoE prior to committing to achalasia-specific interventions, which often involve permanent disruption of the esophageal muscle layer," he added.

Gabbard said this review helps the clinician think beyond gastroesophageal reflux disease (GERD) — the most common cause of esophageal dysfunction — and consider other causes for esophageal dysfunction.

"We are seeing more complex disorders affect the esophagus. It's not just GERD and you absolutely need a high index of suspicion because you can find varying disorders to blame for many esophageal symptoms that could otherwise be thought to be just reflux," he said.

This research had no commercial funding. Disclosures for the authors are listed with the original article. Gabbard had no relevant disclosures.

Could Statins Prevent Hepatocellular Carcinoma?

BY HEIDI SPLETE

Long-term use of statins may delay or deflect the development of hepatocellular carcinoma in adults with chronic liver disease, as well as in the general population, emerging research, including several large cohort studies, suggested.

The most recent study, published in *JAMA Internal Medicine* (2025 Mar. doi:10.1001/jamainternmed.2025.0115), showed a lower incidence of hepatic decompensation among statin users in a registry for adults aged 40 years or older with baseline chronic liver disease.

"Our findings support the idea that statins may offer benefits beyond lipid-lowering in patients with [chronic liver disease], and clinicians may be more confident in prescribing statins when indicated," even in these patients, said corresponding co-author Raymond T. Chung, MD, gastroenterology investigator at Mass General Research Institute, Boston, in an interview.

Dr. Chung

'Moving forward, randomized controlled trials are essential to establish a causal relationship and clarify the molecular and clinical pathways through which statins exert hepatoprotective effects.'

"While prior studies have suggested an association between statin use and reduced hepatocellular carcinoma risk, our study aimed to build on that evidence by using a large, real-world, hospital-based cohort inclusive of all etiologies of chronic liver disease," Chung told *GI & Hepatology News*.

Chung, along with Jonggi Choi, MD, of the University of Ulsan College of Medicine, Seoul, South Korea, and colleagues, reviewed data from the Research Patient Data Registry from 2000 to 2023 for 16,501 participants aged 40 years or older with baseline chronic liver disease and baseline Fibrosis-4 (FIB-4) scores ≥ 1.3.

The study population had a mean age of 59.7 years, and 40.9% were women. The researchers divided the population into statin users (n = 3610) and nonusers (n = 12,891). Statin use was defined as a cumulative defined daily dose ≥ 30 mg.

The primary outcome was the cumulative incidence of hepatocellular carcinoma and hepatic decompensation.

At 10 years follow-up, statin users showed a significantly reduced incidence of hepatocellular carcinoma vs nonusers (3.8% vs 8.0%; $P < .001$) as well as a significantly reduced incidence of hepatic decompensation (10.6% vs 19.5%; $P < .001$).

Incorporating FIB-4 scores, a surrogate marker for liver fibrosis, also showed that statin users were less likely to experience fibrosis progression, offering a potential mechanism of action for the observed reduction in adverse liver outcomes, Chung told *GI & Hepatology News*.

"Similar trends have been observed in prior observational studies, but our findings now support a real effect of statin use on fibrosis progression," he said. "However, what strengthened our study was that the association remained consistent across multiple subgroups and sensitivity analyses."

Another study published in *Clinical Gastroenterology and Hepatology* (2023 Apr. doi: 10.1016/j.cgh.2023.04.017) showed a reduced risk of developing severe liver disease in a Swedish cohort of noncirrhotic adults with chronic liver disease who used statins (n = 3862) compared with control patients with chronic liver disease (matched 1:1) and who did not use statins (hazard ratio [HR], 0.60).

A takeaway from this study is that for persons with chronic liver disease who have indications for statin use, the medication should not be withheld.

In that study, Rajani Sharma, MD, and colleagues found a protective association in both prefibrosis and fibrosis stages at diagnosis, and statin use was associated with reduced rates of progression to both cirrhosis and hepatocellular carcinoma (HR, 0.62 and 0.44, respectively).

Exciting and Necessary Research

The research by Choi and colleagues is "exciting," said Bubu Banini, MD, PhD, an assistant professor in digestive diseases at Yale School of Medicine, New Haven, Connecticut, in an interview.

Liver cancer prevalence has risen over the past few decades in the United States and worldwide, and the 5-year overall survival rate of liver cancer is less than 20%, Banini told *GI & Hepatology News*.

Clinicians often withhold statins out of fear of liver injury in persons with chronic liver disease; however, a takeaway from this study is that for persons with chronic liver disease who have indications for statin use, the medication should not be withheld, she said.

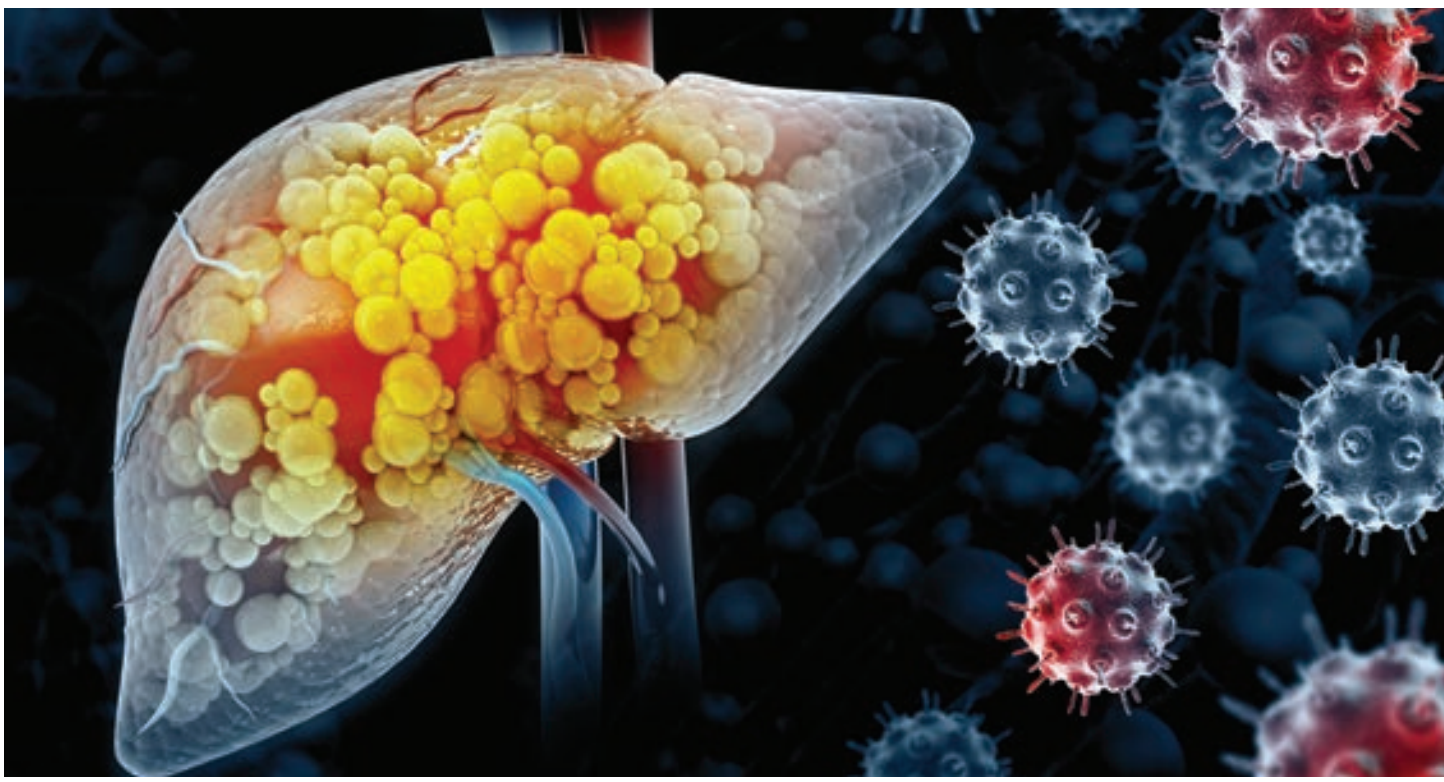
Dr. Banini

Of course, prospective studies are needed to replicate the results, Banini added.

The study findings were limited by several factors, including the inability to adjust for all potential confounding variables, lack of data on post-index treatments, and the use of wide, cumulative, defined daily dose categories to ensure statistical power, the researchers noted.

"Moving forward, randomized controlled trials are essential to establish a causal relationship and clarify the molecular and clinical pathways through which statins exert hepatoprotective effects," Chung added.

Randomized controlled trials are also needed to determine whether statins can actually reduce the risk for hepatocellular carcinoma and hepatic decompensation in patients with chronic liver disease, and



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cost-effectiveness analyses may be essential for translating this evidence into clinical guidelines, he added.

'Our findings support the idea that statins may offer benefits beyond lipid-lowering in patients with [chronic liver disease], and clinicians may be more confident in prescribing statins when indicated.'

Statins, Liver Disease in the General Population

A large cohort study, published in *JAMA Network Open* (2023 Jun. doi: 10.1001/jamanetworkopen.2023.20222) by Mara Sophie Vell, PhD, and colleagues, showed an association between reduced risk for hepatocellular carcinoma and statin use in the general population and in those at increased risk for liver disease.

The study, which included data for individuals aged 37-73 years from the UK Biobank, found a 15% reduced risk for new-onset liver disease and a 28% reduced risk for liver-related death among regular statin users than among nonusers (HR, 0.85 and 0.72, respectively).

In addition, regular statin users showed a 74% reduced risk ($P = .003$) of developing hepatocellular carcinoma compared with those not using statins. The researchers identified a particular impact on liver disease risk reduction among men, individuals with diabetes, and patients with high levels of liver scarring at baseline based on the FIB-4 index.

A meta-analysis of 24 studies, previously published in the journal *Cancers* (2020 Mar. doi:10.3390/cancers12030671), showed a significant reduction of 46% in hepatocellular carcinoma risk among statins users compared with nonusers.

The researchers found this risk reduction was significant in subgroups of patients with diabetes, liver cirrhosis, and those on antiviral therapy, and they suggested that the antiangiogenic, immunomodulatory, antiproliferative, and antifibrotic properties of statins may contribute to their potential to reduce tumor growth or hepatocellular carcinoma development.

The meta-analysis authors noted that although most studies have reported a low risk for statin-induced hepatotoxicity, clinicians should proceed with caution in some patients with existing cirrhosis.

"If the patients are diagnosed with decompensated cirrhosis, then statins should be prescribed with caution at low doses," they wrote.

Advocating statin use solely for chemoprevention may be premature based on observational data, Chung told *GI & Hepatology News*.

"However, in patients with [chronic liver disease] who already meet indications for statin therapy, the potential added benefit of reducing liver-related complications strengthens the rationale for their use," he said. Future randomized clinical trials will be key to defining the risk-benefit profile in this context.

The study by Choi and colleagues was supported by the National Institutes of Health.

The study by Sharma and colleagues was supported by the Karolinska Institutet, Stockholm, Sweden, and the Columbia University Irving Medical Center, New York City; researchers were supported by grants from the Swedish Research Council, Center for Innovative Medicine, the Swedish Cancer Society, and the National Institutes of Health.

The study by Vell and colleagues had no outside funding.

The 2020 meta-analysis was supported by the Ministry of Education and Ministry of Science and Technology, Taiwan.

Chung and Banini had no financial conflicts to disclose. ■

Antibody Profiles Predict IBD 10 Years Before Onset

BY LIAM DAVENPORT

FROM ECCO 2025

BERLIN — An individual's profile of antibody responses to a range of herpes viruses and encapsulated bacteria such as *Streptococcus* could predict the onset of inflammatory bowel disease (IBD) up to 10 years prior to diagnosis, with differential responses between Crohn's disease and ulcerative colitis, a new study suggested.

The research was presented at the European Crohn's and Colitis Organisation (ECCO) 2025 Congress.

"High-throughput and high-resolution antibody profiling delineates a previously underappreciated landscape of selective serological responses in inflammatory bowel disease," said study presenter Arno R. Bourgonje, MD, PhD, of the Henry D. Janowitz Division of Gastroenterology, Icahn School of Medicine at Mount Sinai, New York City.

The discovery represents just the "tip of the iceberg" in terms of understanding how antibody response could predict IBD onset, he added. Although validation studies are ongoing, the findings "allow for novel insights into disease pathogenesis and also for allowing for disease prediction."

In IBD, the integrity of the intestinal barrier is compromised and luminal agents, like bacteria, can leak through, which leads to immune activation, Bourgonje said.

However, only a few serological antibody responses are known to occur in IBD, such as antibodies against the yeast *Saccharomyces cerevisiae* and those against the cytoplasm of neutrophils, he said.

But most antibody responses are directed against bacteria, Bourgonje noted. The gut microbiome represents thousands of different bacterial species, each of which encode for thousands of different genes, representing a tremendous number of potential antigens. But conventional antibody-profiling technologies weren't powerful enough to identify antibodies in patients with IBD that signal an immune response to potential antigens in the gut.

Dr. Bourgonje

To get at that problem, the researchers recently leveraged a high-throughput technology called phage-display immunoprecipitation sequencing (PhIP-Seq) to look for specific immune-based biomarker signatures in the blood of individuals with IBD. This effort revealed a distinct repertoire of antibodies not only against bacteria but also against viruses and cell antigens.

The researchers next turned their sights on discovering whether they could find evidence of immunological alterations before IBD onset to enable disease prediction.

Predictive Signatures Found

The team used a longitudinal preclinical IBD cohort called PREDICTS (Proteomic Evaluation and Discovery in an IBD Cohort of Tri-service Subjects) that is housed in the US Department of Defense Serum Repository.

Using PhIP-Seq, the researchers analyzed serum samples from 200 individuals who developed Crohn's disease, 200 who developed ulcerative colitis, and 100 non-IBD controls matched for age, sex, race, and study time point. The samples were collected approximately 2 years, 4 years, and 10 years prior to diagnosis as well as around the time of diagnosis.

The results showed that, compared with healthy controls, the diversity of the antibody repertoire was significantly lower in the sera of individuals with preclinical Crohn's disease ($P < .05$) and ulcerative colitis ($P < .001$), with the lowest similarity seen in people with preclinical Crohn's disease approximately 4 years prior to their diagnosis ($P < .001$).

The study also found that, compared with healthy controls, antibody responses in individuals with preclinical Crohn's disease against herpes viruses such as Epstein-Barr virus (EBV), cytomegalovirus (CMV), and herpes simplex virus (HSV)–1 and HSV-2 were significantly higher approximately 10 years prior to the diagnosis of Crohn's disease, whereas anti-*Streptococcus* responses were lower.

In individuals with ulcerative colitis, antibody responses to EBV, CMV, HSV-1, and influenza viruses were significantly higher than that in healthy controls approximately 10 years prior to diagnosis, whereas anti-rhinovirus responses were lower.

Further analysis demonstrated that antibody responses to CMV and EBV proteins increased over the course of the preclinical phase of Crohn's disease vs healthy controls ($P = .008$ and $P = .011$, respectively).

Similarly, autoantibody responses to MAP kinase–activating death domain increased during the preclinical phase of ulcerative colitis vs healthy controls ($P = .0025$), whereas anti-*Streptococcus* responses decreased ($P = .005$).

Interestingly, no one single antibody response difference with healthy controls was able to accurately predict the onset of IBD 10 years prior to diagnosis, but distinct sets of antibody responses were, with area under the receiver-operating characteristic curve of 0.90 for Crohn's disease and 0.84 for ulcerative colitis.

A Promising Start

The study has potential to be useful for identifying people at risk for IBD, Robin Dart, MD, PhD, a consultant gastroenterologist at Guy's and St Thomas Hospital, London, who co-chaired the session, said in an interview.

The difference in antibody responses to viral and bacterial antigens between Crohn's disease and ulcerative colitis could point toward underlying biological mechanisms, although it is "too early to say," Dart said.

However, "when you do these kind of big fishing exercises" and identify microbes may be implicated in IBD, "you end up finding more questions than answers," although that "can only be a good thing," he added.

Bourgonje noted that the study cohort consisted entirely of men enrolled in the US Army, limiting the applicability of the findings. Another limitation was that researchers were unable to control smoking, antibiotic use, and diet, all of which could have affected the results.

This study was funded by the Leona M. and Harry B. Helmsley Charitable Trust. Bourgonje declared relationships with Janssen Pharmaceuticals, Ferring, and AbbVie. Other authors also declared numerous relationships. ■

Virtual Chromoendoscopy Beats Other Modalities at Neoplasia Detection in Inflammatory Bowel Disease

BY LIAM DAVENPORT

FROM ECCO 2025

BERLIN — A multicenter study comparing three endoscopic imaging techniques used to monitor patients with inflammatory bowel disease (IBD) for neoplasia found that virtual chromoendoscopy has the highest detection rate.

The research, presented at the European Crohn's and Colitis Organisation (ECCO) 2025 Congress, also found "significant variability in IBD surveillance practice in the real world," said study presenter Chandni Radia, MD, department of gastroenterology, King's College Hospital NHS Foundation Trust, London.

Although dye chromoendoscopy with targeted biopsies traditionally was considered the gold standard for neoplasia detection in patients with IBD, randomized trials have challenged its superiority over virtual chromoendoscopy and high-definition white-light endoscopy, the researchers noted. They hypothesized that the modality used would not affect the neoplasia detection rate.

To investigate, they conducted a retrospective observational cohort study of adults with ulcerative colitis, Crohn's disease, or primary sclerosing cholangitis (PSC) who underwent routine clinical IBD surveillance at one of five centers in the United Kingdom between 2019 and 2023. They examined data from the endoscopy reporting software, alongside endoscopy reports, endoscopy images, and electronic patient records.

In all, 2673 colonoscopies performed on 2050 patients were included, with 1032 procedures using dye chromoendoscopy, 366 using virtual

Continued on following page

AI Model Improves Lesion Detection in IBD

BY BECKY MCCALL

FROM ECCO 2025

BERLIN — Artificial intelligence (AI)–assisted capsule endoscopy (CE) readings showed higher sensitivity and accuracy in detecting ulcers and erosions in patients with inflammatory bowel disease (IBD) than did conventional readings in a first-of-its-kind, multicenter study.

In addition to the model's superior diagnostic performance than standard of care, it also achieved a significant reduction in the mean reading time per exam.

Furthermore, the study clinically validated an AI model in real time for small-bowel CE.

The AI model addresses long-standing limitations of CE interpretation, including time-consuming readings and interobserver variability.

"It's a huge improvement on the technology readiness level of the AI model," said senior study investigator Miguel Mascarenhas, MD, PhD, head of the precision medicine unit at the Hospital São João, Faculty of Medicine, University of Porto, Portugal.

Until now, there has been no AI system using a CE platform that has proven so effective in so many real-life clinical settings, he explained. "This technology is set to transform endoscopic practice and clinical management in inflammatory bowel disease."

The findings were presented at the European Crohn's and Colitis Organisation (ECCO) 2025 Congress by Francisco Mendes, MD, a resident in gastroenterology, also at the Hospital São João.

Dr. Mascarenhas

More Lesions, Less Time

Researchers conducted the prospective study involving centers in Portugal, Spain, and the United States between January 2021 and April 2024. Two CE devices (PillCamSB3 and Olympus EC-10) were analyzed for their performance across 137 CE exams in 137 patients, 49 of whom had Crohn's disease. AI-assisted readings were compared with standard-of-care readings, with expert board consensus considered to be the gold standard. Key performance metrics included sensitivity, specificity, positive predictive value (PPV), and negative PV (NPV).

During expert board review, ulcers and erosions were identified in 56 patients (40.9%), with a sensitivity of 60.7%, specificity of 98.8%, PPV of 97.1%, and NPV of 78.4%, leading to an overall accuracy for the detection of ulcers and erosions of 83.2%.

In comparison, the AI-assisted readings outperformed conventional readings with a sensitivity of 94.6%, specificity of 80.2%, PPV of 76.8%, and NPV of 95.6%, leading to an overall accuracy of 86.1%.

The AI-assisted model diagnosis was noninferior ($P < .001$) and superior ($P < .001$) to conventional diagnosis for detection of ulcers and erosions. The AI model demonstrated consistent performance across different CE devices and centers.

In addition, the mean time taken per reading was under 4 minutes (239 seconds) per exam for AI, compared with around 1.0-1.5 hours for standard-of-care readings.

The increased diagnostic accuracy of this AI model done in far less time allows us to engage more with the patient and attend to other care-related tasks, Mascarenhas said.

CE has great potential not only in IBD but also in other gastrointestinal-related screening, including colorectal cancer screening, he added. Once the bottleneck of reading time with CE is solved, it will become the first-line tool for screening.

Reading time is "one of several barriers" to integration of CE into clinical practice, Shomron Ben-Horin, MD, director, Sheba Medical Center, Tel-Aviv University, Israel, said in an interview. But it "is the most accurate modality for detection of inflammatory activity along the entire small bowel."

Based on these study results, AI is the way to go, said Ben-Horin, who was not involved in the study. "There was even a signal for better accuracy, which is intriguing," he added. This study points toward AI being more accurate than the physicians in reading, and that is important.

Also commenting was Miles Parkes, MD, consultant gastroenterologist at Addenbrooke's Hospital in Cambridge, England.

"Both the sensitivity and the specificity of the output are reassuring, but there might be some devil in the detail," he said. "However, as a general principle the performance of this model is impressive."

Mascarenhas and Mendes declared no financial disclosures. Ben-Horin received fees from Medtronic to attend the conference. Parkes declared no financial disclosures. ■

Continued from previous page

chromoendoscopy, and 1275 using high-definition white-light endoscopy.

The overall neoplasia detection rate was 11.4%, "which is very similar to what has previously been seen in the literature," Radia said.

However, the detection rate varied significantly by procedure: 19% in virtual chromoendoscopy, 12% in dye chromoendoscopy, and 9% in white-light endoscopy ($P < .001$). After a range of potential confounding factors were controlled, virtual chromoendoscopy still had the highest neoplasia detection rate.

Dye chromoendoscopy had a "prolonged withdrawal time and increased need for targeted biopsies without improving their neoplasia yield, which goes against our aspirations of sustainability," Radia noted.

"It was interesting to see that the procedures with the most dye chromoendoscopy seem to have the longest withdrawal time, and those with the most white-light endoscopy seem to have the shortest," she said. The difference remained significant even after controlling for procedures with polypectomy, "which has a significantly longer withdrawal time compared to procedures without."

Results Varied by Center

There was wide variability between the five centers on several findings. The neoplasia detection rate ranged from 7.4% to 17.2%, depending on the center.

The surveillance method also varied. One center, for example, used white-light endoscopy in 82% of cases and dye chromoendoscopy in the other 18%. At another center, 61% of patients had dye chromoendoscopy, 36% white-light endoscopy, and 3% virtual chromoendoscopy. In a third center, 48% had virtual chromoendoscopy, 46% white-light endoscopy, and 6% dye chromoendoscopy.

The centers had varying proportions of patients with each of the three conditions, with ulcerative colitis ranging from 46% to 63%, Crohn's disease from 9% to 39%, and PSC from 14% to 45%.

The heterogeneity of patients between the modality groups is one of the study's limitations, Radia said. Others are the shorter withdrawal time with white-light endoscopy and the lack of standardized withdrawal time for the procedures.

The research team's analyses are ongoing and include examination of the types of neoplasia detected, as well as accounting for endoscopist experience and patients who underwent two procedures with different modalities, Radia said.

Reflection of 'Real-Life Practice'

Because the study was a retrospective analysis, it contains inherent biases and other issues, Raf Bisschops, MD, PhD, director of endoscopy, University of Leuven, Belgium, who co-chaired the session, said in an interview.

However, it was a "thorough analysis" that reflects "real-life practice," he said. As such, it lends "huge support" to virtual chromoendoscopy, which "actually goes against the new [British Society of Gastroenterology] guideline that is about to come out." The society plans to recommend in favor of dye chromoendoscopy, but the new study findings could be still incorporated into the upcoming guidelines so as to also endorse virtual chromoendoscopy.

Whatever the modality used, clinicians need to make sure they "pay attention" when looking for small neoplastic lesions, and "anything that can help you do that, that draws your attention to cell lesions ... can be helpful," Bisschops said.

Performing targeted biopsies, as with dye chromoendoscopy, can be problematic, as "people don't pay attention anymore to those cell lesions; they just focus on taking the 32 biopsies, which is a huge endeavor and it's a pain to do it," he added.

Radia has received a Research Training Fellowship Award from the UK patient organization PSC Support. No other funding was declared. Radia declared relationships with Abbvie, Galapogos, and Dr. Falk Pharma. ■

Treating Barrett's Esophagus: Comparing EMR and ESD

Dear colleagues,
Many of us diagnose and treat patients with Barrett's esophagus (BE), estimated to affect up to 5.6% of the US adult population. There has been an expanding array of tools to help diagnose and effectively treat Barrett's esophagus with dysplasia and malignancy. In particular, endoscopic submucosal dissection (ESD) has emerged as an important method for treating early cancer in the gastrointestinal tract.

But how do we incorporate ESD into our algorithm for management, especially with the popularity and effectiveness of endoscopic mucosal resection (EMR)? In this issue of Perspectives we aim to provide context for the use of ESD, as compared with EMR. Dr. Silvio de Melo discusses his preferred EMR technique and its many advantages in the management of BE, including for residual or refractory areas. In contrast, Dr. Mohamed Othman reviews the power of ESD and when we should consider this approach over EMR. We hope these discussions will facilitate your care for patients with Barrett's esophagus.


Dr. Ketwaroo

We also welcome your thoughts on this topic — join the conversation on X at @AGA_GIHN.

Gyanprakash A. Ketwaroo, MD, MSc, is associate professor of medicine, Yale University, New Haven, and chief of endoscopy at West Haven VA Medical Center, both in Connecticut. He is an associate editor for GI & Hepatology News.

Endoscopic Mucosal Resection: The 'Workhorse'

BY SILVIO W. DE MELO JR, MD, AGAF

Barrett's esophagus (BE) remains an important clinical problem, being one of the modifiable risk factors for esophageal adenocarcinoma. The care for BE is complex and requires several steps to correctly formulate a therapeutic plan. It starts with a proper endoscopic examination.


Dr. de Melo

It is recommended to spend at least 1 minute inspecting and evaluating every centimeter of the salmon-colored epithelium, looking for change in vascular pattern, erosions/ulcers, nodules, and/or masses. After the inspection, random biopsies every 1-2 cm plus targeted biopsies will guide you. It is still controversial if the addition of other sampling strategies, such as brushings or confocal endomicroscopy, is needed.

The introduction of radiofrequency ablation (RFA) was paramount in popularizing the treatment options for BE and sunsetting the previous dominant modality, photodynamic therapy (PDT). RFA proved to have a superior clinical efficacy in replacing the intestinal metaplasia/BE with neosquamous epithelium while boosting a much better safety profile, compared with PDT. However, RFA is most efficacious for "flat BE" and it is not an effective, nor recommended, method to treat nodular BE or early cancer, such as carcinoma in situ or nodular high-grade dysplasia. Endoscopic mucosal resection (EMR) is utilized to overcome those limitations.

There are several techniques utilized for EMR:

- The lift-and-snare technique.
- The snare-in-cap technique.
- The Band-snare technique.

The free-hand submucosal lift and snare is not frequently used in the esophagus. It is difficult to maintain visualization while being confident that one has the whole lesion inside the snare and that the distal (anal side) part of the lesion is free of any unwanted tissue (to minimize complications such as perforations or unwelcomed gastric resections). It is difficult after the first resection to lift an adjacent area, as the fluid easily leaks from the first resected spot; thus removing larger lesions in piecemeal fashion is challenging.

This technique can be used in small (in my personal experience, less than 5 mm) lesions, but, given that there are better and safer alternatives, I almost never use this

EMR *Continued on following page*

ESD Over EMR for Resecting Esophageal Lesions

BY MOHAMED O. OTHMAN, MD, AGAF

Although endoscopic submucosal dissection (ESD) is the preferred endoscopic resection method in the East, the adoption of this technique in the West, particularly in the United States, has faced many hurdles. Many endoscopists who routinely perform piecemeal endoscopic mucosal resection (EMR) question the utility of ESD, arguing that EMR is just as effective. While this may hold true in certain situations, the global trend in the endoscopic treatment of early esophageal squamous cell carcinoma, nodular Barrett's esophagus (BE), and early esophageal adenocarcinoma (EAC) has clearly shifted toward ESD. In this perspective, I will summarize why ESD is preferred over EMR for these indications and explore why ESD has yet to gain widespread adoption in the United States.


Dr. Othman

The superiority of ESD over EMR has been well established in multiple publications from both Eastern and Western literature. Mejia-Perez et al, in a multicenter cohort study from eight centers in North America, compared outcomes of ESD vs EMR for BE with high-grade dysplasia (HGD) or T1a adenocarcinoma in 243 patients. ESD achieved significantly higher en bloc resection rates (89% vs 43%) and R0 resection rates (73% vs 56%), compared with EMR, along with a substantially lower recurrence/residual disease rate on follow-up (3.5% in the ESD group vs 31.4% in EMR group). Additionally, more patients required repeat endoscopic resection after EMR to treat residual or recurrent disease (EMR, 24.2% vs ESD, 3.5%; $P < .001$).

Han et al conducted a meta-analysis of 22 studies comparing ESD and EMR for early esophageal neoplasia, including both squamous cell carcinoma (SCC) and BE-associated lesions. ESD was associated with significantly higher curative resection rates than EMR (odds ratio [OR], 9.74; 95% CI, 4.83-19.62; $P < .0001$). Of note, lesion size was a critical factor in determining the advantage of ESD. For lesions ≤ 10 mm, curative resection rates were comparable between ESD and EMR. However, for lesions > 10 mm, ESD achieved significantly higher curative resection rates. This size-based recommendation has been adopted by the American Society of Gastrointestinal Endoscopy (ASGE) in their recent guidelines on ESD indications for esophageal lesions. ASGE

ESD *Continued on following page*

Read more!

Please find full-length versions of these debates online at MDedge.com/gihepnews/perspectives.

EMR *Continued from previous page*

technique for my esophageal EMR cases. I prefer to use the band-snare technique even for lesions under 5 mm.

The snare-in-cap technique has been utilized in the esophagus. In this technique, a cap is attached to the distal end of the scope and the size of the resection is determined by the size of the cap, usually under 1.5 cm. Because of the risk of perforation without previous lifting, it is required that the lesion is lifted with a submucosal fluid, saline or any Food and Drug Administration–approved EMR solution.

The lesion is then suctioned where the snare had been previously opened inside the cap, the snare is closed, and the tissue is resected. The same limitations regarding the inability to remove larger lesions (greater than 1.5 cm) because of the challenge in lifting the adjacent area applies here. However, the perforation risk for this technique is higher than the traditional lift and the band-and-snare techniques. Thus, this technique has fallen out of favor for most endoscopists.

The third technique (band-snare EMR) is the one that most endoscopists use for endoscopic mucosal resection. It is a small variation of the already time-tested and very familiar procedure of esophageal variceal band ligation (EVL). There are multiple commercially available kits for esophageal EMR. The kit contains the chamber with the bands and a proprietary hexagonal snare used to resect the specimen.

The advantages of this technique are as follows:

- It is widely commercially available.
- It builds on a familiar procedure, EVL; therefore the learning curve is short.
- The setup is quick and the procedure can be completed safely and effectively.
- There is no need for injecting the submucosal with a lifting solution.
- Despite the band having a size limitation of 1 cm, one can remove larger lesions by repeating the band and resect process, using the rosette technique.

Band-snare EMR also has limitations:

- There are only six bands on each chamber. Depending on the size of the lesion, one may need to use multiple kits.
- It is not suitable for en bloc resection of lesions greater than 1 cm.

My experience with band EMR is that we can complete the procedure in under 1 hour. The dreaded complication of perforation occurs in under 1% of cases, most bleeding episodes can easily be controlled endoscopically, and the risk of post-EMR stricture is minimal. Therefore, band EMR is the most used technique for esophageal endoscopic resections.

'My experience with band EMR is that we can complete the procedure in under 1 hour. The dreaded complication of perforation occurs in under 1% of cases ... and the risk of post-EMR stricture is minimal.'

Esophageal EMR is also effective for other indications in BE therapy, such as residual and recurrent BE. Band-snare EMR can be used for an en bloc resection or rosette technique for the areas resistant to ablation therapies with great success and safety.

From a financial standpoint, comparing EMR with endoscopic submucosal dissection (ESD), EMR is the superior strategy given that EMR is widely available, has a much shorter learning curve, has a greater safety profile, is applicable to a wider variety of indications, and has a more favorable return on investment. EMR should be the workhorse for the care of patients with BE, reserving ESD for specific indications.

In summary, there is no "one-size-fits-all" endoscopic therapy in the care of BE. Most Barrett's patients can be successfully treated with a combination of ablation plus EMR, reserving ESD for select cases. ■

Dr. de Melo is section chief of gastroenterology at the Orlando VA Healthcare System in Florida. He declares no conflicts.

ESD *Continued from previous page*

guidelines favor ESD over EMR for SCC lesions > 15 mm and for nodular BE with dysplasia or early EAC > 20 mm.

ESD is particularly beneficial in patients who develop early adenocarcinoma after radiofrequency ablation (RFA) or EMR. Mesureur et al evaluated the efficacy of salvage ESD for Barrett's recurrence or residual BE following RFA. In their multicenter retrospective study of 56 patients, salvage ESD achieved an en bloc resection rate of 89.3%, despite significant fibrosis, with an R0 resection rate of 66%. At a median follow-up of 14 months, most patients remained in endoscopic remission without the need for esophagectomy.

Combining ESD with RFA has also been shown to accelerate the eradication of BE with dysplasia while reducing the number of required sessions. Our group demonstrated the high efficacy of ESD followed by RFA in 18 patients, most of whom had long-segment BE with HGD or EAC. On average, patients required only one to two RFA sessions after ESD to achieve complete eradication of intestinal metaplasia (CE-IM). Over a median follow-up of 42.5 months (interquartile range, 28-59.25), complete eradication of early esophageal cancer was achieved in 13 patients (100%), eradication of dysplasia in 15 patients (100%), and CE-IM in 14 patients (77.8%).

Despite the overwhelming evidence supporting ESD and the strong endorsement from professional societies, adoption in the West continues to lag. Several factors contribute to this gap. First, ESD has a steep learning curve. Our data showed that, on average, an untutored practitioner achieved competency after 150-250 procedures, a finding corroborated by other US groups.

Second, there is no specific Current Procedural Terminology (CPT) code for ESD in the United States. Physicians are forced to bill the procedure as EMR or use an unlisted code, resulting in reimbursement that does not reflect the time and complexity of the procedure. Our group showed that physician reimbursement for ESD is highly variable, ranging from $50 to $800 per case, depending on insurance type.

Third, the increasing emphasis on productivity and RVU [relative value unit] generation in academic settings has hindered the growth of ESD training in many institutions. Still, the outlook for ESD in the United States remains encouraging. Multiple industry-sponsored training courses are held annually, and professional societies are investing heavily in expanding access to structured education in ESD. Industry is also innovating devices that improve procedural efficiency and safety. Adopting novel approaches, such as traction-assisted ESD, has made the technique more appealing to endoscopists concerned about long procedure times. For example, our group proposed a standardized esophageal ESD technique that incorporates specimen self-retraction. This method improves both safety and speed and has helped address several procedural challenges. We've demonstrated that consistency in technique can substantially expedite esophageal ESD.

'The increasing emphasis on productivity and RVU generation in academic settings has hindered the growth of ESD training in many institutions. Still, the outlook for ESD in the United States remains encouraging.'

Fast forward 5 years: We anticipate a dedicated CPT code for ESD, broader access to advanced resection tools, and an expanding number of fellowships offering structured ESD training. These developments are poised to eliminate many of the current barriers. In summary, with robust data supporting the efficacy of ESD in early esophageal cancer, the focus in the United States should shift toward mastering and integrating the technique, rather than dismissing it in favor of piecemeal EMR. ■

Dr. Othman is chief of the gastroenterology and hepatology section at Baylor College of Medicine and Medicine Subspecialities Service Line Chief at Baylor St Luke's Medical Center, both in Houston. He declares no conflicts of interest.

Choosing the Ideal Endoscopic Enteral Access Method: AGA Practice Update

BY DIANA SWIFT

FROM GASTROENTEROLOGY

At least 250,000 US hospitalized patients a year require enteral support using an artificial pathway into the gastrointestinal (GI) tract to deliver nutrition or medication. In light of this, AGA has issued a clinical practice update to improve the practice of endoscopic enteral access.

Covering indications, placement techniques, and management, the comprehensive document is a response to the increasing use of enteral access devices in chronic GI conditions. The update, published in *Gastroenterology* (2024 Nov. doi: 10.1053/j.gastro.2024.09.043), addresses patient factors complicating placement decision-making such as thrombocytopenia, use of dual-antiplatelet therapy, or performance of percutaneous access in the setting of cirrhosis.

Dr. Micic

'We hope this can serve a day-to-day purpose for clinical gastroenterologists and can be referenced as they encounter individuals with or needing an enteral access device.'

"We provide clinical recommendations in these various scenarios understanding that the final decision-making is in the hands of the provider and care team," said first author Dejan Micic, MD, a gastroenterologist at University of Chicago Medical Center at the time of the update (since relocated to Loyola University Medical Center in Chicago). "We hope this can serve a day-to-day purpose for clinical gastroenterologists and can be referenced as they encounter individuals with or needing an enteral access device."

Traditionally, enteral access was reserved for patients with severe malnutrition or those unable to maintain oral intake. Recent recommendations emphasize early nutritional intervention including prehabilitation before major surgery, adjunctive therapy for oncology patients, and use in specific inflammatory conditions such as Crohn's disease. "These shifts recognize the role of enteral nutrition not only in preventing malnutrition but also as a therapeutic strategy," Micic said in an interview.

There is, however, variability in the use of devices including the selection of appropriate units, technical aspects of placement, and subsequent management. "Such variability can lead to complications, suboptimal patient outcomes, and inefficiencies in care delivery," Micic said.

He added that enteral access has been historically underemphasized in GI endoscopic training. "While procedural skill in placing devices such as percutaneous endoscopic gastrostomy, or PEG, tubes is often taught, a comprehensive understanding of the broader clinical context is not always thoroughly covered."

The current update aims to bridge knowledge gaps with evidence-based guidance. "It also underscores the importance of interdisciplinary collaboration to achieve the best outcomes for patients," Micic said.

Commenting on the update but not involved with creating it, Shirley C. Paski, MD, MS, a gastroenterologist at the Cleveland Clinic, called it timely, adding: "As GI training is becoming more subspecialized and interventional radiology has been able to provide enteral access, gastroenterology training in enteral access has declined to where some fellows are graduating with limited enteral access experience."

Dr. Paski

'This is a helpful addition to the literature because if enteral access cannot be obtained ... total parenteral nutrition is the next and much more invasive step.'

Yet malnutrition remains a common consequence when GI disease is severe, chronic, or refractory to treatment, or in the setting of postsurgical anatomy, she added. "Enteral nutrition is increasingly being considered a therapeutic or adjunct treatment in some cases of Crohn's disease or small intestinal bacterial overgrowth. Gastroenterologists need the endoscopic skill to secure enteral access tubes, particularly in more challenging anatomy."

Also commenting on the document, Steven Shamah, MD, director of endoscopy at Northwell Lenox Hill Hospital in New York City, said: "This should serve as a concise review for any general hospitalist or gastroenterologist to understand what we have and when we should offer the proper feeding tube options." He stressed, however, that all gastroenterologists should be trained in the placing of all tube options.

Dr. Shamah

'This should serve as a concise review for any general hospitalist or gastroenterologist to understand what we have and when we should offer the proper feeding tube options.'

"The axiom 'If the gut works, we should use it' is something that I was taught when I was a medical student and it still holds true," Shamah continued. "There's been a jump in interventional procedures to assure continuity of the GI tract even in progressive malignancy. So there's a rise in moving away from intravenous nutrition and a rise in tube-delivered enteral nutrition."

Tubing Options

According to Micic and colleagues, recent data suggest a favorable safety profile of enteral feeding tubes placed endoscopically compared with surgical or radiologic placement. The illustrated AGA document outlines such approaches as synthetic flexible tubes placed into the stomach or small bowel via the oral (orogastric and oroenteral) or nasal routes (nasogastric [NG] and nasojejunal [NJ]) and percutaneous tubes accessing the stomach. The choice of tube, access point, delivery site, and feeding method varies with indication, expected duration of use, and patient anatomy, the authors stressed.

The update notes that NG and NJ tubes can be used immediately after confirmation of placement, most often with abdominal radiography. PEG tubes can be used immediately for medications and after 4 hours for tube feedings. A multidisciplinary team approach after placement provides improved patient care. "Dietitians assist with formula choice, volume, free water needs, and delivery method, and nurses and advanced practice clinicians assist with tube site assessment and troubleshooting," the authors wrote.

Complications can occur but should be infrequent, Micic said. "Frankly, most complications can be predicted based on the duration of use and prevented with appropriate monitoring." Common complications include tube dislodgment, clogging, site infections, buried bumper syndrome, and aspiration. "Minimizing these risks requires a thorough understanding of patient-specific factors, careful technique during placement, and ongoing monitoring after the device is in use," he added.

Paski said the update aligns with established guidelines for enteral access but also offers suggestions to mitigate the risk of tube placement in patients in whom placement has traditionally been more challenging. "This is a helpful addition to the literature because if enteral access cannot be obtained in a patient unable to meet their needs orally, total parenteral nutrition is the next and much more invasive step for nutrition support."

She called the practice update a concise, comprehensive reference for trainees and experienced gastroenterologists to optimize placement conditions and reduce complication risk, noting that

Continued on following page

WATS-3D Biopsy Increases Detection of Barrett's Esophagus in GERD

BY MEGAN BROOKS

In patients with gastroesophageal reflux disease (GERD) symptoms undergoing screening upper endoscopy, adjunctive use of wide-area transepithelial sampling with three-dimensional (3D) computer-assisted analysis (WATS-3D) increases detection of Barrett's esophagus (BE) and dysplasia, new research showed.

Compared with forceps biopsies (FB) alone, the addition of WATS-3D led to confirmation of BE in an additional one fifth of patients, roughly doubled dysplasia diagnoses, and influenced clinical management in the majority of patients.

"The big take-home point here is that the use of WATS-3D brushing along with conventional biopsies increases the likelihood that intestinal metaplasia will be identified," first author Nicholas Shaheen, MD, MPH, AGAF, with the Center for Esophageal Diseases and Swallowing, University of North Carolina School of Medicine at Chapel Hill, said in an interview.

"Almost 20% of patients who harbor BE were only identified by WATS-3D and might have otherwise gone undiagnosed had only forceps biopsies been performed," Shaheen said.

The study was published in *The American Journal of Gastroenterology* (2024 Apr. doi: 10.14309/ajg.0000000000002818).

Beyond Traditional Biopsies

BE develops as a complication of chronic GERD and is the chief precursor to esophageal adenocarcinoma. Early detection of BE and dysplasia is crucial to enable timely intervention.

The current gold standard for BE screening involves upper endoscopy with FB following the Seattle protocol, which consists of four-quadrant biopsies from every 1-2 cm of areas of columnar-lined epithelium (CLE) to confirm the presence of intestinal metaplasia. However, this protocol is prone to sampling errors and high false-negative rates, leading to repeat endoscopy, the study team pointed out.

WATS-3D (CDx Diagnostics) is a complementary technique designed to improve diagnostic yield by using brush biopsy to sample more tissue than routine biopsies.

WATS-3D has been shown to increase detection of dysplasia in patients undergoing surveillance for BE, but less is known about the value of WATS-3D for BE screening in a community-based cohort of patients with GERD.

To investigate, Shaheen and colleagues studied 23,933 consecutive patients enrolled in a prospective observational registry assessing the utility of WATS-3D in the screening of symptomatic GERD patients for BE.

Patients had both WATS-3D and FB in the same endoscopic session. No patient had a history of BE, intestinal metaplasia or dysplasia in esophageal mucosa, or esophageal surgery, endoscopic ablation, or endoscopic mucosal resection.

Overall, 6829 patients (29%) met endoscopic criteria for BE (≥ 1 cm esophageal CLE with accompanying biopsies showing metaplasia).

Of these, 2878 (42%) had intestinal metaplasia identified by either FB or WATS-3D, but 19.3% had their BE diagnosis confirmed solely on the basis of WATS-3D findings.

Among patients who fulfilled the endoscopic criteria for BE, the adjunctive yield of WATS-3D was 76.5% and the absolute yield was 18.1%.

Of the 240 (1.0%) patients with dysplasia, 107 (45%) were found solely by WATS-3D.

Among patients with positive WATS-3D but negative FB results, clinical management changed in 90.7% of cases, mostly involving initiation of surveillance and proton-pump inhibitor therapy.

These results suggest that WATS-3D is a "clinically valuable adjunct" to FB for the diagnosis of BE when used as a screening tool in symptomatic GERD patients and particularly in patients with endoscopic evidence of > 1 cm esophageal columnar-lined epithelium.

Adjunctive use of WATS-3D when BE is suspected "may save endoscopies and lead to quicker, more accurate diagnoses," the authors added.

They said a limitation of the study was a lack of central pathology review, and that over half of the detected dysplasia cases were crypt dysplasia or indefinite, raising concerns about clinical significance.

Reached for comment, Philip O. Katz, MD, AGAF, professor of medicine and director of the GI Function Laboratories, Weill Cornell Medicine in New York, said he's been using WATS for more than a decade as an adjunct to standard biopsy in patients undergoing screening and surveillance for BE and finds it clinically helpful in managing his patients.


Dr. Katz

This new study provides "further information that WATS added to biopsy that has been traditionally done with the Seattle protocol increases the yield of intestinal metaplasia and likely dysplasia in patients being screened for Barrett's," said Katz, who wasn't involved in the study.

Study funding was provided by CDx Diagnostics. Shaheen disclosed relationships with the company. Katz disclosed relationships with Phathom Pharmaceuticals and Sebella.

Continued from previous page

training in nutrition is suboptimal in many GI fellowships.

Becoming familiar with common and advanced enteral access techniques is within the armamentarium of all practicing gastroenterologists, the authors stated. Because malnutrition affects nearly all GI disorders, "understanding common routes of enteral access and the basic principles of nutrition support promotes the initiation of optimal enteral nutrition, mitigating the impact of malnutrition, and improving prognosis for patients at nutritional risk."

Micic served on the advisory board for Ironwood Pharmaceuticals and is on the speaker's bureau for Takeda Pharmaceuticals. One coauthor served as a consultant for Merit Medical, Circa Scientific, and Aspero Medical. Paski and Shamah disclosed no competing interests relevant to their comments.

Low-Quality Food Environments Increase MASLD-Related Mortality

BY WILL PASS
MDedge News

FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

US counties with limited access to healthy food (food deserts) or a high density of unhealthy food outlets (food swamps) have higher mortality rates from metabolic dysfunction–associated steatotic liver disease (MASLD), according to investigators.

These findings highlight the importance of addressing disparities in food environments and social determinants of health to help reduce MASLD-related mortality, lead author Annette Paik, MD, of Inova Health System, Falls Church, Virginia, and colleagues reported.

"Recent studies indicate that food swamps and deserts, as surrogates for food insecurity, are linked to poor glycemic control and higher adult obesity rates," the investigators wrote in *Clinical Gastroenterology and Hepatology* (2024 Nov. doi: 10.1016/j.cgh.2024.08.053). "Understanding the intersection of these factors with sociodemographic and clinical variables offers insights into MASLD-related outcomes, including mortality."

The present study examined the association between food environments and MASLD-related mortality across more than 2195 US counties. County-level mortality data were obtained from the Centers for Disease Control and Prevention (CDC) WONDER database (2016-2020) and linked to food environment data from the US Department of Agriculture Food Environment Atlas using Federal Information Processing Standards (FIPS) codes. Food deserts were defined as low-income areas with limited access to grocery stores, while food swamps were characterized by a predominance of unhealthy food outlets relative to healthy ones.

Additional data on obesity, type 2 diabetes (T2D), and nine social determinants of health were obtained from CDC PLACES and other publicly available datasets. Counties were stratified into quartiles based on MASLD-related mortality rates. Population-weighted mixed-effects linear regression models were used to evaluate associations between food environment exposures and MASLD mortality, adjusting for region, rural-urban status, age, sex, race, insurance coverage, chronic disease prevalence, Supplemental Nutrition Assistance Program participation, and access to exercise facilities.

Counties with the worst food environments had significantly higher MASLD-related mortality, even after adjusting for clinical and sociodemographic factors. Compared with counties in the lowest quartile of MASLD mortality, those in the highest quartile had a greater proportion of food deserts and food swamps, and had a significantly higher prevalence of obesity, type 2 diabetes, and physical inactivity.

Both food deserts and food swamps remained independently associated with MASLD mortality. Counties in the highest quartile of food desert exposure had a 14.5% higher MASLD mortality rate, compared with the lowest quartile, and those in the highest quartile for food swamp exposure had a 13.9% higher mortality rate.

Type 2 diabetes, physical inactivity, and lack of health insurance were also independently associated with increased MASLD-related mortality.

The investigators disclosed no conflicts of interest. ■

A healthy lifestyle continues to be foundational to the management of metabolic dysfunction–associated steatotic liver disease (MASLD). Poor diet quality is a risk factor for developing MASLD in the US general population. Food deserts and food swamps are symptoms of socioeconomic hardship, as they both are characterized by limited access to healthy food (as described by the US Department of Agriculture Dietary Guidelines for Americans) owing to the absence of grocery stores/supermarkets. However, food swamps suffer from abundant access to unhealthy, energy-dense, yet nutritionally sparse (EDYNS) foods.


Dr. Samala

The article by Paik et al shows that food deserts and food swamps are associated not only with the burden of MASLD in the United States but also with MASLD-related mortality. The counties with the highest MASLD-related mortality carried higher food swamps and food deserts, poverty, unemployment, household crowding, absence of broadband internet access, lack of high school education, and elderly, Hispanic residents and likely to be located in the South.

MASLD appears to have origins in the dark underbelly of socioeconomic hardship that might preclude many of our patients from complying with lifestyle changes. Policy changes are urgently needed at a national level, from increasing incentives to establish grocery stores in the food deserts to limiting the proportion of EDYNS foods in grocery stores and conspicuous labeling by the Food and Drug Administration of EDYNS foods. At an individual practice level, supporting MASLD patients in the clinic with a dietitian and educational material, and, where possible, utilizing applications to assist healthy dietary habits empower them in choosing healthy food options.

Niharika Samala, MD, is assistant professor of medicine, associate program director of the GI Fellowship, and director of the IUH MASLD/NAFLD Clinic at the Indiana University School of Medicine, Indianapolis. She reported no relevant conflicts of interest.

Changes Weeks in Advance of Flares

Wearable *from page 1*

sympathetic tone, which in turn affect heart rate and heart rate variability. Heart rate tends to rise during flares, while heart rate variability decreases.

Their prospective cohort study included 309 adults with Crohn's disease (n = 196) or ulcerative colitis (n = 113). Participants used their own or a study-provided Apple Watch, Fitbit, or Oura Ring to passively collect physiological data, including heart rate, resting heart rate, heart rate variability, and step count. A subset of Apple Watch users contributed oxygen saturation data.

Participants also completed daily symptom surveys using a custom smartphone app and reported laboratory values such as C-reactive protein, erythrocyte sedimentation rate, and fecal calprotectin, as part of routine care. These data were used to identify symptomatic and inflammatory flare periods.

Over a mean follow-up of about 7 months, the physiological data consistently distinguished both types of flares from periods of remission. Heart rate variability dropped significantly during flares, while heart rate and resting heart rate increased. Step counts decreased during inflammatory flares but not during symptom-only flares. Oxygen saturation stayed mostly the same, except for a slight drop seen in participants with Crohn's disease.

These physiological changes could be detected as early as 7 weeks before a flare. Predictive models that combined multiple metrics — heart rate variability, heart rate, resting heart rate, and step count — were highly accurate, with F1 scores as high as 0.90 for predicting inflammatory flares and 0.83 for predicting symptomatic flares.

In addition, wearable data helped differentiate between flares caused by active inflammation and those driven by symptoms alone. Even when symptoms were similar, heart rate variability, heart rate, and resting heart rate were significantly higher when inflammation was present—suggesting wearable devices may help address the common mismatch between symptoms and actual disease activity in IBD.

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Infrequent HDV Testing Raises Concern for Worse Liver Outcomes

BY WILL PASS
MDedge News

FROM GASTRO HEP ADVANCES

Only one in six US veterans with chronic hepatitis B (CHB) is tested for hepatitis D virus (HDV)—a coinfection associated with significantly higher risks of cirrhosis and hepatic decompensation—according to new findings.

The low testing rate suggests limited awareness of HDV-associated risks in patients with CHB, and underscores the need for earlier testing and diagnosis, lead author Robert J. Wong, MD, of Stanford University School of Medicine in California, and colleagues, reported.

"Data among US populations are lacking to describe the epidemiology and long-term outcomes of patients with CHB and concurrent HDV infection," the investigators wrote in *Gastro Hep Advances* (2025 Oct. doi: 10.1016/j.gastha.2024.10.015).

Prior studies have found that only 6%-19% of patients with CHB get tested for HDV, and among those tested, the prevalence is relatively low — between 2% and 4.6%. Although relatively uncommon, HDV carries a substantial clinical and economic burden, Wong and colleagues noted.

The present study analyzed data from the Veterans Affairs Corporate Data Warehouse between 2010 and 2023. Patients who tested positive for HDV were propensity score–matched 1:2 with CHB patients who tested negative. Matching accounted for age, sex, race/ethnicity, hepatitis B e antigen (HBeAg) status, antiviral treatment, hepatitis C virus (HCV) and HIV coinfection, diabetes, and alcohol use. Patients with cirrhosis or hepatocellular carcinoma (HCC) at baseline were excluded.

Among 27,548 veterans with CHB, only 16.1% underwent HDV testing. Of those tested, 3.25% were HDV positive. Testing rates were higher among patients who were HBeAg positive, on antiviral therapy, or identified as Asian or Pacific Islander.

Conversely, testing was significantly less common among patients with high-risk alcohol use, past or current drug use, cirrhosis at diagnosis, or HCV coinfection.

Among those tested, HDV positivity was more likely in patients with HCV coinfection, cirrhosis, or a history of drug use. On multivariable analysis, these factors were independent predictors of HDV positivity.

In the matched cohort of 71 HDV-positive patients and 140 HDV-negative controls, the incidence of cirrhosis was more than threefold higher in HDV-positive patients, and hepatic decompensation was over five times more common. There was also a nonsignificant trend toward increased HCC risk in the HDV group.

"These findings align with existing studies and confirm that among a predominantly non-Asian US cohort of CHB patients, presence of concurrent HDV is associated with more severe liver disease progression," the investigators wrote. The study was supported by Gilead. The investigators disclosed additional relationships with Exact Sciences, GSK, Novo Nordisk, and others. ■

Hepatitis D virus (HDV) is an RNA "sub-virus" that infects patients with co-existing hepatitis B virus (HBV) infections. HDV infection currently affects approximately 15-20 million people worldwide but is an orphan disease in the United States with fewer than 100,000 individuals infected today.


Dr. Gish

Those with HDV have a 70% lifetime risk of hepatocellular carcinoma (HCC), cirrhosis, liver failure, death, or liver transplant. But there are no current treatments in the US that are Food and Drug Administration–approved for the treatment of HDV, and only one therapy in the European Union with full approval by the European Medicines Agency.

Despite HDV severity and limited treatment options, screening for HDV remains severely inadequate, often testing only those individuals at high risk sequentially. HDV screening, would benefit from a revamped approach that automatically reflexes testing when individuals are diagnosed with HBV if positive for hepatitis B surface antigen, then proceeds to anti-HDV antibody total testing, and then double reflexed to HDV-RNA polymerase chain reaction quantitation. This is especially true in the Veterans Administration's hospitals and clinics, where Wong and colleagues found very low rates of HDV testing among a national cohort of US Veterans with chronic HBV.

This study highlights the importance of timely HDV testing using reflex tools to improve diagnosis and HDV treatment, reducing long-term risks of liver-related morbidity and mortality.

Robert G. Gish, MD, AGAF, is principal at Robert G Gish Consultants LLC, clinical professor of medicine at Loma Linda University in California, and medical director of the Hepatitis B Foundation. His complete list of disclosures can be found at www.robertgish.com/about.

Continued from previous page

"These findings support the further evaluation of wearable devices in the monitoring of IBD," the investigators concluded.

The study was supported by the National Institute of Diabetes and Digestive and Kidney Diseases and Jenny Steingart. The investigators disclosed additional relationships with Agomab, Lilly, Merck, and others. ■

Dana J. Lukin, MD, PhD, AGAF, of New York–Presbyterian Hospital/Weill Cornell Medicine, New York City, described the study by Hirten et al as "provocative."

"While the data require a machine-learning approach to transform the recorded values into predictive algorithms, it is intriguing that routinely recorded information from smart devices can be used in a manner to inform disease activity," Lukin said in an interview. "Furthermore, the use of continuously recorded physiological data in this study likely reflects longitudinal health status more accurately than cross-sectional use of patient-reported outcomes or episodic biomarker testing."


Dr. Lukin

In addition to offering potentially higher accuracy than conventional monitoring, the remote strategy is also more convenient, he noted.

"The use of these devices is likely easier to adhere to than the use of other contemporary monitoring strategies involving the collection of stool or blood samples," Lukin said. "It may become possible to passively monitor a larger number of patients at risk for flares remotely," especially given that "almost half of Americans utilize wearables, such as the Apple Watch, Oura Ring, and Fitbit."

Still, Lukin predicted challenges with widespread adoption.

"More than half of Americans do not routinely [use these devices]," Lukin said. "Cost, access to internet and smartphones, and adoption of new technology may all be barriers to more widespread use."

He suggested that the present study offers proof of concept, but more prospective data are needed to demonstrate how this type of remote monitoring might improve real-world care.

"Potential studies will assess change in healthcare utilization, corticosteroids, surgery, and clinical flare activity with the use of these data," Lukin said. "As we learn more about how to handle the large amount of data generated by these devices, our algorithms can be refined to make a feasible platform for practices to employ in routine care."

Lukin disclosed relationships with Boehringer Ingelheim, Takeda, Vedanta, and others.

Member SPOTLIGHT

Providing HCC Patients With Hope Through Trials, Treatments

BY JENNIFER LUBELL
MDedge News


REENA SALGIA

Dr. Reena Salgia (3rd from R) accompanies her GI fellows at their graduation from Henry Ford Health in Detroit.

For Reena Salgia, MD, the most rewarding part about working with patients with hepatocellular carcinoma (HCC) is being there for their entire journey, thanks to advancements in treatment. "It brings a smile to my face just to think about it," says Dr. Salgia, medical director of Henry Ford Health's Liver Cancer Clinic in Detroit.

HCC accounts for 80% of all liver cancer. When she first entered the field, Dr. Salgia often heard that survival rates 5 years after diagnosis were less than 10%. Over the last decade however, "I've seen an expansion in the procedural options that we offer these patients. We have an array of options both surgically as well as procedurally," she said.

Especially over the last 3-4 years, "we've seen meaningful responses for patients with medications that we previously didn't have in our toolbox. That's really been exciting, along with continued involvement in clinical trials and being able to offer patients a number of different approaches to their care of liver cancer," said Dr. Salgia.

As program director of Henry Ford's Gastroenterology and Transplant Hepatology Fellowship, Dr. Salgia enjoys mentoring up-and-coming gastroenterologists and hepatologists and watching their skill sets evolve. A regular attendee and presenter at national meetings, Dr. Salgia participated in AGA's Women's Executive Leadership Conference in 2023. Her academic resume includes a long list of clinical trials to assess treatments for patients at different stages of HCC.

In an interview, she discussed the highlights of her career as a researcher and mentor of fellows, and how she guides and supports her transplant patients.

What drove you to pursue the field of hepatology and transplant hepatology?

I came across this field during my fourth year of medical school. I didn't know anything about hepatology when I reached that stage and had the opportunity to do an elective. I just fell in love with the specialty. I liked the complex pathophysiology of liver disease, the long-term follow-up and care of patients. It appealed to the type of science that I had enjoyed back in college.

As I went into my GI fellowship training, I got to learn more about the field of transplant medicine. For instance, how you can take these patients who are incredibly ill, really at a very vulnerable point of their illness, and then offer them great hope and see their lives turn around afterwards. When I had the opportunity to see patients go from end-stage liver disease to such significant improvement in their quality of life, and restoring their physical functioning beyond what we would've ever imagined when they were ill, it reaffirmed my interest in both hepatology as well as in transplant medicine.

How do you help those patients waiting on transplant lists for a liver?

We are intimately involved in their care all the way through their journey with liver disease, up until the time of physically getting the liver transplant, which is performed by our colleagues in transplant surgery. From the time they are transplanted, we are involved in their inpatient and outpatient post-transplant care. We've helped to get them on the transplant list with the work of the multidisciplinary team. If there are opportunities to help them understand their position on the list or obtaining exceptions — though that is done in a very objective fashion through the regulatory system — we help to guide them through that journey.

You've worked on many studies that involve treatments for hepatocellular carcinoma. Can you highlight a paper that yielded clinically significant benefits?

What really stands out the most to me was our site's involvement in the IMbrave150 trial, which was published in 2020. This multicenter study made a big difference in the outcomes and treatments for patients, as it brought the adoption of first-line immunotherapy (atezolizumab plus bevacizumab) for patients with advanced hepatocellular carcinoma. I remember vividly the patients we had the opportunity to enroll in that trial — some who we continue to care for today. This stands out as one of the trials that I was involved in that had a lasting impact.

What were the clinical endpoints and key results of that trial?

The endpoint was to see an improvement in overall survival utilizing immunotherapy, compared


HENRY FORD FELLOWS

Dr. Reena Salgia (first row, center) greets her colleagues at Henry Ford Health GI Fellows program.

utilizing immunotherapy, compared with the prior standard of care then available, oral therapy. The results led to the adoption and [Food and Drug Administration] approval of immunotherapy in the first-line setting for advanced unresectable hepatocellular carcinoma patients.

What are some of the highlights of serving as director of Henry Ford's fellowship program?
Education is my passion. I went into medical training feeling that at some point I would love to blend in teaching in a formal role. Becoming program director of the gastroenterology and hepatology fellowship at Henry Ford in 2018 was one of the most meaningful things that I've had the opportunity to do in my career. I get to see trainees who are at a very impressionable point of their journey go on to become gastroenterologists and then launch into their first job and really develop in this field. Seeing them come in day 1, not knowing how to hold a scope or do a procedure on a patient of this nature, then quickly evolve over the first year and grow over 3 years to achieve this specialty training [is rewarding]. I've learned a lot from the fellows along the way. I think of them as an extension of my family. We have 15 fellows currently in our program and we'll be growing this summer. So that's really been a highlight of my career thus far.

What fears did you have to push past to get to where you are in your career?
I think that there have been a few. One is certainly the fear of making the wrong choice with your first career opportunity. I did choose to leave my comfort zone from where I had done my training. I met that with some fear, but also excitement for new opportunities of personal and professional growth.

Another fear is: Am I going to be able to be ambitious in this field? Can I pursue research, become a program director, and do things that my role models and mentors were able to achieve? There's also the fear of being able to balance a busy work life with a busy home life and figuring out how to do both well and minimize the guilt on both sides. I have a family with two girls. They are definitely a top priority.

What teacher or mentor had the greatest impact on you?
Helen Te, MD, a hepatologist at the University of Chicago. When I was a medical student there, I had the opportunity to work with her and saw her passion for this field. She really had so much enthusiasm for teaching and was a big part of why I started to fall in love with liver disease.

Karen Kim, MD, now the dean of Penn State College of Medicine, was one of my assigned mentors as a medical student. She helped me explore the fields where there were opportunities for residency and helped me make the decision to go into internal medicine, which often is a key deciding point for medical students. She was also a very influential teacher. The other individual who stands out is my fellowship program director, Hari Sree Conjeevaram, MD, MSc, at University of Michigan Health. He exhibited the qualities as an educator and program director that helped me recognize that education was something that I wanted to pursue in a formal fashion once I moved on in my career.

Describe how you would spend a free Saturday afternoon.
Likely taking a hike or go to a park with my family, enjoying the outdoors and spending time with them. ■


LAURIE TARASI
Dr. Reena Salgia enjoys free time with her family.

LIGHTNING ROUND

Career if you weren't a gastroenterologist?
Philanthropist

Favorite city in US besides the one you live in?
Chicago

Place you most want to travel?
New Zealand

Favorite breakfast?
Avocado toast

Favorite ice cream flavor?
Cookies and cream

Number of cups of coffee you drink per day?
Two ... or more

Cat person or dog person?
Dog

Texting or talking?
Talk

Favorite season?
Autumn

Favorite type of music?
Pop

Favorite movie genre?
Action

New Quality Benchmark

Prep *from page 1*

the task force recommends considering the individual's medical history, medications, and, when available, the adequacy of bowel preparation reported from prior colonoscopies. Other considerations include patient preference, associated additional costs to the patient, and ease in obtaining and consuming any purgatives or adjuncts.

In terms of timing and dose, the task force now "suggests that lower-volume bowel preparation regimens, such as those that rely on only 2 liters of fluid compared to the traditional 4 L, are acceptable options for individuals considered unlikely to have an inadequate bowel preparation. This assumes that the purgative is taken in a split-dose fashion (half the evening prior to colonoscopy and half the morning of the colonoscopy)," co–lead author Brian C. Jacobson, MD, MPH, AGAF, with Massachusetts General Hospital and Harvard Medical School, both in Boston, said in an interview.

The task force also states that a same-day bowel preparation regimen for afternoon, but not morning, colonoscopy is a "reasonable alternative to the now-common split-dose regimen," Jacobson said.

The group did not find one bowel preparation purgative to be better than others, although table 7 in the document details characteristics of commonly used prep regimens including their side effects and contraindications.

Recommendations regarding dietary modifications depend upon the patient's risk for inadequate bowel prep. For patients at low risk for inadequate bowel prep, the task force recommends limiting dietary restrictions to the day before a colonoscopy, relying on either clear liquids or low-fiber/low-residue diets for the early and midday meals. Table 5 in the document provides a list of low-residue foods and sample meals.

Dr. Jacobson

The task force also suggests the adjunctive use of oral simethicone (≥ 320 mg) to bowel prep as a way to potentially improve visualization, although they acknowledge that further research is needed.

How might these updated consensus recommendations change current clinical practice?

Jacobson said, "Some physicians may try to identify individuals who will do just as well with a more patient-friendly, easily tolerated bowel preparation regimen, including less stringent dietary restrictions leading up to colonoscopy."

He noted that the task force prefers the term "guidance" to "guidelines."

The task force includes representatives from the American Gastroenterological Association, the American College of Gastroenterology, and the American Society for Gastrointestinal Endoscopy.

New Quality Benchmark

The task force recommends documenting bowel prep quality in the endoscopy report after all washing and suctioning have been completed using reliably understood descriptors that communicate the adequacy of the preparation.

They recommend the term "adequate bowel preparation" be used to indicate that standard screening or surveillance intervals can be

Continued on following page

Simple Ways to Create Your Legacy

Creating a legacy of giving is easier than you think. As the spring season begins, take some time to start creating your legacy while supporting the AGA Research Foundation.

Gifts to charitable organizations, such as the AGA Research Foundation, in your future plans ensure your support for our mission continues even after your lifetime.

Here are two ideas to help you get started.

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2. **Include the AGA Research Foundation in your will or living trust.** This gift can be made by including as little as one sentence in your will or living trust. Plus, your gift can be modified throughout your lifetime as circumstances change.

Want to learn more about including a gift to the AGA Research Foundation in your future plans? Visit our website at https://foundation.gastro.org/gift-planning/. ■

Continued from previous page

assigned based on the findings of the colonoscopy.

Additionally, the task force recommends that endoscopy units and individual endoscopists track and aim for ≥ 90% adequacy rates in bowel preparation — up from the 85% benchmark contained in the prior recommendations.

Jacobson told this news organization it's "currently unknown" how many individual endoscopists and endoscopy units track and meet the 90% benchmark at present.

David Johnson, MD, professor of medicine and chief of gastroenterology at Eastern Virginia Medical School, Norfolk, who wasn't on the task force, said endoscopy units and providers "need to be accountable and should be tracking this quality metric."

Johnson noted that bowel prep inadequacy has "intrinsic costs," impacting lesion detection, CRC incidence, and patient outcomes. Inadequate prep leads to "increased risk for morbidity, mortality, longer appointment and wait times for rescheduling, and negative connotations that may deter patients from returning."

Brian Sullivan, MD, MHS, assistant professor of medicine, division of gastroenterology, Duke University School of Medicine, Durham, North Carolina, who wasn't on the task force, said the recommendation to target a 90% or higher bowel preparation adequacy rate is "appreciated."

"This benchmark encourages practices to standardize measurement, tracking, and reporting of preparation quality at both the individual and unit levels. Specifically, it should motivate providers to critically evaluate their interpretation of preparation quality and ensure adequate cleansing before making determinations," Sullivan said in an interview.

"At the unit level, this metric can identify whether there are opportunities for quality improvement, such as by implementing evidence-based initiatives (provided in the guidance) to enhance outpatient preparation processes," Sullivan noted.

Dr. Sullivan

The task force emphasized that the majority of consensus recommendations focus on individuals at average risk for inadequate bowel prep. Patients at high risk for inadequate bowel prep (eg, diabetes, constipation, opioid use) should receive tailored instructions, including a more extended dietary prep and high-volume purgatives.

'Timely and Important' Updates

Sullivan said the updated consensus recommendations on optimizing bowel preparation quality for colonoscopy are both "timely and important."

"Clear guidance facilitates dissemination and adoption, promoting flexible yet evidence-based approaches that enhance patient and provider satisfaction while potentially improving CRC prevention outcomes. For instance, surveys reveal that some practices still do not utilize split-dose bowel preparation, which is proven to improve preparation quality, particularly for the right-side of the colon. This gap underscores the need for standardized guidance to ensure high-quality colonoscopy and effective CRC screening," Sullivan said.

He also noted that the inclusion of lower-volume bowel prep regimens and less intensive dietary modifications for selected patients is a "welcome update."

"These options can improve patient adherence and satisfaction, which are critical not only for the quality of the index exam but also for ensuring patients return for future screenings, thereby supporting long-term CRC prevention efforts," Sullivan said.

The task force includes representatives from the American Gastroenterological Association, the American College of Gastroenterology, and the American Society for Gastrointestinal Endoscopy.

The consensus document was published online in the three societies' respective scientific journals — *Gastroenterology* (2025 Mar. doi: 10.1053/j.gastro.2025.02.002), the *American Journal of Gastroenterology*, and *Gastrointestinal Endsocopy*.

This research had no financial support. Jacobson is a consultant for Curis and Guardant Health. Sullivan had no disclosures. Johnson is an adviser to ISOThrive and a past president of the American College of Gastroenterology. ■

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