8 THE NEW GASTROENTEROLOGIST
Disorders of gut-brain interaction

14 GUIDELINES
Polyposis gene testing tied to adenoma count

23 MEMBER SPOTLIGHT
Treating further upstream with Dr. Radha Tamerisa



22 NEWS FROM AGA
Improving access to care: 2026 Advocacy Day recap

GI&Hepatology News

American Gastroenterological Association's official newspaper
November 2026 | news.gastro.org



Crohn's surgery risk held steady as advanced therapy use climbed

Crohn's disease often damages the bowel before diagnosis, and "current therapies can't reverse that damage," the corresponding author said.

By Doug Brunk

Advanced therapies are increasingly used within the first year after an inflammatory bowel disease (IBD) diagnosis, but outcome trends differed between Crohn's disease (CD) and ulcerative colitis (UC), a large U.S. claims study found.

Among patients diagnosed from 2019 through 2023, 53% with CD and 27% with UC started an advanced therapy within one year. Repeated corticosteroid use declined compared with patients diagnosed from 2007 through 2012, although overall corticosteroid use remained common.

In CD, the estimated five-year risk of IBD-related hospitalization fell from 18% to 14%, but the adjusted comparison was not statistically significant (adjusted hazard ratio, 0.80; 95% confidence interval, 0.62-1.03). Major abdominal surgery also did not decline significantly. In UC, hospitalization remained relatively stable, while colectomy declined significantly.

Reporting in *Clinical Gastroenterology and Hepatology*, corresponding author Siddharth Singh, MD, MS, professor of medicine in the division of gastroenterology and hepatology at Mayo Clinic in Arizona, Scottsdale, and colleagues conducted a retrospective cohort study using the OptumLabs Data Warehouse, which contains medical and pharmacy claims from commercially insured patients across the U.S.

Continues · Page 6

Custom 1-liter bowel prep clears noninferiority bar against 4-liter standard

A custom 1-liter bowel prep outscored a standard 4-liter regimen on the Boston Bowel Preparation Scale (8.47 vs. 7.85), clearing a noninferiority bar in a randomized screening trial. Thirst was more common, and colonoscopies took about eight minutes longer.

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Baveno VIII shifts portal hypertension care toward prevention

"PHT management is becoming increasingly preventive, personalized, and noninvasive. With Baveno VIII, noninvasive tests allow us to identify risk earlier, carvedilol effectively treats portal hypertension before the first clinical complication, and unnecessary endoscopies can increasingly be avoided."

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YOU CAN'T TRUST IgG4-RD TO RESPECT BOUNDARIES

Immunoglobulin G4-related disease (IgG4-RD) is a chronic, systemic, immune-mediated disorder that can manifest in nearly any organ.[1]

- By the time IgG4-RD is diagnosed, patients have **3 affected organs** on average[2]

- Within 3 years of any flare, **up to 90% of patients** will experience flare recurrence in the same affected organ or at a different anatomical site[3]



EXAMPLE PATIENT CASE

PANCREATOBILIARY INVOLVEMENT

Presentation

A 66-year-old patient presents with painless obstructive jaundice.

Potentially misdiagnosed as:

Pancreatic cancer, cholangiocarcinoma, primary sclerosing cholangitis

Diagnostic workup

Serology: Elevated IgG4 levels

Imaging: Diffuse pancreatic enlargement, biliary strictures, and enlarged lymph nodes in abdomen

Pathology: EUS-guided core biopsy of the pancreas showing a small vein surrounded by lymphoplasmacytic inflammation

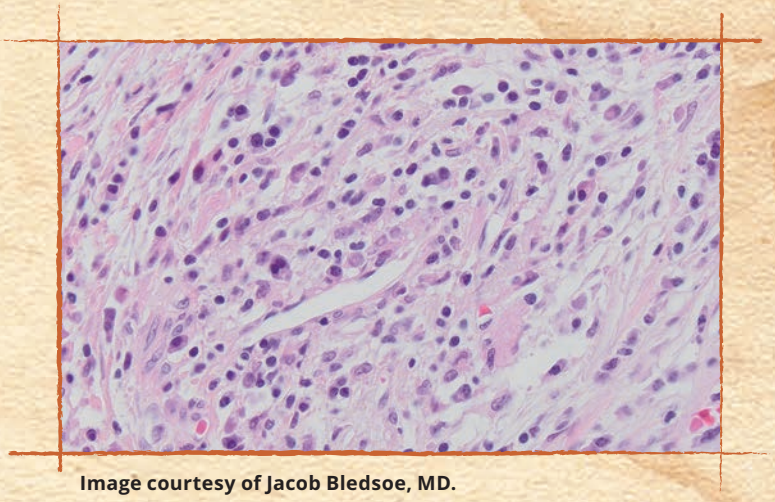


Image courtesy of Jacob Bledsoe, MD.

Biopsy of the pancreas.

Steroid trial

Responsive

Diagnosis

Type 1 autoimmune pancreatitis (IgG4-related pancreatitis) and IgG4-related cholangitis

Know when IgG4-RD belongs on your differential

Scan the code or visit IgG4related.com to learn more

IgG4-RD ICD-10 code: D89.84*

*This information is provided for educational purposes only. It is the responsibility of the healthcare provider to select the proper codes and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

EUS, endoscopic ultrasound; ICD, International Classification of Diseases.

References: 1. Katz G, Stone JH. *Annu Rev Med*. 2022;73:545-562. **2.** Yamada K, Yamamoto M, Saeki T, et al. *Arthritis Res Ther*. 2017;19:262. **3.** Lanzillotta M, Mancuso G, Della-Torre E. *BMJ*. Published online June 16, 2020:m1067.

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AMGEN Rare Disease

Innovation drives improvement in patient care

A 1-L bowel prep held up against the standard 4-L regimen on cleanliness, but questions about polyp detection show why progress in medicine takes time.



As a specialist in inflammatory bowel disease (IBD), I often marvel at how rapidly research advances have transformed clinical practice. The steady stream of FDA approvals for advanced IBD therapies has been a boon for patients, providing more options for safe and effective treatment. Similarly, our growing understanding of disease mechanisms, best practices, and quality measures has contributed to better clinical outcomes.

As our appreciation of the multifaceted nature of IBD and its modifiers has grown, treatment plans have expanded beyond conventional pharmacologic therapies to include discussions of diet, lifestyle, and mental health. Together, these advances have improved patient care and the lives of people with gastrointestinal conditions.

In this issue of *GI & Hepatology News*, we are pleased to highlight several research innovations with practical implications for clinical care. One of our top stories features a single-blind randomized trial of 110 participants showing that a custom 1-L bowel prep was noninferior to the standard 4-L formula. The 1-L bowel prep even scored higher on Boston Bowel Preparation Scale. Although participants who took the 1-L prep reported thirst more often, allowing patients to drink more water should not compromise bowel cleanliness.

The more important question, however, is whether the 1-L bowel prep is equally effective for polyp detection. Compared with the 4-L prep, the 1-L regimen yielded significantly fewer polyps (2 vs. 3 per colonoscopy; P=0.008). ADRs (35% vs. 50%; P=0.120) and serrated polyp detection rates (13% vs. 17%; P=0.502) were also lower, although these differences were not statistically significant. Because the study was powered for bowel cleanliness and not polyp detection, the 1-L prep's adequacy for identifying neoplasia remains uncertain.

More studies are needed, but such is the nature of research. Progress rarely occurs in a straight line. Discoveries must be carefully scrutinized, replicated, and validated. At the very least, we see a glimmer of progress and a possible future where bowel preparations might not be as grueling as they are today. If validated and broadly adopted, the 1-L bowel preparation would become another clear example of research innovation improving patient care. Change in medicine is often slow and deliberate, but as we all remember, the tortoise ultimately finished the race.

Berkeley N. Limketkai, MD, PhD
Editor in Chief



Call for nominations

Know an inspiring AGA member? Nominate them to be featured in a Member Spotlight.

Do you know an AGA member with a unique, inspiring, or particularly interesting career path? Nominate them for our Member Spotlight! We would love to share their story with the AGA community. Our members are doing remarkable work in clinical care, research, education, advocacy, and innovation, and highlighting these journeys helps celebrate the diverse experiences that shape the field of gastroenterology.

To submit a nomination or suggestion, please email the member's name and a brief note about why they would be a great feature to ginews@gastro.org. We look forward to hearing about the inspiring members in your network!

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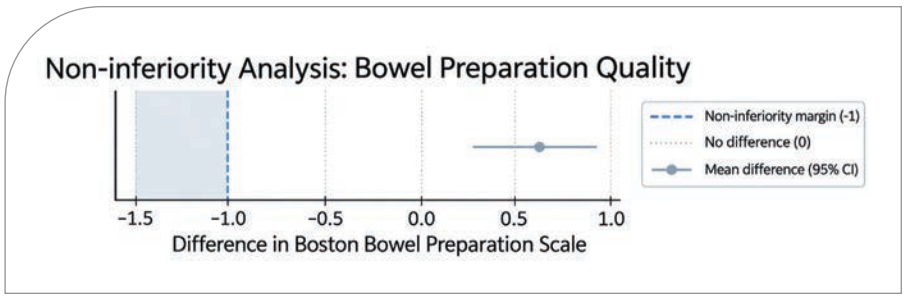


Radha Tamerisa, MD, MBA •
See page 23

Custom 1-liter bowel prep clears noninferiority bar against 4-liter standard

Mean cleansing scores were higher with the 1-liter prep, but patients reported thirst more often and colonoscopies took longer.

By Doug Brunk



Noninferiority analysis of bowel preparation comparing PEG 3350-105 g/4 L and PEG 3350-105 g plus ascorbic acid/1 L regimens. PEG, polyethylene glycol. Figure courtesy of *Techniques and Innovations in Gastrointestinal Endoscopy.*

A custom 1-L bowel prep cleaned the colon at least as well as a standard 4-L prep in a 110-patient randomized trial of patients having their first screening colonoscopy, researchers reported in *Techniques and Innovations in Gastrointestinal Endoscopy*. The 1-L prep scored higher on a nine-point scale of bowel cleanliness, but nearly all patients in both groups had an adequately clean colon. Patients who received the 1-L prep were more likely to report thirst.

"This custom-prepared, ultra-low-volume regimen represents a promising alternative that achieves cleansing efficacy comparable to standard protocols," corresponding author Ricardo Flores-Rendón, MD, a gastroenterologist at the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Gobierno y Municipios del Estado de Baja California in Mexicali, Mexico, told *GI & Hepatology News*.

At two endoscopy centers in Mexico, Dr. Flores-Rendón and team randomly assigned 110 patients aged 45 to 80 to split-dose 4-L polyethylene glycol (PEG) or a custom 1-L preparation containing PEG and ascorbate. Endoscopists did not know which prep patients received. Three patients assigned to the 4-L prep did not finish it and were excluded from the analysis. The results are based on 52 patients who completed the 4-L prep and 55 who completed the 1-L prep.

The 4-L group drank 2 L of PEG solution the evening before colonoscopy and 2 L the next morning. The 1-L group drank 500 mL of a PEG and ascorbate solution the evening before colonoscopy and 500 mL of a PEG solution the next morning, plus 2 to 3 L of water. Both groups followed a clear-liquid diet and finished the prep three to four hours before colonoscopy.

The 1-L prep was compounded in the pharmacy of the researchers' institution. Commercial ascorbate-containing preparations are not currently available in Mexico, the authors wrote.

The researchers measured bowel cleanliness using the Boston Bowel Preparation Scale, which runs from zero to nine. The average score was 8.47 with the 1-L prep and 7.85 with the 4-L prep, a difference of 0.62 points (P=0.003). The 1-L prep met the study's standard for being at least as effective as the 4-L prep. The study defined an adequate prep as a score of at least seven. Nearly all patients met that mark (at least 96% in each group) and the difference was not statistically significant.

The endoscopists reached the cecum in every patient. They also passed through the ileocecal valve in all 55 patients in the 1-L group and 51 of 52 in the 4-L group. The groups did not differ significantly in the amount of bubbles seen during colonoscopy. Fewer polyps were found in the 1-L group (median, two vs. three per colonoscopy; P=0.008). Adenomas were found in 50% of patients in the 4-L group and 35% in the 1-L group, a difference that was not statistically significant. The trial was powered to assess cleansing scores, not adenoma detection, and may not have had enough statistical power to detect small differences in adenoma detection, the authors wrote.

Colonoscopies took longer on average in the 1-L group (44.8 vs. 37.2 minutes; P=0.005), as did reaching the cecum (13.5 vs. 8.74 minutes; P=0.001). The authors did not discuss the difference in procedure times. No major adverse events were reported. Minor symptoms occurred in 53% of patients in the 1-L group and 44% in the 4-L group, a difference that was not statistically significant. Thirst was the only symptom that differed significantly between groups; 45% of patients in the 1-L group reported it. Altered taste was the most common symptom in the 4-L group, reported by 23%. The authors concluded that the custom-prepared regimen is a safe, simple, and effective option for bowel preparation.

The trial excluded patients with chronic kidney disease (CKD) stage 3b or higher, chronic heart failure, cirrhosis, electrolyte imbalance, and uncontrolled hypertension, among other conditions. The authors wrote that the higher rate of thirst may have clinical implications for patients in whom fluid balance is critical, such as those with heart failure with reduced ejection fraction or CKD with impaired urine output. The researchers did not report cleanliness scores for individual colon segments. Without baseline blood tests, they could not quantify electrolyte shifts, though they observed no clinically significant electrolyte changes after the prep.

The authors reported no external funding or conflicts of interest.

Dr. Flores-Rendón spoke with *GI & Hepatology News* about the study results.

Which patients are the best candidates for the 1-L PEG-ascorbate regimen, and who should continue to receive a traditional high-volume preparation?

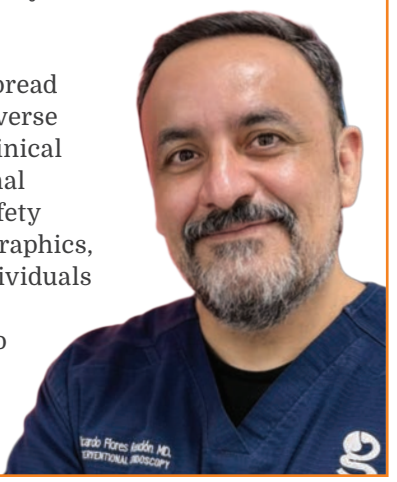
Dr. Flores-Rendón: The 1-L PEG-ascorbate regimen is ideal for patients without significant cardiometabolic or renal comorbidities who have a documented history of poor compliance or intolerance to high-volume preparations, particularly those prone to severe upper GI side effects such as nausea, abdominal bloating, and vomiting. Conversely, traditional high-volume regimens should remain the standard of care for patients with a history of electrolyte disturbances, baseline renal insufficiency, or volume depletion, as well as those who have previously tolerated high-volume protocols without issue.

Excessive thirst was common with the low-volume regimen. How should physicians advise patients about hydration and monitor those at risk for fluid imbalance?

Dr. Flores-Rendón: Clinicians must provide explicit pre-procedural counseling on maintaining adequate clear fluid intake throughout the preparation period, with specific vigilance required for elderly patients or those with a blunted thirst response. Furthermore, individualized fluid management strategies are crucial for patients at risk for electrolyte shifts or fluid overload, particularly those with chronic kidney disease or congestive heart failure.

What additional evidence is needed before this custom-prepared regimen can be widely adopted in routine practice?

Dr. Flores-Rendón: To support widespread adoption, prospective validation in diverse multicenter cohorts and real-world clinical practice settings is essential. Additional studies should focus on evaluating safety profiles across broader patient demographics, including elderly populations and individuals with mild-to-moderate renal or cardiovascular comorbidities and also in patients with special conditions like severe constipation.



Ricardo Flores-Rendón, MD

Crohn's surgery risk held steady as advanced therapy use climbed

Continued From Page 1

The analysis included 3,044 adults with newly diagnosed CD and 3,893 with newly diagnosed UC from 2007 through 2023. Patients were aged 18-64 years, had at least four years of claims before diagnosis, had not received previous IBD treatment, and met claims-based criteria for a new IBD diagnosis. Investigators compared patients diagnosed in 2007-2012, 2013-2018, and 2019-2023, assessing medication use, hospitalization, surgery, and safety events over up to five years.

Among patients with CD, use of advanced therapies within five years of diagnosis rose from 30% in the 2007-2012 group to 65% in the 2019-2023 group, while immunomodulator use fell from 34% to 24%. Corticosteroid use within five years rose from 69% to 76%. However, among those who received corticosteroids, the proportion receiving at least two courses within one year fell from 27% to 22%. In the most recent group, 44% received corticosteroids and 53% started an advanced therapy within one year.

The estimated five-year risk of CD-related hospitalization fell from 18% among patients diagnosed in 2007-2012 to 14% among those diagnosed in 2019-2023, although the adjusted comparison was not statistically significant. Serious infections fell from 23% to 6%.

Major abdominal surgery did not decline significantly, with five-year risks of 13% in the earliest cohort and 10% in the most recent cohort.

Among patients with UC, five-year use of advanced therapies rose from 16% to 38%, while immunomodulator use fell from 24% to 10%. Corticosteroid exposure increased from 68% to 74%, but repeated use declined from 31% to 26%.

UC-related hospitalizations remained relatively stable, with five-year risks of 12% in the earliest cohort and 10% in the most recent cohort. However, colectomy declined significantly from 7% to 4%, while serious infections fell from 17% to 4%.

Several subgroup differences emerged. Black patients with CD had higher rates of hospitalization and corticosteroid use than white patients, but rates of repeated corticosteroid use, surgery, and advanced therapy use were similar. Hispanic patients with CD were less likely to receive advanced therapy. Among patients with UC, Hispanic patients had lower corticosteroid use and lower all-cause hospitalization. Overall, the authors reported no consistent racial, ethnic, age, or sex differences in treatment and outcomes.

For both diseases, advanced therapy use was lower among patients diagnosed at ages 40-64 years than among those diagnosed at ages 18-39 years. Patients with UC diagnosed at ages 40-64 years also had a higher risk of colectomy.

The observational study could not determine whether earlier advanced therapy led to changes in outcomes. Claims lacked information on disease activity, disease characteristics, complications, medication adherence, and patient-reported outcomes. Race and ethnicity were imputed for about 70% of patients. In addition, the commercially insured cohort excluded adults older than 64 years and may not represent patients who depend on public insurance. Follow-up was limited to five years.

The National Institute of Diabetes and Digestive and Kidney Diseases supported the study. Dr. Singh reported research funding from Pfizer, and several coauthors disclosed financial relationships with pharmaceutical companies.

Treatment and Outcomes in Newly Diagnosed Adults with IBD in the U.S., 2007-23

3,044 adults newly diagnosed with CROHN'S DISEASE, followed over 4.3y;
mean age 39±15y, 47% male,
83% White, 8% Black, 7% Hispanic patients

Outcome	5-year risk, 2007-12	5-year risk, 2019-23
Corticosteroid use	69%	76%
• Excess use (2 or more/y)	27%	22%
Immunomodulator use	34%	23%
Advanced therapy use	30%	65%
CD-related hospitalization	18%	14%
CD-related major surgery	13%	10%
Serious infections	23%	6%

3,893 adults newly diagnosed with ULCERATIVE COLITIS, followed over 4.2y;
mean age 41±14y, 52% male,
80% White, 7% Black, 8% Hispanic patients

Outcome	5-year risk, 2007-12	5-year risk, 2019-23
Corticosteroid use	68%	74%
• Excess use (2 or more/y)	31%	26%
Immunomodulator use	24%	10%
Advanced therapy use	16%	38%
UC-related hospitalization	12%	10%
UC-related major surgery	7%	4%
Serious infections	17%	4%

Ahuja, Park, Qi, et al.

Graphical abstract courtesy of *Clinical Gastroenterology and Hepatology.*

Dr. Singh shared his insights.

Has this study changed how you treat newly diagnosed CD or UC?

Dr. Singh: It reinforces how I already practice. I don't wait for patients with CD or moderate-to-severe ulcerative colitis to fail repeated steroid courses. It's reassuring to see that shift nationally: fewer repeat steroid courses, earlier advanced therapy, and fewer serious infections.



Siddharth Singh, MD

Why do you think earlier use of advanced therapies has not reduced Crohn's-related surgery?

Dr. Singh: CD often causes bowel damage, such as strictures and fistulas, before it is even diagnosed, and current therapies can't reverse that damage. UC is largely inflammatory, so early treatment lowers colectomy risk, which is what we saw. In CD, early diagnosis and early treatment before bowel damage sets in matters a lot.

Which patients should move to advanced therapy sooner rather than receive another steroid course?

Dr. Singh: AGA guidelines are very informative on the approach to managing patients with IBD. In my practice, anyone needing a second steroid course within a year has uncontrolled disease and should move to advanced therapy. Ideally, most patients with CD, especially those with high-risk features like perianal or stricturing disease or extensive disease, should start advanced therapy early, not after steroids fail.

Is there anything else you'd like to add about this study?

Dr. Singh: This is one of the largest contemporary U.S. studies following adults from the time of IBD diagnosis. The encouraging news is less steroid dependence, earlier effective therapy, and fewer serious infections, with broadly similar treatment across racial and ethnic groups. The next challenge is changing the long-term course of CD.

More than one sugary drink a day tied to double gastric cancer risk

Drinking more than one sugar-sweetened beverage daily was tied to 2.45 times the gastric cancer risk of rare intake. Artificially sweetened drinks showed no link.

By Doug Brunk

People who drank more than one sugar-sweetened beverage (SSB) a day were more than twice as likely to develop gastric cancer as those who drank less than one a month, according to a study of 112,284 U.S. healthcare professionals.

The study, published in *Gastro Hep Advances*, drew on the Nurses' Health Study and the Health Professionals Follow-up Study. Researchers identified 278 cases of gastric cancer, including 140 in women and 138 in men, over 3,204,001 person-years of follow-up.

Compared with people who drank less than one SSB per month, those who drank more than one 8-ounce serving per day were 2.45 times as likely to develop gastric cancer after researchers accounted for other factors.

Gastric cancer was diagnosed in 31 participants over 190,674 person-years in the highest-intake group, compared with 57 participants over 744,034 person-years among those who drank less than one serving a month — roughly 16 vs. eight cases per 100,000 person-years.

The authors reported the association was similar in both cohorts, though the estimate among men was borderline. Women who drank more than one serving daily were three times as likely to develop gastric cancer, while men were two times as likely.

In contrast, drinking artificially sweetened beverages was not linked to the risk of developing gastric cancer, even after researchers accounted for other factors. The authors described the analysis as the first to demonstrate an association between SSB intake and gastric cancer incidence.

According to corresponding author Andrew T. Chan, MD, MPH, a gastroenterologist at Harvard Medical School, Boston, the findings are a reminder that diet can influence the risk of cancers beyond those typically associated with it, such as colorectal cancer.

"While more research is needed to confirm this and understand why, cutting back on sugary drinks is a reasonable, low-risk step people can take in the meantime, especially since these drinks have been linked to other chronic health conditions, such as overweight and diabetes," Dr. Chan told *GI & Hepatology News*.

For the analysis, Dr. Chan and colleagues began follow-up in 1986, when both groups first reported their beverage intake, and continued through June 2021 for the nurses' cohort and January 2022 for the men's cohort.

Participants completed food questionnaires every four years and updated information about their lifestyle, medical history, and health every two years. SSBs included carbonated beverages, punch, lemonade, and sports drinks, while artificially sweetened beverages included low-calorie carbonated beverages. Researchers accounted for known or possible gastric cancer risk factors, including consumption of red and processed meat.

Researchers also examined *Helicobacter pylori* infection in a subgroup of 616 women and 324 men with available antibody test results. Infection was found in 36.7% of women and 34.0% of men. Neither sugar-sweetened nor artificially sweetened beverage consumption was linked to *H. pylori* infection. Higher overall fructose intake was linked to gastric cancer in the full cohort and among women.

Because the study was observational, it cannot prove that SSBs cause gastric cancer. Other limitations included a lack of detailed information about H. pylori infection, tumor location, family history of gastric cancer, and previous upper endoscopy. Most participants were white and between ages 30 and 75 when they joined the study, so researchers could not further examine findings across racial and ethnic groups or younger adults.

For clinicians, the findings may suggest that frequent consumption of SSBs may be a dietary sign of higher gastric cancer risk. However, Dr. Chan and his coauthors said more research is needed to confirm the association and determine whether sugary drinks directly contribute to gastric cancer. Possible explanations include weight gain, insulin resistance, steroid hormone imbalance, inflammation, DNA damage, and changes in the gut microbiome.

National Cancer Institute grants and a Stand Up to Cancer Gastric Cancer Interception Dream Team award funded the study. Dr. Chan reported consulting for Pfizer and Boehringer Ingelheim and grant support from Freenome Holdings outside the submitted work. The other authors reported no relevant disclosures or conflicts of interest.

"If this association holds up ... it means there may be a meaningful, actionable way for people to lower their risk of a cancer that is often diagnosed late and is difficult to treat."

Dr. Chan shared his take on the findings with *GI & Hepatology News.*

Do your findings support counseling patients to limit SSB intake specifically for gastric cancer prevention, or is it too early to make that clinical recommendation?

Dr. Chan: Most people who drink sugary beverages could choose to cut back or substitute something else. If this association holds up in future research, it means there may be a meaningful, actionable way for people to lower their risk of a cancer that is often diagnosed late and is difficult to treat.

Because *H. pylori* status was available only for a subset, how confident are you that the observed SSB–gastric cancer association is independent of *H. pylori* infection?

Dr. Chan: It was reassuring that our findings held up even when accounting for *H. pylori* infection in a subset of our population. However, future studies are needed to look at this more carefully with a larger sample size.

Could the lack of tumor location data be masking clinically important differences in the association between SSB intake and cardia vs. non-cardia gastric cancers?



Andrew T. Chan, MD, MPH

Dr. Chan: We don't know if our association is the same for both cardia vs. non-cardia gastric cancer. This also requires further research.

Is there anything else you'd like to say about this work?

Dr. Chan: We don't yet know the precise mechanism, but several biological pathways have been proposed for how these beverages might contribute to cancer risk generally, including their effects on weight gain, insulin resistance, chronic inflammation, and changes to the gut microbiome. Any or several of these could plausibly play a role in stomach cancer specifically.

Bridging the behavioral health gap: Disorders of gut-brain interaction

By Leena Sai Penumalee, MD; Leila Kia, MD, AGAF

Disorders of gut-brain interaction (DGBI) are commonly encountered in gastroenterology (GI) practice and can pose a therapeutic challenge for providers with limited access to behavioral health resources. DGBI affect over 40% of the global population and account for at least one-third of GI consultations.[1,2] These disorders are characterized by dysfunction of the gut-brain axis — a bidirectional communication network including neuroendocrine, immune, and microbiome pathways between the central nervous system and GI tract.[3] Treatment involves a multimodal approach including a therapeutic patient-provider relationship, brain-gut behavior therapy (BGBT), and pharmacotherapy. Although robust evidence supports brain-gut behavior therapies, few gastroenterologists receive dedicated training in these interventions, and access to GI health psychologists (GHPs) is very limited.[4] In this article, we provide an overview of how gastroenterologists can integrate simple, high-yield behavioral health principles into their practices and when to refer to a GHP.

Building a therapeutic relationship

Building a strong patient-provider therapeutic relationship is a cornerstone of DGBI treatment. Perceived stigma among patients is common. In one study, 45% of individuals with irritable bowel syndrome (IBS) felt their condition was not taken seriously, and 31% were told that the disease was "all in their head."[5] Shame was also associated with bowel symptom severity and poor patient-reported outcomes.[6] Unfortunately, many providers also demonstrate negative attitudes towards patients with DGBI, which can become a barrier in building a therapeutic relationship; commonly cited reasons include frustration with medical uncertainty and significant emotional toll in caring for this population.[5]

Aligning with patients early can reduce patient fears and build a strong, therapeutic foundation. This can be achieved through several strategies. First, clinicians should consistently employ empathetic, patient-centered communication. Next, patients should be educated on the brain-gut axis early using clear, accessible language. The software vs. hardware analogy can be helpful (i.e., "If you think of your gut like a computer, the hardware (organs) is intact, but the software (brain-gut communication) isn't working properly. This can cause real symptoms without structural abnormalities showing up on tests.")[7] Lastly, providers should set realistic expectations for treatment. Most patients with DGBI will not achieve complete symptom relief. Focusing on improving function and quality of life can set realistic expectations and maintain patient engagement.



Conducting a psychosocial assessment

Up to two-thirds of patients with DGBI have a major psychological disorder. Early, efficient psychosocial screening can help diagnose concurrent disorders among patients with DGBI and guide treatment plans.[8] Validated screening tools, such as Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and Primary Care Post-Traumatic Stress Disorder Screen for DSM-5 (PC-PTSD-5), are often used to assess presence and severity of comorbid psychiatric conditions and can be completed virtually before the visit.[9-11] During the visit, informal, open-ended questions should be used to assess other important domains, including symptom-specific anxiety, illness-coping behaviors, and impact on quality of life. Helpful prompts are detailed by Ballou et al.; examples include "Do you think or worry quite a bit about your symptoms?" and "Do you make significant efforts to avoid certain situations because of your symptoms?"[12] Adopting this biopsychosocial model can help clinicians strengthen patient-provider relationships and introduce BGBT early.

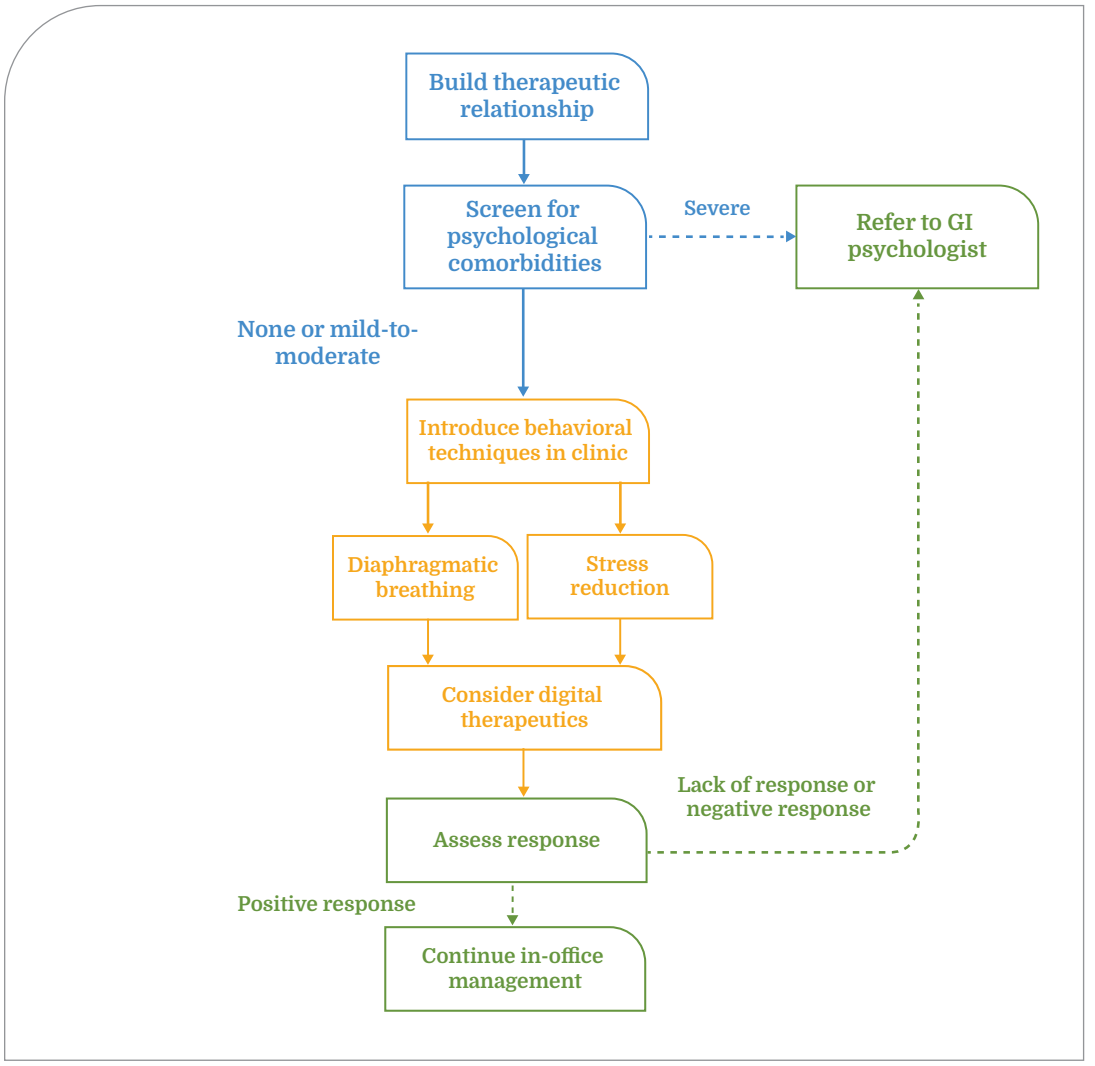


Figure 1. Framework for behavioral health integration in gastroenterology practice.

Introducing behavioral techniques

Although most gastroenterologists do not receive formal training in brain-gut behavior therapy, several simple techniques can easily be introduced during clinic visits. Diaphragmatic breathing, for example, involves slow breathing using the diaphragm at a rate of approximately 6 breaths/minute with prolonged exhalation; adopting this technique for 20-30 minutes daily has demonstrated efficacy in decreasing bloating/distention, belching, and IBS symptoms.[13] Demonstrating this technique during an office visit is quick, simple, and low-cost. Stress mitigation techniques, including regular exercise and sleep hygiene, should also be discussed. Although there are no official exercise recommendations, patients with IBS who engaged in a moderate-intensity aerobic exercise program (150-180 minutes per week over 12 weeks, reaching 60%-75% of maximum heart rate) demonstrated significant improvements in abdominal symptoms.[14]

Recommending digital therapeutics

Novel digital therapeutics can provide brain-gut behavior therapy for patients who cannot access GI health psychologists or are limited by cost and time investment. Clinicians must screen for appropriateness prior to recommending these tools — individuals with severe psychological

Key moment	Patient-centered language	Reference
Introducing the brain-gut axis	"If you think of your gut like a computer, the hardware (organs) is intact, but the software (brain-gut communication) isn't working properly. This can cause real symptoms without structural abnormalities showing up on tests."	Post et al. (2023)[7]
Screening for psychological comorbidities	"Mood changes or stress can often affect a patient's GI symptoms. I'd like to ask you some questions about your medical history and mood so we can make sure we're treating the whole picture."	Lacy et al. (2021)[19]
Introducing behavioral techniques	"Some of the most effective therapies for treating your condition work on the brain-gut connection. Examples include targeted breathing techniques and incorporation of exercise into your daily life."	Keefer et al. (2018)[20]
Introducing digital therapeutics	"Digital therapeutics are effective options and can help you easily access care through your phone. These are also great alternatives if you are having difficulty accessing a psychologist. Let's talk through a couple options and the evidence behind them."	Brenner et al. (2024)[15]
Referring to a GI psychologist	"I'd like to connect you with a psychologist who specializes in digestive health. This is a specialist who understands the brain-gut connection and can provide additional support. I will still be a part of your care team, and we'll work together."	Keefer et al. (2018)[20]

Table 1. Patient-centered language for key moments in DGBI care.

disorders (anxiety, depression, obsessive-compulsive disorder, or PTSD), eating disorders, or substance misuse are not eligible and should be referred to a GI psychologist instead.[15] Adult patients with high technological literacy and no severe psychological comorbidities are appropriate candidates for digital therapeutics.

There are two main categories of digital therapeutics for patients with IBS: FDA-cleared prescription apps and direct-to-consumer apps.[15] Mahana IBS is an FDA-cleared prescription app that provides cognitive behavior therapy over 10 sessions and can be prescribed for adults ≥22 years old with IBS.[16] Program completion was associated with a significant decrease in IBS symptom severity.[16] Nerva is a popular direct-to-consumer app and provides gut-directed hypnotherapy (42 sessions over 6 weeks).[17] In one trial, 81% of patients (compared with 63% of controls) achieved clinically meaningful improvement in IBS symptom scores after program completion.[17] Unfortunately, adherence to digital therapeutics tends to be low (i.e., 19% for Mahana IBS), but rates improve when apps are prescribed by the patient's provider.[16] Assessment of app usage and symptom response during follow-up clinic visits can also help bolster adherence.

Referring to a GI health psychologist

Knowing when to refer to a GI health psychologist is an important part of managing patients with DGBI. As mentioned above, those with severe psychological disorders, eating disorders, or substance use should be referred to a GHP. Patients with complex presentations (i.e., trauma history) would also benefit from an individualized assessment and treatment plan from a trained psychologist.[15] Lastly, patients with limited insight into the brain-gut connection, lack of commitment to digital therapeutics, or low digital literacy should also receive a referral.[15]

Finding a GHP can be difficult, but accessibility is significantly improving with telehealth. Providers can use registries such as the Rome Foundation GastroPsych Directory, which allows individuals to search for trained psychologists within a specific city or ZIP code.[18] Nearby academic hospitals often employ GI psychologists who can take referrals from community gastroenterologists. Psychiatric associations can also be contacted for psychologists familiar with evidence-based BGBT.

Summary

Incorporating behavioral health into clinic visits through introducing the brain-gut axis and conducting a brief psychosocial assessment is efficient and effective. A basic framework including these steps is outlined in Figure 1, and examples of helpful patient-centered language are included in Table 1. Overall, integrating these principles into clinical practice will ensure individuals with DGBI receive comprehensive, evidence-based care.

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Panel sets 10% ceiling on incomplete resection of 10-19 mm polyps

The international Delphi consensus also backs a minimum 1-mm margin and stepwise protocols for inspecting resection defects after removal of colorectal polyps smaller than 20 mm.

By Doug Brunk

Endoscopists should remove colorectal polyps smaller than 20 mm with at least a 1-mm margin, carefully inspect the resection defect, and document the result, according to an international expert consensus published online in *Clinical Gastroenterology and Hepatology*.

The Standardized Assessment of Complete Colorectal Polyp Resection, or SCOPE, initiative also recommended that endoscopists know their incomplete resection rate (IRR) for polyps measuring 10-19 mm. The IRR is the proportion of polyps with histologically confirmed residual neoplastic tissue after resection, and the panel said it should not exceed 10% and preferably should remain below 5%.



Querijn van Bokhorst, MD

The consensus addresses what the authors described as a lack of standardized methods for assessing whether colorectal polyps have been completely removed. Incomplete removal may lead to polyp recurrence and is estimated to account for 7%-19% of colorectal cancers diagnosed after colonoscopy, the authors wrote.

"The most important change is to make assessment of the resection defect a deliberate, standardized procedure rather than a quick visual check," first author Querijn van Bokhorst, MD, a research fellow at Amsterdam University Medical Center, the Netherlands, told *GI & Hepatology News*. "Until now, guidelines have provided extensive advice on which resection technique to use, but relatively little guidance on how to confirm that the polyp has actually been removed completely. The recommendations provided may serve as a valuable starting point."

Dr. van Bokhorst and colleagues surveyed gastrointestinal endoscopy experts in a modified Delphi process — three rounds of anonymous online surveys conducted from March to December 2025. A steering committee of four endoscopists drafted the questions and statements. The surveys covered resection margins, visual inspection of the resection defect, photo documentation, histopathologic margin assessment, and IRR measurement.

The researchers invited 103 experts. Of those, 67 from 18 countries completed the first survey, 54 completed the second, and 53 from 16 countries completed all three. Consensus was reached when at least 80% of participants agreed or strongly agreed with a statement.

Of the 53 who completed all three rounds, 42 reported more than 10 years of endoscopy experience, 41 had performed more than 5,000 colonoscopies, and nearly four in five worked in academic hospital-based practices. Most were based in Europe or North America.

After three rounds, the panel agreed on 18 of 20 statements. Among the experts, 89% agreed with a recommendation to include at least a 1-mm margin of normal tissue when using a cold snare on polyps measuring 1-19 mm. For polyps measuring 10-19 mm removed with a hot snare, 93% agreed that a margin of at least 1 mm was acceptable.

The panel agreed that careful visual inspection is the cornerstone of assessing resection completeness in daily practice. However, the authors cautioned that visual inspection alone is often insufficient to confirm complete resection, even for polyps smaller than 10 mm. The lateral margin (89% agreement) and base (96%) of a resection defect can be presumed clear if they are fully visualized and no residual polyp tissue is seen, according to the panel; at the base, the submucosa should be visible without "islands" or "bridges" of mucosal tissue.

The panel recommended using a water jet to make the resection defect easier to see after cold snare resection, with 94% agreement. The experts also encouraged using magnification endoscopy, if available, when a polyp may not have been completely removed (85%).

The panel fell just short of consensus on routine virtual chromoendoscopy for polyps 10-19 mm (79% agreement). Panelists cited its presumed limited feasibility on coagulated or bleeding defects and the absence of strong evidence of superiority over high-definition white-light endoscopy. It did agree on two stepwise protocols, one for daily practice and one for quality assurance and research. Under the daily practice protocol, high-definition white-light inspection alone is sufficient for polyps 1-9 mm, while inspection of polyps 10-19 mm should add image enhancement — magnification endoscopy, virtual chromoendoscopy, or both (93% agreement). The authors said the apparent discrepancy may reflect the broader scope of image enhancement, which includes magnification.

The panel recommended taking adequate images before and after removing all polyps, with 82% agreement. Under the daily practice protocol, photos of the resection defect are standard for polyps 10-19 mm. The authors said documentation should include at least one high-quality image of the polyp before removal and one of the resection defect afterward.

The panel recommended histopathologic margin assessment for



all polyps in which it is feasible (87% agreement). Nonpedunculated polyps qualify when resected en bloc and not fragmented during retrieval (93%), and pedunculated polyps when resected en bloc with a clearly identifiable stalk (91%). For polyps that do not meet those criteria, the authors wrote, margin assessment may be unreliable. When high-grade dysplasia or cancer is suspected, they advised considering submitting specimens in an oriented manner, such as pinned or in a tissue cassette.

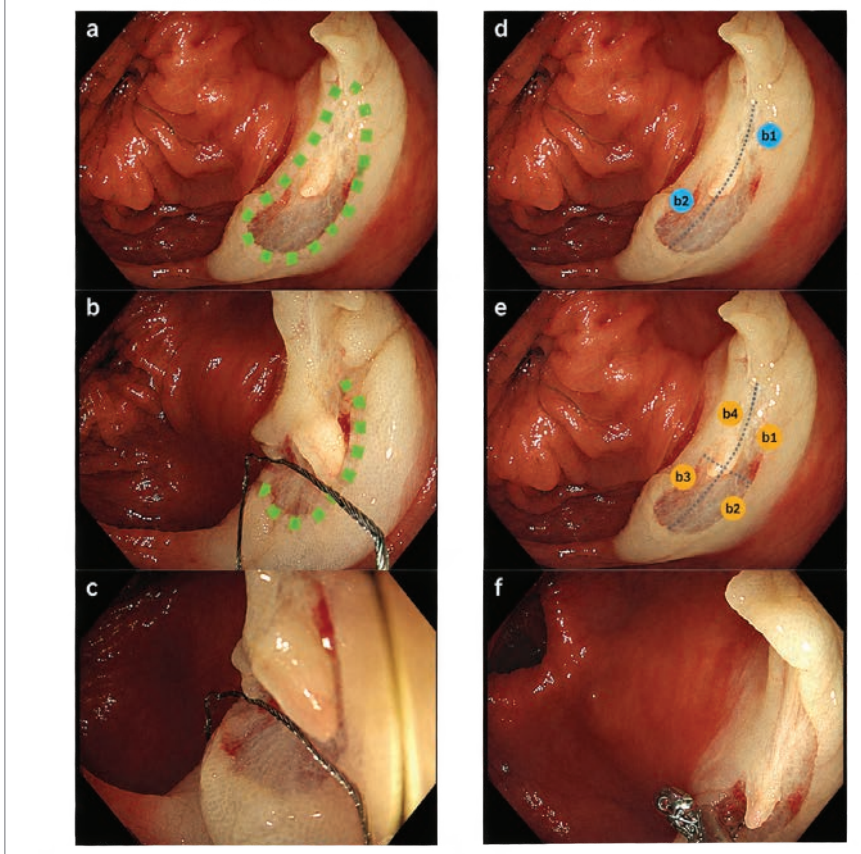
The panel agreed that routine biopsy sampling of resection defects is not recommended in daily practice (96% agreement). For quality assurance and research, the protocol applies the daily practice standards for polyps 10-19 mm to polyps of all sizes. It prefers confirming complete removal with extended resection — using a cold snare to remove a rim of normal-appearing mucosa around the defect. If this approach is unsafe or impractical, the protocol recommends two biopsies from opposite edges for polyps measuring 1-9 mm. For polyps measuring 10-19 mm, it recommends four biopsies, one from each quadrant of the defect's lateral margin. For pedunculated polyps resected en bloc, the panel agreed that careful visual inspection combined with histopathologic margin assessment is sufficient to determine complete resection, with no extended resection or biopsy needed (98%).

Standardized IRR measurement could help identify endoscopists with high rates early and enable targeted training, the authors wrote. They added that an IRR above 10% for polyps 10-19 mm may signal a need for more detailed review of an endoscopist's resection practices. However, the panel fell short of the 80% threshold on intermittent IRR measurement in daily practice (79% agreement), mainly because of concerns about time, logistics, and cost. The steering committee wrote that it nonetheless views the overall findings as supportive of monitoring and encouraged endoscopy units to set their own schedules. The 10% target reflects expert opinion rather than evidence derived directly from clinical data, the authors acknowledged.

Limitations included the 65% response rate in the first round, the loss of participants in later rounds, and possible selection bias. Some experts were identified through the steering committee's professional network, and the study did not use formal selection criteria or set targets for geographic or gender representation. The recommendations apply only to polyps smaller than 20 mm, may be difficult to follow where magnification endoscopy is unavailable, and have not been formally endorsed by endoscopy societies. The panel included only gastroenterologists, and the authors said future evaluations should involve pathologists.

The recommendations "are based on expert consensus rather than definitive outcome evidence and do not represent formal society guidelines," Dr. van Bokhorst said. "Future studies should evaluate the clinical feasibility of proposed protocols, validate the proposed incomplete resection rate (IRR) threshold, determine how often IRR should be measured, develop training for defect inspection and demonstrate whether implementation ultimately reduces recurrence and post-colonoscopy colorectal cancer."

Multiple authors disclosed research support, consulting or speaking fees, equipment loans, royalties, stock interests, or advisory roles involving medical device, diagnostic, and pharmaceutical companies.



Endoscopic images illustrating the extended resection and biopsy sampling of a resection defect to confirm complete resection.

(a) Resection defect with the purple line indicating the additional rim of normal-appearing mucosa to be included in the extended margin resection. (b) Snare grab for the extended margin resection, with the purple line indicating the rim to be resected. (c) Close-up of a snare grab for extended margin resection. (d) Potential biopsy sites (b1, b2) for polyps 1 to 9 mm: 2 biopsies from opposing sites of the resection defect, preferably taken at the locations with the smallest margins. (e) Potential biopsy sites (b1–b4) for polyps 10 to 19 mm: 4 biopsies, 1 per quadrant, preferably taken at the locations with the smallest margins. (f) Biopsy sampling of the resection defect margin. Note: the central stump is a cold snare defect protrusion.

Figure courtesy of *Clinical Gastroenterology and Hepatology.*

Senior author Aasma Shaukat, MD, MPH, a gastroenterologist at NYU Langone Health, discussed the consensus recommendations with *GI & Hepatology News.*

What are the most important changes endoscopists should make in daily practice based on these recommendations?

Dr. Shaukat: Endoscopists should consider ways to evaluate their polypectomy completeness. This can be done by close exam of the site after resection using near magnification or narrow-band imaging, photos documenting the before and after pictures or other ways.

Why should endoscopists know their incomplete resection rate for 10-19 mm polyps, and how should they use that information to improve care?

Dr. Shaukat: IRRs are higher than we think, and a common source of post-colonoscopy colon cancers. IRRs can be as high as 30%. Measuring and improving these will improve the effectiveness of colonoscopy.



Aasma Shaukat, MD, MPH

What should physicians do when they are unsure whether a polyp has been completely removed?

Dr. Shaukat: We recommend respecting the margins of the polyp area and doing close inspection or biopsies. If there's residual tissue, repeat resection is important.

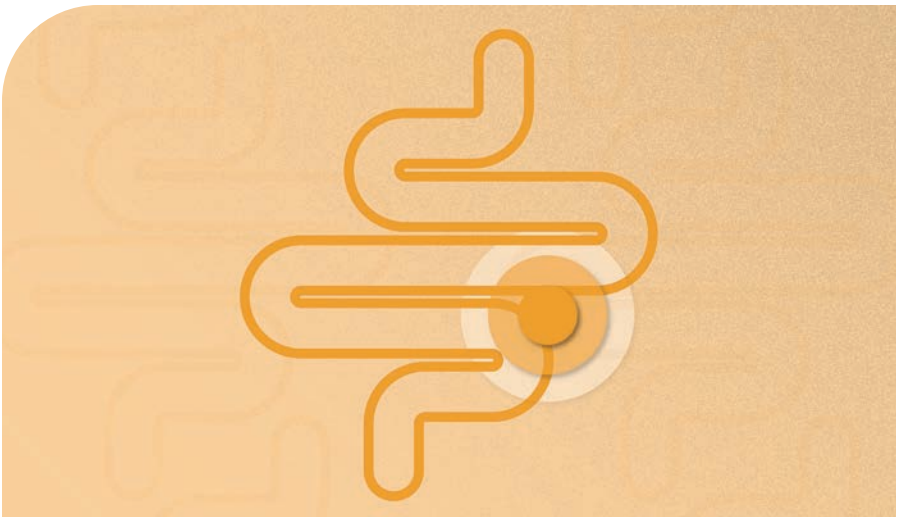
Is there anything else you'd like to say about this work?

Dr. Shaukat: As a next step we will be evaluating the polypectomy technique and the safety of different techniques to be able to guide endoscopists.

AI-assisted second look may raise right-colon adenoma detection

The right-colon adenoma detection rate was 36.4% with the combined approach vs. 27.9% with standard colonoscopy, though investigators said the design could not isolate AI's contribution.

By Julie Greenbaum



An artificial intelligence (AI)-assisted second forward-view examination of the right colon increased the right-colon adenoma detection rate (ADR) by 8.5 percentage points compared with standard colonoscopy in a multicenter randomized controlled trial that included 606 patients in the final analysis, according to a study published in *The American Journal of Gastroenterology*.

The open-label, prospective trial, conducted at three centers in Japan between July 2023 and October 2025, enrolled patients aged 35 to 75 years undergoing colonoscopy for indications including a positive fecal immunochemical test, surveillance after previous colorectal polypectomy, gastrointestinal symptoms, or opportunistic screening. Participants were randomly assigned 1:1 to an AI-assisted second examination of the right colon or standard colonoscopy, with randomization stratified by study center, age, sex, colonoscopy indication, and endoscopist experience.

In both groups, endoscopists initially examined the right colon from the cecum to the hepatic flexure without AI assistance. They were blinded to group assignment until completing this first examination. In the AI group, the colonoscope was then reinserted into the cecum and a second forward-view examination was performed using the Wise Vision real-time computer-aided detection system. Patients in the standard-colonoscopy group instead continued standard withdrawal from the hepatic flexure to the rectum without a second right-colon examination. The primary outcome was the right-colon ADR, defined as the proportion of patients with at least one adenoma detected in the right colon.

Of 620 patients randomized, 14 were excluded after randomization because of protocol deviations or postrandomization ineligibility, leaving 305 patients in the AI group and 301 in the standard-colonoscopy group. The median age was 60 years, and 43% of patients were female. Baseline characteristics were well balanced between groups.

Primary outcome

Right-colon ADR was 36.4% with AI-assisted reinspection vs. 27.9% with standard colonoscopy, a statistically significant absolute increase of 8.5 percentage points.

"The increase was particularly evident for lesions that can be difficult to detect during routine examination, including flat and sessile lesions and those located in the ascending colon," lead study author Yusuke Nishikawa, MD, PhD, of the Department of Gastroenterology at Toho University Omori Medical Center in Tokyo, told *GI & Hepatology News*.

AI-assisted reinspection was associated with 1.48 times the odds of detecting at least one right-colon adenoma. Overall ADR was 60% vs. 52%, respectively, but the difference was not statistically significant.

The right-colon polyp detection rate was also significantly higher with AI-assisted reinspection, at 46% vs. 35%, as was the number of right-colon adenomas per colonoscopy. However, advanced neoplasia detection did not differ significantly between groups (6.6% vs. 7.3%), nor did sessile serrated lesion detection (7.5% vs. 5.3%).

Differences by lesion characteristics

Flat lesions were detected in 24% of patients in the AI group vs. 16% in the standard-colonoscopy group, corresponding to 1.67 times the odds of detection. Sessile lesions were detected in 31% vs. 23%, corresponding to 1.52 times the odds. No significant difference was observed for pedunculated lesions.

For lesions smaller than 5 mm, detection was 29% with AI-assisted reinspection vs. 22% with standard colonoscopy, although this difference did not reach statistical significance. Detection of lesions measuring 5 to 9 mm or at least 10 mm also did not differ significantly.

The strategy increased lesion detection in the ascending colon, where detection rates were 40% with AI-assisted reinspection vs. 29% with standard colonoscopy, representing 1.64 times the odds of detection. No significant difference was found in the cecum.

Endoscopist experience, procedure time, and safety

Exploratory subgroup analyses indicated a similar direction of effect regardless of endoscopist experience. Among experts who had performed at least 1,500 previous colonoscopies, right-colon ADR was 37% with AI-assisted reinspection vs. 29% without it. Among trainees with fewer than 1,500 previous procedures, ADR was 36% vs. 27%, respectively. Neither subgroup difference was statistically significant, and there was no significant interaction between AI use and endoscopist experience.

The additional examination increased examination time. The second AI-assisted right-colon examination had a median duration of 2.5 minutes, and median total right-colon examination time was 5.7 minutes in the AI group vs. 2.9 minutes in the standard-colonoscopy group. Median total colon examination time was also longer, at 13.3 vs. 11.7 minutes, although total procedure time did not differ significantly between groups (median 20.3 vs. 19.7 minutes). No procedure-related or AI-related adverse events were reported.

"These findings suggest that combining AI assistance with a second examination of the right colon may provide a practical strategy for improving the detection of lesions that might otherwise be missed," said Dr. Nishikawa.

Clinical implications

Dr. Nishikawa further noted that the right colon remains a challenging area for lesion detection because of its complex anatomy and the subtle appearance of many right-sided lesions. "Our findings suggest that combining a simple second forward-view examination with real-time AI assistance could be incorporated into routine colonoscopy practice to improve lesion detection," he said. "Similar trends were observed across endoscopist experience levels, suggesting that this approach may be applicable in a broad range of routine clinical settings."

The investigators wrote that the incremental benefit appeared to be mainly related to detection of nonadvanced lesions.

For patients, Dr. Nishikawa said the potential benefit is more complete detection of right-sided adenomas that might otherwise be missed during routine examination. "More reliable detection and removal of these precancerous lesions could potentially contribute to colorectal cancer prevention," he said. "However, our study did not assess interval colorectal cancer or other long-term patient outcomes, so whether the improved detection translates into a reduction in colorectal cancer will require further investigation."

Study limitations

The investigators noted that the trial could not determine the independent contribution of AI because the intervention combined AI assistance with a second examination, whereas the standard-colonoscopy group underwent only a single forward-view examination. Baseline ADRs for individual endoscopists were not prospectively collected, and the study evaluated only one AI platform. In addition, the investigators did not assess interval colorectal cancer or other long-term clinical outcomes, and the study focused specifically on the right colon rather than overall colonoscopy performance.

Dr. Nishikawa also noted that future randomized trials directly comparing a conventional second examination with an AI-assisted second examination are needed to determine the independent incremental benefit of AI.

The authors reported no conflicts of interest. The study was supported by a research grant from the Japan Health Promotion Foundation, which had no role in study design, data collection, data analysis, data interpretation, or manuscript preparation.

ASGE ties lower GI bleeding workup to stability, not timing

The guideline strongly recommends full bowel preparation before colonoscopy and suggests band ligation for right-sided diverticular bleeding when feasible.

By Doug Brunk



Credit: Adobe Stock

A new American Society for *Gastrointestinal Endoscopy* guideline published in *Gastrointestinal Endoscopy* suggests colonoscopy as the initial test for acute lower GI bleeding in patients who are hemodynamically stable at presentation or after resuscitation, and contrast-enhanced CT, with or without angiography, for those who remain unstable.

The guideline considers either approach acceptable as a first test. Prepared by ASGE's Standards of Practice Committee, it also covers treatment of diverticular, vascular, and procedure-related bleeding.

The choice between colonoscopy and CT angiography "should largely be guided by a patient's initial presentation with lower GI bleeding," first author Nauzer Forbes, MD, MSc, FASGE, of the University of Calgary in Alberta, Canada, told *GI & Hepatology News*. "This is probably the single most important decision node when it comes to investigating and managing these patients."

"Existing ASGE guidance was somewhat outdated regarding the management of lower GI bleeding," Dr. Forbes said.

The guideline states that upper endoscopy should be performed in all patients presenting with hematochezia and initial hemodynamic instability to rule out an upper GI source, unless imaging directly shows a lower GI source. In a randomized trial of 85 patients with hematochezia and hemodynamic instability or a rapid hemoglobin drop, an upper GI source was identified in 15% of those who underwent upper endoscopy within six hours, most commonly peptic ulcers or varices.

On the choice of initial test, a meta-analysis of eight retrospective cohort studies found similar rates of bleeding identification and initial control with CT and colonoscopy. Patients who underwent CT first were older, had more comorbidities, presented with lower blood pressures, and received more transfusions. The panel cautioned that patients with the most severe presentations may have been preselected for CT, making the CT group's higher mortality and longer hospital stays difficult to interpret. The recommendation is conditional, based on very low-quality evidence.

The guideline suggests performing colonoscopy once patients are stable enough for the procedure and able to tolerate a full bowel preparation, regardless of timing — a conditional recommendation based on moderate-quality evidence. In a pooled analysis of four randomized trials involving 463 patients, recurrent bleeding did not differ between urgent and nonurgent colonoscopy; three trials involving 385 patients showed no difference in 30-day mortality.

In a sensitivity analysis limited to the two trials that defined urgent colonoscopy as within 24 hours, urgent colonoscopy was associated with about three times the odds of recurrent bleeding. It was also associated with shorter hospital stays, which the panel characterized as roughly a one-day reduction. The panel found no differences in need for surgery, radiologic intervention, or transfusion, or in adverse events.

Full bowel preparation carries the guideline's only strong recommendation, despite very low-quality evidence. The panel limited exceptions to a strongly suspected distal source or iatrogenic bleeding at a known, easily identifiable location, such as after polypectomy or endoscopic resection. Patients with established radiation proctopathy should still receive a full bowel preparation before argon plasma coagulation, the panel noted, given the risk of colonic explosion with higher levels of intestinal gas.

The guideline suggests choosing between band ligation and clipping for diverticular bleeding based on the lesion's location, clinical expertise, and device availability. It suggests band ligation for lesions in the transverse or proximal colon when feasible and through-the-scope clipping for distal lesions. In seven observational studies involving 2,329 patients, banding was associated with about one-third the odds of recurrent bleeding compared with clipping, although the benefit appeared limited to right-sided lesions.

Banding was also associated with less radiologic intervention and a nonsignificant trend toward more adverse events. All comparative studies were conducted in Asia. Much of the research used band ligators mounted on gastroscopes, and colonoscope-specific banding devices have limited availability in North America. The panel advised attempting banding only when the endoscopist is experienced with the approach and a colonoscope-compatible device is available.

When clipping is used, ASGE suggests placing clips directly on the bleeding vessel rather than closing the diverticular opening, particularly in the proximal colon. Nine observational studies associated direct clipping with 42% lower odds of recurrent bleeding and 50% lower odds of radiologic intervention than indirect clipping. Initial hemostasis, transfusion, surgery, and adverse events were similar. The panel noted that direct clipping may not be feasible with small-mouthed diverticula or when no clear vessel is visible.

For bleeding after polypectomy or endoscopic resection, the panel suggested through-the-scope clips or thermal coagulation, with hemostatic powder as an additional or rescue treatment. Argon plasma coagulation was suggested for angioectasia and radiation proctopathy. For bleeding from malignancy, the panel suggested hemostatic powder or Nd:YAG laser therapy to achieve temporary hemostasis, either for palliation or before surgery.

Surgery "should be considered a last resort," the guideline states, reserved for bleeding that is not amenable to endoscopic or radiologic treatment or that continues after both fail.

The panel used the Grading of Recommendations Assessment, Development, and Evaluation framework. It noted that most evidence came from retrospective studies prone to selection bias, that some data were older or from outside the U.S., and that definitions of urgent colonoscopy varied. All comparative studies of diverticular bleeding therapies were conducted in Asia, and the clipping studies included much higher proportions of right-sided lesions than are seen in Western settings.

ASGE funded the guideline. Dr. Forbes and several coauthors reported financial relationships with medical device and pharmaceutical companies.



ACG guideline ties polyposis gene testing to adenoma count

The panel found the evidence insufficient to support an age cutoff for testing patients with 10 to 19 adenomas.

By Doug Brunk

Updated American College of Gastroenterology guidance strongly recommends germline multigene panel testing (MGPT) for patients with at least 20 lifetime colorectal adenomas and suggests it for those with 10 to 19. The guideline was published in the *American Journal of Gastroenterology*.

"This is a timely guideline given the increasing use of MGPT in patients with or at risk for hereditary cancer," corresponding author Carol A. Burke, MD, MACG, of the Department of Gastroenterology, Hepatology, and Nutrition at Cleveland Clinic, and the Director of Hereditary Polyposis in the Weiss Center in the Department of Colorectal Surgery at the clinic, told *GI & Hepatology News*. It addresses who should undergo testing and how to manage affected patients and families, she said.

The eight-member writing group — five gastroenterologists with hereditary polyposis expertise, two methodologists, and a medical librarian — searched the literature through January 2025 and issued 12 graded recommendations, three of them strong, along with 31 key concept statements that were not graded.

According to Dr. Burke and her fellow guideline panel members, large studies found a disease-causing gene variant in 12.3% to 20.5% of patients with 20 to 99 lifetime adenomas and 5.3% to 11.3% of those with 10 to 19 adenomas.

For patients with 10 to 19 adenomas, testing is favored in those younger than 60 or with a personal or first-degree family history of colorectal cancer, and "may reasonably be deferred" in older patients without such history, the panel wrote. The evidence is insufficient to support an age-specific cutoff, according to the guideline.

The panel debated adding an age cutoff for testing at 10 to 19 adenomas but did not, Dr. Burke said. She cited a large U.S. commercial lab study that found a detection rate at or above 5% at any age and adenoma number. "We did not impose the restriction and acknowledge the limitations to the currently available evidence," she said.

The guideline advises that panels include at least 17 genes linked to polyposis and inherited cancer syndromes. It advises further evaluation for patients whose earlier negative testing did not include those genes, whose personal or family cancer history has changed, or who were tested before 2013, with referral to a hereditary cancer specialist. Patients with 20 or more adenomas and uninformative results should be considered for referral to weigh adenomatous polyposis coli (APC) mosaicism testing case by case, according to the guideline.

The panel also strongly recommends APC gene testing for patients with signs linked to familial adenomatous polyposis (FAP). These include desmoid tumors, a rare type of thyroid cancer called cribriform-morular thyroid carcinoma, specific retinal abnormalities in both eyes or in multiple areas, and hepatoblastoma.

For patients with a harmful APC gene variant, or who may have classic FAP but have not been tested, the guideline advises a first colonoscopy between ages 10 and 15, followed by another every one to three years. For attenuated FAP and MUTYH-associated polyposis (MAP), it advises starting colonoscopy between ages 18 and 20 and continuing

"More patients in my practice that were clinically managed as FAP but without a detectable APC GPV are undergoing a discussion of the approach to mosaicism as a cause..."

Dr. Burke spoke with *GI & Hepatology News* about the guideline.

In your opinion, what are the top concepts from this document?

Dr. Burke: The key concepts in the guideline include 1. how to identify individuals who should undergo germline genetic testing to uncover a hereditary adenomatous colorectal polyposis syndrome; and 2. the management strategies for individuals and families found to harbor a germline pathogenic variant for a hereditary adenomatous polyposis syndrome and approach to patients with colonic polyposis of unknown etiology (CPUE).

As you and your coauthors put together this guideline, was there a topic, or perhaps more than one, that caused more deliberation than usual?

Dr. Burke: There is disparity between countries regarding the use of germline MGPT in CPUE/multiple colorectal adenomas (MCRA)/idiopathic adenomatous polyposis (IAP). Many European countries restrict MGPT to specific populations based on number of adenomas and age or other clinical risk factors. However, the use of germline MGPT is relatively common in the U.S., covered by insurance when patients meet specific clinical criteria (or usually, for less than a few hundred dollars if not covered by insurance) and considered by most U.S. guidelines to be indicated for patient[s] with 10 or more cumulative lifetime adenomas regardless of age.

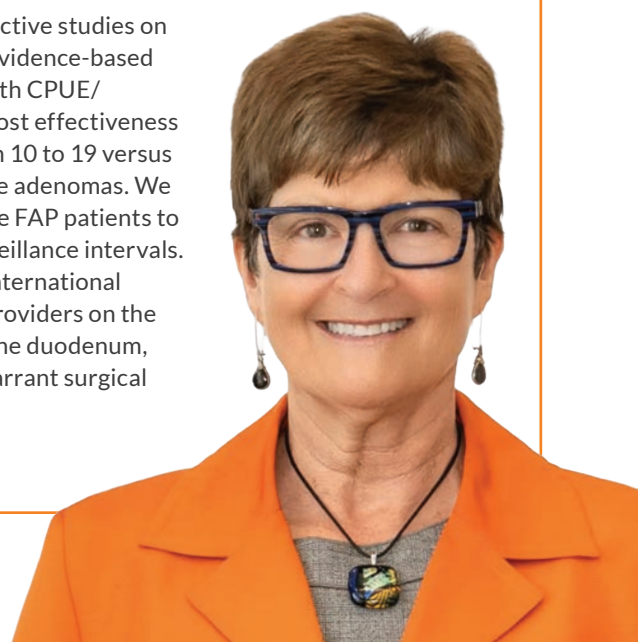
The evidence shows the yield of MGPT in patients with 10 to 19 cumulative adenomas is significantly less than individuals with 20 to 99 adenomas particularly when the individual is diagnosed with the syndrome over age 60. We deliberated over whether there is enough data to add an age cutoff for MGPT in CPUE. In the end, we did not add an age cutoff. Since the impact of finding a germline pathogenic variant (GPV) has substantial impact for the patient and family and the detection rate of a GPV for a hereditary colorectal polyposis or cancer syndrome in a large study from a commercial lab in the U.S. was at or above 5% at any age and adenoma number, we did not impose the restriction and acknowledge the limitations to the currently available evidence.

Did any aspect of your clinical practice change because of helping to form this guideline?

Dr. Burke: Yes. More patients in my practice that were clinically managed as FAP but without a detectable APC GPV are undergoing a discussion of the approach to mosaicism as a cause and appropriate patients are encouraged to consider mosaicism testing.

What additional research may be needed/what questions remain unanswered on this topic?

Dr. Burke: We need prospective studies on the clinical outcomes and evidence-based management of patients with CPUE/MCRA/IAP. Likewise, the cost effectiveness of MGPT in individuals with 10 to 19 versus 20 to 99 cumulative lifetime adenomas. We need trials which randomize FAP patients to different colonoscopy surveillance intervals. Prospective, multicenter, international studies which can inform providers on the noncancerous features in the duodenum, stomach, or colon which warrant surgical intervention.



Carol A. Burke, MD, MACG

every one to three years, depending on the number, size, and histology of polyps found. For rarer syndromes, the guideline advises referral to an expert center, citing their rarity, evolving cancer risks, and need for multispecialty care. These include polymerase proofreading-associated polyposis and NTHL1-, AXIN2-, MSH3-, MLH3-, and MBD4-associated syndromes.

The guideline calls colectomy the cornerstone of colorectal cancer risk reduction in FAP. For patients with FAP who need surgery and have more than 20 rectal adenomas, the panel suggests total proctocolectomy with ileal pouch-anal anastomosis over total colectomy with ileorectal anastomosis. That suggestion applies to those who prioritize a marginal reduction in the risk of secondary proctectomy and rectal cancer over functional outcomes. For patients with 20 or fewer rectal adenomas, it suggests colectomy with ileorectal anastomosis to improve quality of life after surgery.

The panel emphasized that the rectal adenoma cutoff is "not immutable" and that the decision must be individualized. According to the guideline, surgical decisions should also consider cancer risk, rectal involvement, symptoms, desmoid risk, complications, bowel function, and psychosocial well-being. After either procedure, the guideline advises annual lower endoscopy, or more frequent exams with a high or advanced adenoma burden.

The panel strongly recommends against using medicines to prevent polyps in place of colectomy when surgery is needed. It suggests sulindac (150 mg twice daily) or celecoxib (400 mg twice daily) as an adjunct to endoscopic surveillance and polypectomy. The panel noted that the drugs can reduce colorectal polyps but that whether they lower cancer risk or delay surgery is unclear.

The guideline advises starting upper endoscopic surveillance at ages 20 to 25 in FAP and attenuated FAP and 30 to 35 in MAP, or earlier based on family history. The panel suggests surveillance that includes visualization of the duodenal papilla. It ties duodenal intervals to Spigelman stage, from every three to five years at stage 0 to every three to six months at stage IV.

For duodenal adenomas larger than 10 mm or with any high-grade dysplasia, the panel suggests treatment over surveillance alone. It says the choice between endoscopic and surgical resection should be individualized to duodenal and ampullary disease burden, patient preference, and access to an experienced therapeutic endoscopy team.

Gastric cancer, reported in 1.3% to 5% of Western patients with FAP or attenuated FAP, is becoming a leading cause of FAP-related cancer death among patients who have undergone colectomy, according to the guideline. The guideline lists the high-risk gastric features as carpeting of proximal polyposis, polypoid mounds, solitary polyps 10 mm or larger, and white mucosal patches. The panel suggests removing all antral polyps, gastric adenomas, polyps 10 mm or larger, proximal polypoid mounds, and white mucosal patches.

Only one of the 12 recommendations — against using chemoprevention in place of colectomy — rests on moderate-certainty evidence, the panel noted. The other 11 are based on low- or very low-certainty evidence, drawn largely from retrospective studies at high-risk centers. Evidence was especially limited for rare syndromes, surveillance intervals, long-term chemoprevention, and whether endoscopic treatment prevents cancer, according to the guideline.

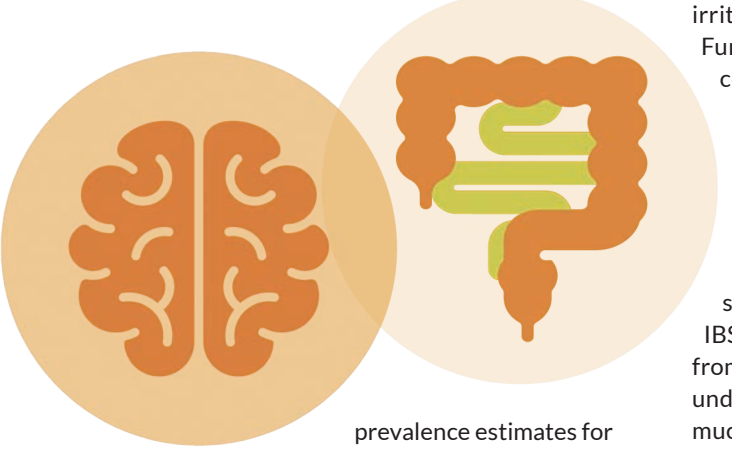
Even so, "this is an important comprehensive resource that all digestive disease providers should review," Dr. Burke said.

The guideline received no outside funding. Dr. Burke reported research support from Emtora/Biodexa and consulting fees from Lumabridge. Three coauthors also reported research support from Emtora/Biodexa, and one reported research support from Exact Sciences. Two reported consulting fees from Phathom Pharmaceuticals that they described as unrelated to the guideline.

DGBI burden holds steady under Rome V, but IBS prevalence doubles

About four in 10 adults across 15 countries met criteria for at least one gut-brain disorder — nearly identical to Rome IV — while looser pain thresholds more than doubled the share meeting IBS criteria.

By Doug Brunk



About four in 10 adults across 15 countries met criteria for at least one disorder of gut-brain interaction (DGBI) under the new Rome V criteria, nearly the same proportion identified using Rome IV, according to a multinational population survey.

The findings, published in *Gut*, provide an early global look at the new Rome V criteria and suggest that changes to individual diagnostic definitions had little effect on the overall prevalence of these disorders. Investigators also examined how bothersome symptoms were and how much they interfered with daily life to help develop diagnostic criteria that better reflect their clinical impact.

"One of the highlights of this new study is its comparison with the previous Rome Foundation Global Epidemiology Study (Rome IV)," Ami D. Sperber, MD, of Ben-Gurion University of the Negev in Israel, told *GI & Hepatology News*. "The two studies, conducted seven years apart, had the identical rigorous methodology and the same 22 DGBI were surveyed in the same 15 countries with worldwide distribution. Thus, it was both intriguing and of great potential significance to compare the results of the two studies."

Dr. Sperber and colleagues surveyed 28,771 adults online across 15 countries. About 2,000 participants were recruited from each country, with quotas to ensure representation by sex and age. The survey included the Rome V diagnostic questionnaire, along with questions about healthcare use and other clinical factors.

For the comparison with the earlier survey, investigators analyzed prevalence estimates for disorders assessed under both Rome IV and Rome V criteria. The data were weighted to account for differences in sample size among countries.

Based on the 22 disorders assessed in both surveys, the prevalence of at least one DGBI was 40.9% under Rome V and 40.5% under Rome IV. Including all 25 disorders assessed under Rome V raised the overall figure only slightly, to 41.4%. Women were more likely than men to meet criteria, 46.9% vs. 34.8%. Prevalence also declined with age, from 45.9% among adults aged 18-34 years to 33.3% among those aged 65 years or older.

Bowel disorders remained the most common category, affecting 34.7% of participants under Rome V vs. 33.9% under Rome IV. Unclassified bowel disorder was the most common bowel disorder, affecting 9.6%, followed by chronic constipation at 8.9% and irritable bowel syndrome (IBS) at 8.5%. Functional dyspepsia was the most common gastroduodenal disorder at 8.1%, proctalgia fugax the most common anorectal disorder at 7.3%, and functional dysphagia the most common esophageal disorder at 4.1%.

Some diagnoses changed substantially under the new criteria. IBS prevalence more than doubled, from 3.9% under Rome IV to 8.5% under Rome V. The authors attributed much of the increase to changes in the criteria, including lowering the minimum frequency of abdominal pain to three days per month and again including abdominal discomfort as a qualifying symptom. Chronic constipation — termed functional constipation under Rome IV — declined from 11.8% to 8.9%, which the authors said likely reflects an internal shift as more people with constipation-type symptoms met IBS criteria.

Functional dyspepsia increased from 6.9% under Rome IV to 8.1% under Rome V, while rumination syndrome declined from 2.8% to 1.5%. Fecal incontinence increased from 1.7% to 4.1%; the authors attributed the increase largely to Rome V lowering the required frequency of episodes from twice a month to once a month.

Rome V also added abdominal migraine and inability to belch syndrome as disorders in adults,

Dr. Sperber shared his perspective on the study with *GI & Hepatology News*.

How might the Rome V criteria change the way gastroenterologists diagnose and manage IBS in clinical practice?

Dr. Sperber: The Rome V criteria re-introduced abdominal discomfort as a diagnostic criterion (alongside abdominal pain) and lowered the minimum frequency of pain/discomfort required for diagnosis compared to Rome IV criteria. These changes bring the Rome V criteria more into alignment with how IBS is commonly diagnosed in clinical practice. That may improve acceptance of the Rome criteria by clinicians, some of whom have felt that the Rome IV criteria were too stringent and excluded many patients who likely had IBS. With the aim of developing specific clinical criteria that will be easy for clinicians to adopt and use globally, three new variables, i.e., bothersomeness of symptoms, interference of symptoms with life function, and perceived need to consult with a doctor for the symptoms were introduced in the Rome V global study after they were validated in focus groups. Thus, a groundwork was laid in this study for clinicians to benefit more from the Rome criteria in clinical practice.

Should symptom bothersomeness and life interference play a greater role in diagnosing and treating DGBI?

Dr. Sperber: These two new variables that were reported first in the present study are, together with the perceived need to consult with a doctor, factors that can have a strong effect on the patient's perspective on their illness and the impact on their daily functioning and quality of life. Thus, these are important foundations for future clinical diagnostic criteria for DGBI and for the doctor's ability to develop a multidimensional clinical profile of the patient, which will facilitate working with patients to develop a patient-centered treatment plan and follow-up.

What should gastroenterologists know about the newly recognized Rome V disorders, particularly abdominal migraine and inability to belch syndrome?

Dr. Sperber: These two newly defined DGBI diagnoses were shown, in this study, to be considerably prevalent in the general population at a rate of 5.1% for abdominal migraine and 1.4% for inability to belch. They were also found, in most cases, to overlap with other DGBI. Where they co-exist with other DGBI, they likely add to the disease burden, because DGBI overlap has been associated, in papers from the Rome IV global epidemiological study, with greater psychosocial distress, higher disease severity, higher rates of somatization, and lower quality of life. Gastroenterologists should be more aware of these additional entities, their diagnosis and care. There were other new diagnoses introduced in Rome V as well, e.g., rectal hypo- and hypersensitivity, but these require both clinical recognition and laboratory testing for confirmation, so they were not included in the present survey.



Ami D. Sperber, MD

affecting 5.1% and 1.4% of participants, respectively. More than 90% of those with abdominal migraine and more than 95% of those with inability to belch syndrome also met criteria for another disorder. As a result, adding these diagnoses contributed little to overall prevalence.

Among participants with at least one disorder, 42.6% had ever seen a physician for a GI problem, 39% said their symptoms were at least moderately bothersome, and 28.1% said symptoms interfered at least moderately with daily life. In an analysis adjusted for age and sex, the authors reported that bothersomeness was more strongly associated with having consulted a doctor than life interference was, with odds ratios of 3.53 and 2.25, respectively.

Participants with painful disorders more often reported physician visits than those with nonpainful disorders, 54.4% vs. 43.2%; bothersome symptoms, 56.1% vs. 39.9%; and interference with daily life, 42.4% vs. 29.2%.

Limitations included the lack of diagnostic testing, reliance on self-reported symptoms, and the possibility of selection and recall bias. The study also included fewer countries than the earlier survey (15 vs. 26 in the internet arm of the Rome IV survey) and relatively few participants from rural areas, which may limit how broadly the findings apply.

The study was conducted and funded by the Rome Foundation Research Institute. The authors reported no competing interests.

Baveno VIII shifts portal hypertension care toward prevention

"Portal hypertension management is becoming increasingly preventive, personalized, and noninvasive."

By Doug Brunk



Credit: Adobe Stock

Updated Baveno VIII recommendations for portal hypertension, published online in the *Journal of Hepatology*, place greater emphasis on noninvasive risk assessment and prevention of hepatic decompensation. They also refine guidance on managing variceal bleeding, decompensated cirrhosis, and cirrhosis recompensation.

The consensus updates guidance based on evidence that has emerged since Baveno VII. It was developed by the Baveno Cooperation, a consortium of the European Association for the Study of the Liver (EASL), and is endorsed by EASL, the European Society of Gastrointestinal Endoscopy, and the European Reference Network for Rare Hepatological Diseases. At a March 2026 conference in Baveno, Italy, more than 80 faculty members worked in nine panels to review and vote on proposed statements. Approval required agreement from at least 80% of participants. Overall, the group reached consensus on 272 statements and recommendations.

A major focus is the use of noninvasive tests to identify clinically significant portal hypertension (CSPH) in patients with compensated advanced chronic liver disease (cACLD). A liver stiffness measurement of 15 kPa or less combined with a platelet count of at least 150 × 10^9/L can rule out CSPH with a negative predictive value above 90%. CSPH can be diagnosed based on a predicted probability of at least 75% using validated models; liver stiffness of at least 25 kPa in patients with viral- or alcohol-related cACLD or nonobese patients with metabolic dysfunction-associated steatotic liver disease (MASLD); or spleen stiffness greater than 55 kPa measured at 100 Hz. Patients with indeterminate results may be reassessed after 12 months.

"Portal hypertension management is becoming increasingly preventive, personalized, and noninvasive," one of the consensus panelists, Thomas Reiberger, MD, of the division of gastroenterology and hepatology at Medical University of Vienna, Austria, told *GI & Hepatology News*. "With Baveno VIII, noninvasive tests allow

us to identify risk earlier, carvedilol effectively treats portal hypertension before the first clinical complication, and unnecessary endoscopies can increasingly be avoided."

The guidance also shifts the focus from determining whether CSPH is present to predicting a patient's risk of hepatic decompensation. Key prognostic factors include the presence of CSPH, liver function, and the cause of liver disease. "The paradigm is shifting," the faculty wrote, toward using noninvasive tests to directly predict decompensation — an approach the document frames as a way to identify patients at substantial risk who would benefit most from preventive treatment.

For patients with compensated cirrhosis and CSPH, the guidance recommends nonselective beta-blockers (NSBB), particularly carvedilol, to prevent decompensation and improve survival. These drugs are not recommended for preventing decompensation in patients without CSPH. Patients already taking an NSBB do not need screening endoscopy for varices because the results would not change treatment.

Baveno VIII also adds guidance for patients with MASLD. Weight loss of at least 10% is associated with at least a 30% relative reduction in liver stiffness, which may indicate lower liver-related risk. Metabolic and bariatric surgery may be considered for selected patients without CSPH but carries greater risk in those with CSPH and is generally contraindicated in patients with decompensated cirrhosis, except in highly specialized settings such as in conjunction with liver transplantation. GLP-1-based therapies and sodium-glucose cotransporter 2 inhibitors may be used for approved indications in patients with cACLD who have no contraindications.

For acute variceal bleeding, vasoactive therapy should begin as soon as possible, and preventive antibiotics are recommended at presentation. The duration of antibiotic treatment — and whether it is needed at all — may be individualized based on infection risk and the severity of cirrhosis. Preemptive transjugular intrahepatic portosystemic shunt (TIPS) is recommended within 72 hours, and ideally within 24 hours, for selected high-risk patients. New guidance suggests that patients who miss this window may still benefit from TIPS within one to two weeks, depending on disease severity.

The document also provides a more detailed definition of cirrhosis recompensation. Patients must have the cause of cirrhosis removed, controlled, or suppressed; have no ascites without diuretics and no hepatic encephalopathy without specific treatment; and have no recurrent variceal bleeding. These criteria must be sustained for more than six consecutive months. Patients also must show improvement in liver function to Child-Turcotte-Pugh class A. Even after recompensation, patients should continue hepatology follow-up every six months and undergo ongoing surveillance for hepatocellular carcinoma.

For the first time, Baveno recommendations also include guidance for children. The document cautions that liver and spleen stiffness measurements alone should not yet be used to guide portal hypertension management in children because the thresholds for identifying or ruling out varices need further study.

Each statement in the document is graded by level of evidence, and a substantial number — including several new statements on recompensation, pediatric disease, and vascular liver disease — rest on lower-level evidence or expert opinion. The panels identified 153 priority topics for future research, reflecting important gaps in knowledge.

Texas Children's Hospital sponsored the pediatric symposium held with the meeting. The Baveno Cooperation also received financial support from several pharmaceutical and medical device companies, as well as scientific organizations. The document does not include conflict-of-interest disclosures for individual authors.

Which recommendations are likely to change day-to-day practice?

Dr. Reiberger: Several Baveno VIII recommendations underline the paradigm shift from managing complications of portal hypertension to preventing the first decompensation. Prevention is most effectively achieved via etiological therapy and treatment of CSPH by NSBB, preferably using carvedilol. Carvedilol does not only prevent decompensation but also improves survival. Endoscopic treatment of varices is not recommended for primary bleeding prophylaxis since it has no effect on nonbleeding related complication nor on survival.

How do the new noninvasive CSPH criteria change who gets endoscopy or preventive treatment?

Dr. Reiberger: The Baveno VI criteria of liver stiffness <20 kPa and normal platelet count (PLT ≥150 G/L) remain valid to rule out high-risk varices. Baveno VIII strengthens the role of noninvasive tests, particularly liver and spleen stiffness and platelet count, that should preferably be used in validated prediction models, such as the ANTICIPATE (±NASH) and NICER models, which provide an actual CSPH probability. Based on a validated ANTICIPATE or NICER cut-off at ≥75%, carvedilol should be initiated to prevent hepatic decompensation. This means that in many patients we can identify clinically relevant portal hypertension without invasive testing.

When should clinicians start carvedilol in patients with compensated cirrhosis, and when can endoscopy be avoided?

Dr. Reiberger: The indication for carvedilol is based on the presence of CSPH, not simply on the presence of varices. Endoscopic treatment of varices is not preferred, since treatment with NSBBs, particularly carvedilol, reduces the risk of both bleeding and non-bleeding decompensation and improves survival. In contrast, if CSPH is absent (i.e., can be ruled out by noninvasive tests), NSBB/carvedilol should not be prescribed simply to prevent future decompensation. Once a patient with CSPH is receiving NSBB/carvedilol, routine endoscopic screening/surveillance for varices is not needed because finding varices would generally not change treatment.



HLA typing may help identify past celiac disease misdiagnoses

All newly diagnosed patients in a Norwegian screening study carried a known genetic risk type, while 6% of those diagnosed years earlier carried none.

By Doug Brunk

A population-based Norwegian study found that all patients newly diagnosed with celiac disease through systematic screening had known genetic risk types. In contrast, many patients diagnosed in the past who lacked these genetic types appeared to have been misdiagnosed. The findings suggest genetic testing may be especially helpful for ruling out celiac disease or re-evaluating a questionable earlier diagnosis.

"Our findings highlight how improvements in diagnostic methods have increased the accuracy of celiac disease diagnosis over time," first author Rebecka Hjort, PhD, of the HUNT Research Center at the Norwegian University of Science and Technology in Trondheim, Norway, told *GI & Hepatology News*. "The study also demonstrates the value of large population-based screening studies, both for identifying undiagnosed disease and for improving diagnostic quality. Genetic testing can be a useful tool in this process, but it must always be interpreted together with symptoms, blood tests, and biopsy findings."

The study, published in *Clinical Gastroenterology and Hepatology*, examined human leukocyte antigen (HLA)-DQ allotypes in adults participating in Norway's fourth Trøndelag Health Study, or HUNT4, conducted from 2017 to 2019. Researchers screened 52,588 adults for celiac disease and studied 376 patients with previously diagnosed disease, 465 newly diagnosed patients, 163 patients with potential celiac disease, and 1,412 randomly selected controls without celiac disease.

Screening used immunoglobulin A (IgA) and immunoglobulin G antibodies against transglutaminase 2 (TG2). Seropositive patients underwent repeat serology and upper endoscopy with small-intestinal biopsies. Two independent pathologists confirmed celiac disease when villous blunting corresponding to Marsh grade 3 was present. Patients with Marsh grades 1-2 were classified as having potential celiac disease.

Researchers analyzed two genes, HLA-DQA1 and HLA-DQB1, to identify genetic types associated with celiac disease. Every newly diagnosed patient carried at least one of three established genetic risk types: HLA-DQ2.5, HLA-DQ2.2, or HLA-DQ8. In contrast, 21 of the 376 previously diagnosed patients, or 6%, had none of these genetic types.

That difference led researchers to take another look at the 21 patients' biopsy results. Only five had the intestinal damage needed to confirm celiac disease. The other 16, or 76%, were considered to have been misdiagnosed, usually because their biopsies showed little or no intestinal damage or because biopsy records were unavailable. After removing those cases, the previously diagnosed group fell from 376 to 360 patients.

Researchers also reviewed 40 randomly selected patients with a previous celiac disease diagnosis who did carry DQ2 or DQ8 allotypes. Three, or 7.5%, were classified as false positives. Based on that finding, the researchers estimated that about 43 of the original 376 previously diagnosed patients, or 11.4%, may have received a false-positive historical diagnosis. Additional analyses that accounted for these possible misdiagnoses showed a higher prevalence of the genetic types most strongly linked to celiac disease.

After confirmed misdiagnoses were removed, DQ2.5 remained the most common genetic risk type. It was found in 86% of previously diagnosed patients and 88% of newly diagnosed patients, compared with 22% of people without celiac disease. Having two copies of DQ2.5 was linked to the greatest risk, with 16.7 times the odds of celiac disease relative to patients without DQ2.5, DQ2.2, or DQ8. Another DQ2.5 combination, DQ2.5/DQX, was associated with 5.7 times the odds.

A gene-dose pattern also emerged for DQ8. After accounting for DQ2.5, patients with two copies of DQ8 had 8.8 times the odds of celiac disease, and those with one copy had 2.6 times the odds relative to patients without DQ2.5, DQ2.2, or DQ8. Patients with two copies of DQ2.2 had 3.4 times the odds, although the study did not find a clear overall association between DQ2.2 and celiac disease.

Subgroup analyses showed few major differences in HLA-DQ patterns between previously and newly diagnosed patients, and HLA-DQ patterns did not vary meaningfully with IgA TG2 antibody levels among newly diagnosed patients.

For clinicians, the findings suggest that HLA testing is more useful for ruling out celiac disease than confirming it. After confirmed misdiagnoses were excluded, the negative predictive value of testing for DQ2.5, DQ2.2, and DQ8 was 100% among newly diagnosed patients and 99% among previously diagnosed patients. The positive predictive value was 38% and 32%, respectively.

Limitations included the possibility that some previously diagnosed patients were still misclassified and that duodenal bulb biopsies may have contributed to false-positive diagnoses. The study also included patients from a single region of Norway, which may limit how broadly the findings apply.

The Research Council of Norway, the Liaison Committee for Education, Research and Innovation in Central Norway/ Samarbeidsorganet, and the Norwegian Celiac Society funded the study. The authors reported no competing interests.

Dr. Hjort elaborated on the findings with *GI & Hepatology News*.

Given the 11.4% estimated false-positive rate among previously diagnosed patients, should gastroenterologists consider reassessing older celiac diagnoses, particularly when the original serology or biopsy documentation is incomplete?

Dr. Hjort: Our findings suggest that some historical diagnoses may warrant re-evaluation, especially when the original test results are missing, difficult to verify, or were made using diagnostic methods that differ from today's standards.

Importantly, we do not suggest that all historical celiac diagnoses should be questioned. Most previously diagnosed patients in our study had findings consistent with celiac disease. However, among individuals lacking the necessary HLA risk alleles, a substantial proportion appeared to have been diagnosed on insufficient evidence.

For patients with incomplete documentation, uncertain histology, or atypical clinical histories, reassessment using current diagnostic tools, including HLA typing, may help clarify the diagnosis.

All newly diagnosed cases carried DQ2.5, DQ2.2, or DQ8, giving HLA testing a 100% negative predictive value in this group. How should that finding change the way clinicians use HLA typing when celiac disease remains diagnostically uncertain?

Dr. Hjort: HLA testing is particularly valuable when the diagnosis is unclear. For example, some patients start a gluten-free diet before they are properly tested, while others have inconclusive biopsy results or conflicting blood test results. In these situations, a negative HLA test can provide reassurance that celiac disease is not the explanation. A negative HLA result may spare patients from further invasive investigations and prompt clinicians to consider alternative explanations for symptoms.

You found clear gene-dose effects for DQ2.5 and DQ8, but HLA-DQ type was not associated with IgA TG2 levels in newly diagnosed patients. Does HLA genotype have any practical role in predicting disease phenotype or severity once celiac disease is established?



Dr. Hjort: Our study confirms that HLA genotype is strongly associated with disease susceptibility, but we found little evidence that it predicts serological activity once celiac disease has developed. While individuals carrying two copies of DQ2.5 had the highest risk of developing celiac disease, HLA genotype was not associated with anti-TG2 antibody levels among newly diagnosed patients.

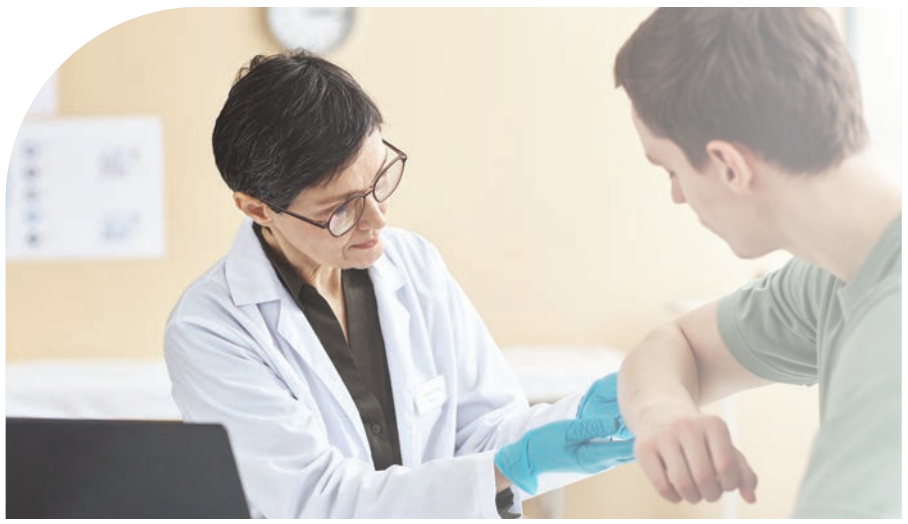
These findings suggest that HLA typing is more useful for understanding disease risk than disease severity.

Rebecka Hjort, PhD. Photo credit: Anne-Line Bakken/NTNU

Most excess cancer in Crohn's disease may be nonmelanoma skin cancer

Excluding skin cancers, a Swedish registry study of 38,733 patients found about one additional cancer per 1,000 person-years in the three largest cohorts.

By Olivia Anderson



Credit: Adobe Stock

Patients with Crohn's disease (CD) had a higher overall incidence of cancer than matched members of the general population in most treatment cohorts, including treatment-naive patients, but much of the excess was attributable to nonmelanoma skin cancer, according to a nationwide population-based cohort study published in *The American Journal of Gastroenterology*.

After nonmelanoma skin cancers were excluded, the study found that the absolute excess cancer incidence was small, amounting to approximately one additional cancer case per 1,000 person-years — roughly one extra case for every 1,000 patients followed for one year — in the largest cohorts. The remaining difference was attributed to lung, small bowel, hepatobiliary, and hematologic cancers.

Real-world data quantifying absolute cancer risk in CD by treatment status "are lacking but are essential for patient counselling," the authors wrote.

The researchers used Swedish nationwide registry data from 2007 through 2023 to examine cancer incidence among 38,733 patients with CD and more than 360,000 matched general population comparators. Patients were followed for a median of 7.3 years. Each patient with CD was matched by birth year, sex, and place of residence with up to 10 people without inflammatory bowel disease. Of 50,855 patients with CD identified, 12,122 were excluded because of contraindications to immunomodulatory drugs, such as HIV, advanced liver or kidney disease, or transplantation, or because of prior use of those drugs.

Treatment cohorts comprised patients naive to immunomodulatory drugs and new users of thiopurines, tumor necrosis factor inhibitors (TNFi), combined thiopurine and TNFi therapy, vedolizumab, or ustekinumab. The researchers used a "once exposed, always exposed" design, meaning patients could contribute follow-up time and events to more than one treatment group and were not censored when they discontinued a treatment.

The study measured excess cancer incidence — the number of additional cancers per 1,000 person-years in each CD cohort compared with its matched comparators. Cancers required histopathologic confirmation, and the researchers used a one-year lag between CD diagnosis or treatment start and cancer assessment to reduce detection bias.

Compared with matched comparators, excess incidence of any cancer ranged from 2.42 to 3.14 cases per 1,000 person-years in the treatment-naive, thiopurine, TNFi, and combination therapy cohorts. The excess in the vedolizumab and ustekinumab cohorts, the two smallest groups, was not statistically significant.

"Most of the observed excess cancer risk in CD in our study was due to elevated rates of basal and squamous cell skin carcinomas," the authors wrote.

After nonmelanoma skin cancers were excluded, the excess was 1.27 cases per 1,000 person-years in the treatment-naive cohort, 1.14 in the thiopurine cohort, and 0.96 in the TNFi cohort. It was not statistically significant in the other three cohorts.

The study also found elevated lymphoma incidence compared with the general population in the thiopurine and TNFi cohorts, at 0.14 and 0.34 extra cases per 1,000 person-years, respectively. In contrast, the researchers found no elevated incidence for common cancers including colorectal, breast, and prostate cancer in any of the treatment cohorts.

For several other cancer types, including cervical, uterine, and nervous system cancers, the authors also reported no elevated cancer rates regardless of treatment group.

The researchers found that age had an important relationship with absolute cancer risk. Excess incidence was not significantly elevated among pediatric patients but was elevated among adults. In the thiopurine cohort, for example, the excess rose from 0.41 cases per 1,000 person-years in patients younger than 18, which was not statistically significant, to 6.65 in patients 60 and older.

Absolute excess incidence increased with age, but the relative increase in risk compared with the general population followed the opposite pattern: It was highest in younger patients and near general population levels in patients 60 and older, the authors reported.

Because cancer incidence increases steeply with age in the general population, "similar relative risks may translate into larger absolute differences in older patients," the authors noted.

"Importantly, age modified both baseline cancer risk and the absolute impact of therapy and disease severity," the authors wrote. They added that shared decision-making should consider patient age, comorbidities, and inflammatory burden.

"From a clinical perspective, these findings are reassuring. The absence of an increased overall cancer incidence in pediatric patients supports the continued use of thiopurines and biologics when clinically indicated, as the absolute cancer risk seems to be very low in this age group," the authors wrote.

For most patients with CD, they wrote, the absolute excess cancer risk was small and should be weighed against the benefits of sustained control of inflammation.

The authors cautioned against using the findings to compare malignancy risk among individual treatments. Differences between the treatment cohorts could be affected by disease duration, disease phenotype, age, and other factors, and "this study does not provide any direct comparison across treatment groups."

Other limitations included the median 7.3-year follow-up, which the authors wrote may be insufficient to capture malignancies with long latency periods. The once-exposed-always-exposed design also did not account for actual treatment duration and could underestimate risk because patients remained classified as exposed after discontinuing therapy.

As an observational study, the analysis also could not fully account for potential confounding from smoking, obesity, disease severity, cancer screening participation, genetic and environmental factors, and other comorbidities.

The authors also noted that overall cancer incidence is somewhat lower in Sweden than in the United States — age-standardized rates of about 310 vs. 367 new cases per 100,000 person-years in 2022 — and that differences in lifestyle, screening, and diagnostic practices may affect cancer incidence. Swedish registries also do not capture race, they wrote.

"These findings are reassuring ... as the absolute cancer risk seems to be very low in this age group."

The study was funded by the Swedish Research Council, the Swedish Cancer Society, and other Swedish and European research grants. Several authors reported grants or advisory, consulting, or speaker fees from companies including AbbVie, Bristol Myers Squibb, Janssen, Pfizer, and Takeda.

Cancer risk comparable across advanced IBD therapies in claims analysis

Three-year cumulative incidence ranged from 2.0% to 2.7% across four therapy classes in 15,687 patients.

By Meg Barbor

Incident cancer risk was low and comparable across contemporary advanced therapy classes in patients with inflammatory bowel disease (IBD), according to findings from an administrative claims-based study published online in *Clinical Gastroenterology and Hepatology*.

The retrospective active-comparator, new-user cohort study included 15,687 adults with IBD and no cancer diagnosis in the preceding year who initiated tumor necrosis factor (TNF) antagonists, vedolizumab, anti-interleukins, or Janus kinase (JAK) inhibitors between 2016 and 2023. The primary outcome was incident cancer, excluding nonmelanoma skin cancer, occurring at least three months after treatment initiation.

In an interview with *GI & Hepatology News*, corresponding author Siddharth Singh, MD, MS, professor of medicine in the Division of Gastroenterology and Hepatology at Mayo Clinic Arizona, said the findings were reassuring across treatment classes.

"In nearly 15,700 patients with IBD, the overall risk of incident cancer was low and comparable across all contemporary advanced therapies, TNF antagonists, vedolizumab, anti-interleukins, and JAK inhibitors, with consistent findings in Crohn's disease and ulcerative colitis and at the individual-agent level," Dr. Singh said.

"We found no signal that any one class of advanced therapy carried a higher overall cancer risk than another," he added.

Incidence by therapy class

The study used deidentified medical and pharmacy claims from the OptumLabs Data Warehouse. Patients had Crohn's disease or ulcerative colitis and initiated an advanced therapy between January 2016 and May 2023. The analysis included 8,031 patients who initiated TNF antagonists, 3,985 who initiated vedolizumab, 3,287 who initiated anti-interleukin therapies, and 384 who initiated JAK inhibitors.

Patients were followed for a median of 2.6 years. Mean patient age was 45 years, 52% were female, 58% had Crohn's disease, and 42% had ulcerative colitis.

Overall, 273 patients developed cancer during follow-up. The three-year cumulative incidence of cancer was 2.1% with TNF antagonists, 2.7% with vedolizumab, 2.0% with anti-interleukins, and 2.5% with JAK inhibitors.

After adjustment, cancer risk with vedolizumab, anti-interleukins, and JAK inhibitors was not significantly different from cancer risk with TNF antagonists, the study's primary comparator group. The adjusted hazard ratios were 1.01 for vedolizumab, 0.94 for anti-interleukins, and 0.85 for JAK inhibitors.

Findings were similar in analyses stratified by IBD phenotype. In patients with Crohn's disease, hazard ratios compared with TNF antagonists were 1.00 for vedolizumab, 0.95 for anti-interleukins, and 0.44 for JAK inhibitors. In patients with ulcerative colitis, the corresponding hazard ratios were 1.03, 0.84, and 0.99.

Comparative estimates were also similar in analyses by cancer type — solid organ, hematological, and melanoma — although the authors noted that event rates were low. Across the cohort, 13 patients developed lymphoma and 17 developed melanoma.

The findings also were consistent in an exploratory agent-level analysis restricted to the six agents with adequate sample size — adalimumab, infliximab, vedolizumab, ustekinumab, risankizumab, and tofacitinib — with no statistically significant difference in overall cancer risk in pairwise comparisons.

What the authors say it means for practice

Concerns about malignancy often influence treatment selection in IBD, particularly as more patients receive advanced therapies earlier and for longer periods, the authors noted.

"The results are reassuring: concern about overall cancer risk shouldn't, by itself, steer clinicians away from any particular class, freeing therapy choice to be driven mainly by efficacy, disease phenotype, and patient preference," Dr. Singh said.

In a separate comparison with 6,937 immunomodulator- and advanced therapy-naive patients with newly diagnosed IBD, standardized overall cancer incidence was not increased among patients initiating advanced therapy. Incidence with advanced therapies, at 0.68 to 0.90 cases per 100 person-years, was broadly consistent with the 0.75 cases per 100 person-years observed in the treatment-naive cohort — a finding the authors wrote reinforces the inference that elevated malignancy risk in IBD may be driven substantially by the disease itself rather than by its treatment.

The authors emphasized that individualized risk assessment and longer-term surveillance remain important.

Limitations

The authors cautioned that with only 384 patients initiating JAK inhibitors and few cancer events, the comparative estimates are imprecise and should be viewed as hypothesis-generating rather than as evidence of equivalent long-term safety.

The investigators also cautioned that the findings should be interpreted in light of the study's observational design, relatively short follow-up, and low number of cancer events, particularly for newer agents.

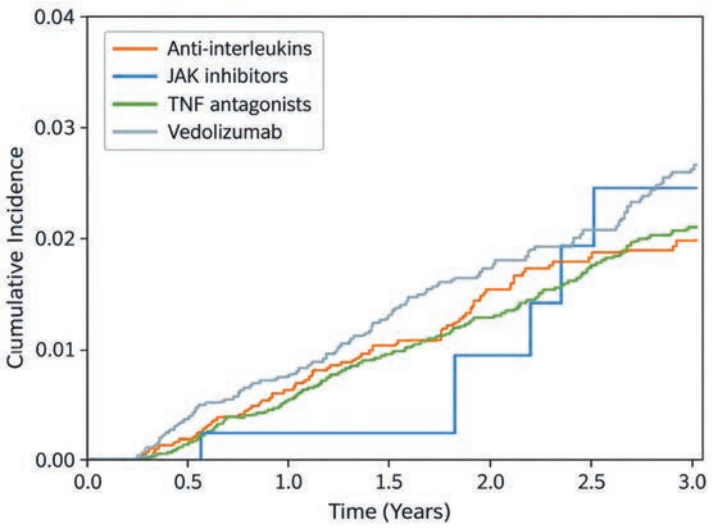
Because the study used claims data, residual confounding and channeling bias could not be excluded. Prior cancer history could only be assessed during the year before advanced therapy initiation, and several established cancer risk factors, including family history of malignancy and prior colonic dysplasia, could not be captured. The authors also noted that claims-based proxies may not fully capture differences in imaging, dermatologic, or oncologic surveillance.

Dr. Singh cautioned that the findings should not be treated as definitive for the newest agents or for rare, long-latency malignancies.

"These are reassuring real-world data, but not the final word — longer follow-up is needed especially with newer agents, before we can speak to rare, long-latency malignancies or individual drugs," he said.

The authors concluded that the findings support use of advanced therapies when clinically indicated, while underscoring the need for individualized risk assessment, cancer surveillance, and longer-term studies to clarify malignancy risks associated with specific agents and patient subgroups.

The study was supported by the Crohn's and Colitis Foundation. Dr. Singh is supported by the National Institute of Diabetes and Digestive and Kidney Diseases. Dr. Singh reported no relevant disclosures. Several coauthors reported research support, consulting fees, advisory board fees, speaker's fees, and/or other relationships with industry. Additional author disclosures are available with the study.



Cumulative incidence	TNF antagonists	Vedolizumab	Anti-ILs	JAK inhibitors
1-y	0.6% (0.4%–0.7%)	0.8% (0.5%–1.0%)	0.7% (0.4%–0.9%)	0.3% (0.001%–0.7%)
3-y	2.1% (1.7%–2.5%)	2.7% (2.1%–3.3%)	2.0% (1.4%–2.6%)	2.5% (0.5%–4.6%)

Cumulative incidence of cancer with different advanced therapies in patients with IBD. Figure courtesy of *Clinical Gastroenterology and Hepatology*.

Corticosteroids tied to higher serious infection risk across IBD therapies

In a nationwide Swedish study, corticosteroid use was associated with one additional serious infection per 50 to 111 courses, depending on concomitant therapy.



Credit: Adobe Stock

By Doug Brunk

Patients with inflammatory bowel disease (IBD) were two to four times as likely to develop a serious infection during periods when they also received corticosteroids, compared with similar patients receiving the same therapy without corticosteroids, according to a nationwide Swedish study published in *Clinical Gastroenterology and Hepatology*.

The risk extended across conventional and advanced therapies and generally rose with higher cumulative corticosteroid doses, the researchers reported. These therapies included immunomodulators, tumor necrosis factor inhibitors, vedolizumab, ustekinumab, and Janus kinase inhibitors.

"Corticosteroids carry a meaningful, dose-related infection risk that should be incorporated into treatment decisions," co-first authors Anders Forss, MD, PhD, associate professor of gastroenterology at Karolinska Institutet and Karolinska University Hospital in Stockholm, and Jordan Axelrad, MD, MPH, co-director of the Inflammatory Bowel Disease Center at NYU Langone Health, said in a joint response to *GI & Hepatology News*. "Clinicians should use the lowest effective dose, corticosteroid-sparing therapies, and consider infection-relevant variables such as patient age, comorbidities, and concomitant immunosuppression."

The investigators used nationwide Swedish health and population registries to identify patients with IBD from 2007 through 2024. They matched each patient by age, sex, and county with up to 10 people without IBD.

The analysis included 145,125 treatment periods without immunomodulators or advanced therapies, 82,675 involving immunomodulators, and 90,181 involving advanced therapies. These included tumor necrosis factor inhibitors alone or with an immunomodulator, vedolizumab, ustekinumab, risankizumab, and Janus kinase inhibitors. Corticosteroid exposure was based on filled oral corticosteroid prescriptions, with each course assumed to last 12 weeks. Median follow-up per treatment period was 0.2 years for periods with corticosteroids and 0.3 to 1.4 years for periods without, depending on therapy.

The primary outcome was the first serious infection requiring hospitalization. The researchers excluded treatment periods preceded by a serious infection within six months. They also excluded patients with conditions recorded in the previous five years that could raise infection risk and affect IBD management, such as cancer, chronic kidney or liver disease, HIV, immunodeficiency, or an organ transplant.

Among patients receiving immunomodulators or advanced therapies without corticosteroids, serious infection was three to four times as likely as in matched population controls, or about one to two additional infections per 100 person-years. With corticosteroids, it was eight to 16 times as likely — seven to 10 additional infections per 100 person-years, or one additional infection for every 10 to 15 patients followed for one year or every 43 to 67 corticosteroid courses. Among patients receiving neither immunomodulators nor advanced therapies, serious infection was 1.6 times as likely as in controls without corticosteroids and 4.5 times as likely with them. The authors noted that these estimates cannot be directly compared across therapy groups because the analyses did not account for differences in risk factors between groups.

Because patients who need corticosteroids may differ from those who do not, the researchers used propensity score matching to create more comparable groups. They matched treatment periods with and without corticosteroids based on demographic characteristics, other health conditions, healthcare use, previous infections, time since IBD diagnosis, and prior advanced therapy.

> *"Corticosteroids carry a ... dose-related infection risk that should be incorporated into treatment decisions."*

In comparisons of patients receiving the same therapy, those also treated with corticosteroids were two to four times as likely to develop a serious infection. Corticosteroid use was associated with about four to nine additional infections per 100 person-years, or one additional serious infection for every 50 to 111 twelve-week courses, depending on the accompanying therapy.

Risk also generally increased with cumulative corticosteroid dose per course. Among patients receiving neither immunomodulators nor advanced therapies, for example, serious infection was about 1.6 times as likely with 500 mg or less of prednisolone equivalents as with no corticosteroids. It was twice as likely with 500 to 1,500 mg and three times as likely with more than 1,500 mg. However, the authors did not identify a dose threshold consistently associated with higher risk across therapies.

Absolute and relative risk varied by age. Patients aged 60 years or older had the highest overall infection rates, while those younger than 18 years had the greatest risk relative to matched population controls. Absolute risk differences compared with controls were largely similar across age groups, the researchers reported. Children receiving corticosteroids with immunomodulators or advanced therapy were 30 to 50 times as likely as controls to develop a serious infection, although estimates for some therapies were based on few events.

Opportunistic infections were rare, according to the study. Compared with the general population, corticosteroid-exposed patients had a two- to 80-fold higher relative risk of opportunistic infection across therapies. Among those receiving immunomodulators, tumor necrosis factor inhibitors, or both, this corresponded to about one additional opportunistic infection per 515 to 540 corticosteroid courses. In a post hoc analysis, 3% of patients starting triple immunosuppression — an immunomodulator, a tumor necrosis factor inhibitor, and corticosteroids — filled a prescription for antimicrobial prophylaxis.

Because the study was observational, it could not determine whether corticosteroid use, more severe disease, or both explained the higher infection risk. The registers lacked data on endoscopic and biochemical disease activity, flare severity, treatment decisions, and lifestyle factors. The analysis included only infections requiring hospitalization, and admission thresholds may differ between patients with IBD and the general population. An analysis of infection-related deaths closely paralleled the main findings, the authors wrote, but there were enough deaths to analyze only among patients receiving neither immunomodulators nor advanced therapies. The study also measured prescriptions filled rather than actual medication use and included few patients treated with newer therapies such as risankizumab. In addition, its dose categories may not have captured prescribing patterns in younger children.

The study was supported by Swedish and U.S. research organizations and other fellowships. Dr. Forss, Dr. Axelrad, and several authors reported financial relationships with pharmaceutical companies.

GI patients deserve better access to care: Advocacy Day recap

127 clinicians, researchers, and patient advocates joined us for our annual Advocacy Day.

By AGA

GI patients deserve better access to care. That's what AGA leaders and patient advocates told lawmakers during AGA's annual Advocacy Day.

In total, 127 clinicians, researchers, and patient advocates from 26 states and territories represented GI priorities in 107 meetings, including seven meetings with members of Congress.

Our advocates represented 55 House districts and 52 Senate offices and met with lawmakers and staffers on both sides of the aisle. Together, we urged policymakers to:

- Reform utilization management programs like prior authorization and step therapy.
- Increase research funding for the National Institutes of Health (NIH).
- Reform Medicare reimbursement and enact long-term payment reform.

We were honored to be joined by patient advocates who shared firsthand experiences living with chronic digestive illness. Their stories highlighted how healthcare policy and NIH research can directly impact patient outcomes. One patient shared how she suffered vision loss after giving birth, and how it was restored thanks to being able to go to NIH, where she received testing and treatment recommendations.

The partnership between clinicians, researchers, and patient advocates fostered meaningful conversations with individuals who dictate healthcare policy and helped strengthen AGA's visibility and influence on Capitol Hill.

During the participants' dinner that evening, AGA leaders reflected on the value of Advocacy Day and the importance of bringing together voices across the GI community to advocate for their patients and the profession.

Advocacy Day generated meaningful momentum for GI priorities. We look forward to building on the conversations started in Washington and working with lawmakers to advance policies that improve and protect GI patient care.

Thank you again to our AGA leaders and patient advocates for showing how AGA leads the way through GI advocacy! Because of you, GI priorities were front and center on Capitol Hill.



Stay involved: join the Congressional Advocates Program

AGA's Congressional Advocates Program is a national grassroots network of GIs who advocate for the specialty. CAP members participate in ways ranging from contacting their legislators via email or social media, to meeting them in-person or virtually. Members are accepted on a rolling basis.

Supporting digestive health research funding

In May 2026, the AGA Research Foundation supported 84 researchers, helping fuel discoveries that could shape the future of digestive health.

By AGA













Did you know that the AGA Research Foundation helped support 84 researchers this past May? At the AGA Research Foundation, it's our purpose to fund dedicated investigators to achieve their research project goals.

But we can't do it without the support of AGA members like you. The AGA Research Foundation depends on the generosity of our supporters to help advance discoveries that are transforming digestive health.

When you donate to the AGA Research Foundation, you don't just give funds — you personally give our beneficiaries grant funding that will lead to new discoveries in GI. Your support goes directly towards funding GI research, helping us address immediate needs while building the foundation for long-term solutions. Plus, you'll become part of a community full of passionate members like you.

It's easy to make your mark on our efforts to support investigators. Simply visit our website or learn more ways to give at foundation.gastro.org or contact us at foundation@gastro.org.

Taking GI care further upstream with Dr. Radha Tamerisa

Why a community gastroenterologist built her practice around diagnostics, nutrition, and obesity medicine



In this month's Member Spotlight, Radha Tamerisa, MD, MBA, explains why she prefers "integrative gastroenterology" to "functional medicine," what a typical visit involves, the business gaps that sent her back for an MBA, and what she would tell AGA members thinking about starting a practice of their own.

What led you to start your own practice?

Dr. Tamerisa: I wanted autonomy, the ability to build a practice around what patients actually need, rather than fitting patients into a pre-existing model. Independence also meant I could innovate: bring in diagnostics and program structures that a lot of traditional GI practices don't offer, and iterate on them as I learn what works, instead of waiting on a larger system to catch up.

Would you describe your practice as functional medicine?

Dr. Tamerisa: I'd actually put it differently. Early on we used "functional medicine" as shorthand, but it doesn't quite capture what we do; we rewrote how we describe the practice earlier this year to be more precise. What we practice is integrative gastroenterology: mainstream GI care built out with objective, data-driven diagnostics, nutrition as a core part of care, and metabolic and obesity medicine, with genetic testing coming into the picture for rare disease and response to therapies like GLP-1s. And this isn't fringe. I was recently at a lecture where an academic GI speaker discussed the use of L-glutamine for IBS, something now being studied and used across mainstream institutions; there's actually a randomized, placebo-controlled trial published in the journal *Gut* showing real benefit in postinfectious IBS with diarrhea. I've been using it in my own practice for seven years. The field is moving toward this kind of approach; it's just a matter of when you start.

What does that look like in a typical patient visit?

Dr. Tamerisa: A visit often goes beyond the standard GI workup. Alongside a standard consultation, we can run FibroScan for liver fat and fibrosis, anorectal manometry, breath testing for SIBO and *H. pylori*, and stool-based diagnostics same-day in-office. Nutrition counseling is built into the visit structure rather than an outside referral, and for patients with a metabolic or weight component, that's integrated with our obesity medicine program. We're also expanding into genetic testing, for rare disease where it's indicated, and increasingly to help predict how a patient might respond to therapies like GLP-1s, so treatment decisions are more personalized from the start.

You've added physicians to the practice this year. What were you looking for when you brought them on?

Dr. Tamerisa: We brought on three physicians this year: Dr. Natalia Martin, Dr. Salaah Siddiqui, and Dr. Ruth Bell. What I looked for wasn't just clinical competence — it was alignment with the integrative philosophy: physicians willing to look further upstream for root causes rather than just manage symptoms, and who wanted to practice in a structure built for that kind of care.

All three have joined AGA. Was that something you encouraged?

Dr. Tamerisa: I did encourage it. I wanted them to see the value of being involved early, both for their own professional growth and for advocacy, so they'd understand early on how much of the future of GI practice gets shaped by physicians who show up and participate, not just by those who sit on the sidelines.

What's been the hardest part of running an independent practice?

Dr. Tamerisa: The hardest part has been learning the business side itself. Medical training doesn't prepare you for running a practice: staffing and training infrastructure, credentialing timelines, coordinating across multiple locations and entities. I actually went back and got my MBA a few years ago because I felt that gap directly, and it's been invaluable since. What surprised me most was how much of running a practice is systems-building — writing the playbooks, checklists, and protocols so quality doesn't depend on any one person being in the room.

How do you talk about your approach with GI colleagues?

Dr. Tamerisa: I try to make the point that I'm not all that different from them. I'm conventionally trained and evidence-based, just like any other GI physician. The difference is more about scope than philosophy: I'm willing to implement and test other therapies a bit further upstream, and I've been able to see a genuinely good clinical impact on outcomes for my patients as a result. It also means I actually know the positives and negatives of these therapies firsthand, so when a patient comes in having seen something on social media and wants to talk about it, I can have a real, informed conversation with them instead of dismissing it outright. If I had a narrow mindset, I wouldn't be able to meet patients where they are on topics they're genuinely curious about.

Any advice for AGA members considering starting their own practice?

Dr. Tamerisa: Build your operational infrastructure before you need it — training documentation, onboarding protocols, financial tracking — because it's much harder to build under pressure once you're growing. And be clear early about what makes your practice distinct clinically; it shapes every other decision, from hiring to how you talk to patients.

Is there anything else you'd want AGA members to know?

Dr. Tamerisa: One thing that doesn't come up naturally elsewhere: We also run active clinical research at the practice, with trials currently in progress spanning IBD, eosinophilic esophagitis, and celiac disease. It means our patients have access to emerging therapies, not just what's already approved, and it's a part of the practice I'm proud of that I'd want other independent practice owners to know is possible, even outside an academic setting.

Lightning round

What is the biggest misconception about GI or your career?

That GI is just about scopes and symptom management.

A lot of what we do now is upstream, metabolic, whole-patient work.

What is the best piece of advice you have been given?

Build the infrastructure before you need it.

What's a recent breakthrough in the field you're excited about?

AI and new treatment options for fatty liver disease.

What is your favorite GI organ and why?

The small bowel.

It's the absorption and immune hub of the gut, which ties directly into everything I focus on with nutrition and metabolic health.

What's your favorite way to unwind?

I like to paint — resin art and textured paints, especially.

It's a nice contrast to the analytical side of medicine.

I picked it up during COVID-19, when I suddenly had downtime I wasn't used to and needed somewhere to put my mind.

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