GI&Hepatology News

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Shirley Cohen-Mekelburg, MD

Hospital care for IBD patients gets practical clinical refresh

"IBD experts around the country are receiving many more calls from community gastroenterologists for advice treating their hospitalized patients," Dr. Shirley Cohen-Mekelburg said.

By Doug Brunk

AGA has released a clinical practice update examining how adults with inflammatory bowel disease (IBD) should be managed when they are hospitalized, with an emphasis on timely care, clear decision-making, and smoother transitions back to outpatient treatment.

"IBD care is growing more complex and IBD experts around the country are receiving many more calls from community gastroenterologists for advice treating their hospitalized patients," corresponding author Shirley Cohen-Mekelburg, MD, of the Division of Gastroenterology and Hepatology at the University of Michigan, Ann Arbor, told *GI & Hepatology News*. "For example, 20 years ago, biologics were just becoming available, and most patients who were hospitalized with IBD were biologic naïve. We now have many more advanced therapies for IBD, indications for hospitalization are shifting as patients are more likely to be successfully treated for relatively serious symptoms in the outpatient setting, and patients who are hospitalized are more likely to be treatment-experienced."

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Four reasons to add intestinal ultrasound to your practice

"Intestinal ultrasound is the present; it's here," said Rishika Chugh, MD. "If you are not incorporating ultrasound into your practice, you may find yourself left behind, because it's really made its way already into the mainstream of IBD care."

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Applications open for editor-in-chief

Applications are now open for the next editor-in-chief of *GI & Hepatology News*. The editor will work collaboratively with AGA, GI & Hep News' publisher Conexiant, and the board of associate editors. This is an exciting opportunity to enhance your leadership skills in the editorial space and make a direct impact on the future of AGA's content.

Applications are due by **March 31, 2026**. More information can be found at *gastro.org/GIHN*.

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CRC prevention: Beyond the endoscopy suite

There is increasing recognition that non-endoscopic screening tests allow us to reach patients who may be hesitant or unable to undergo colonoscopy.

As we celebrate National Colorectal Cancer Awareness Month this March, it's a timely opportunity to reflect on the important role we, as gastroenterologists, play in CRC prevention.

While screening and surveillance remain a core part of our endoscopic practice, our influence in CRC prevention extends well beyond the endoscopy suite. There is increasing recognition that nonendoscopic screening tests, such as fecal immunochemical testing, allow us to reach patients who may be hesitant or unable to undergo colonoscopy. These tests improve access and adherence and broaden the impact of our preventive efforts. Several promising blood-based screening tests and other noninvasive approaches are emerging, and gastroenterologists play a pivotal role in ensuring these tools are used as adjuncts — not replacements — for established high-quality screening tests and only when supported by strong evidence for clinical adoption.

Our ability to deliver comprehensive care continues to rely on robust collaboration with our primary care colleagues, who are often the first to engage patients on CRC screening and risk factor modification. By maintaining open communication and presenting unified, evidence-based recommendations, we can maximize screening uptake and empower patients to make informed choices.

Along with age and family history, lifestyle factors — including diet, exercise, smoking, and alcohol — are known to play a significant role in shaping CRC risk. Complementing our procedural acumen, gastroenterologists play a vital role (in partnership with primary care) in assessing modifiable and non-modifiable CRC risk factors, tailoring screening to patient preferences and risk, and counseling patients on appropriate lifestyle modifications to reduce risk. Together, we are helping to shape the future of CRC prevention well beyond the endoscopy suite — a responsibility we should embrace.

In this month's issue, we summarize a new clinical practice update on management of IBD patients in the hospital setting and highlight emerging evidence presented at the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas. Our Perspectives column tackles endoscopic surveillance beyond average-risk screening, including best practices in dysplasia surveillance in IBD and gastric cancer prevention in patients with intestinal metaplasia.

Finally, our Member Spotlight features GI psychologist Megan Riehl, PsyD, AGAF (my colleague at the University of Michigan), who highlights the important partnership between gastroenterologists and GI psychologists in providing high-quality, integrated digestive care.

Megan A. Adams, MD, JD, MSc
Editor in Chief

CRC Awareness Month resources

March is Colorectal Cancer (CRC) Awareness Month, and AGA is committed to raising awareness of the importance of getting screened starting at age 45. CRC is the third most common cancer among men and women, but we know that early detection leads to easier treatments and higher survival rates. Browse our resources below and join us in reminding everyone that screening saves lives!

Provider resources
Our CRC toolkit (gastro.org/guideline-toolkits) is your one-stop hub for all CRC-related resources. Review our clinical guidance and clinical practice update library for evidence-based recommendations on topics including:

- Use of computer-aided detection systems (CADe) in colonoscopy.
- Optimal bowel prep for better colonoscopy outcomes.
- Follow-up after colonoscopy and polypectomy.

You'll also find tips for coding and reimbursement for the most common screening tests.

Patient resources
Use the AGA Patient Center (patient.gastro.org) to access patient education materials, including:

- What to expect before, during and after colonoscopy.
- Tips to make bowel prep less intimidating.
- Insurance and payment guidance.

GI&Hep News

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AGA Sales Contact
Director of Business Development – Advertising Sales Wynn Hansen
Contact Information +1 813-797-6033 wynn.hansen@conexiant.com

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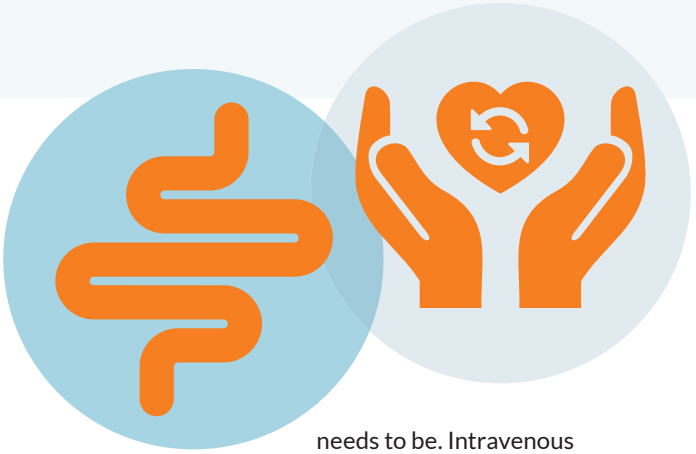
"Chromoendoscopy with targeted biopsies nearly doubles dysplasia detection versus high-definition white light endoscopy."

Dr. Samir A. Shah • Perspectives • See Page 20

Hospital care for IBD gets practical refresh



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As Dr. Cohen-Mekelburg and coauthors Jana G. Hashash, MD, Edward V. Loftus, Jr., MD, and David T. Rubin, MD, note in their expert review published in *Gastroenterology*, patients admitted with ulcerative colitis or Crohn's disease still face wide variation in testing, treatment, surgical timing, and discharge planning. These gaps contribute to complications and high 30-day readmission rates. The authors developed 13 best practice advice statements to address key clinical issues from hospital admission through discharge.

One key message is knowing when hospitalization is needed. Best practice advice statement 1 notes that adults with IBD should be admitted promptly when severe symptoms do not respond to outpatient treatment, when complications such as bowel obstruction or abscess are suspected, or when there is significant malnutrition or failure to thrive. "This is a top best practice advice because it addresses the evolution of inpatient IBD care," Dr. Cohen-Mekelburg said. "For example, it addresses updated indications for hospitalization including for severe disease refractory to outpatient treatment, serious complications, or nutritional needs that can't be managed as well outside the hospital."

According to the update, hospitalization allows faster evaluation and coordination among gastroenterologists, surgeons, radiologists, and dietitians. Once admitted, supportive care is foundational. This includes intravenous fluids, electrolyte replacement, treatment of anemia, and pain control. Avoid opioids when possible and focus instead on treating the underlying inflammation or complication driving the pain. Screening for malnutrition and vitamin deficiencies is also highlighted, with early involvement of dietitians.

Infection testing is another early priority. According to the authors, symptoms that look like an IBD flare may be driven by infections, particularly *Clostridioides difficile*. Patients with worsening symptoms or poor response to steroids should also be evaluated for cytomegalovirus. Imaging plays a key role when obstruction, abscess, or toxic megacolon is a concern.

Early assessment of severity in patients with ulcerative colitis helps guide treatment. As outlined in the update, blood tests such as C-reactive protein, along with endoscopic evaluation when appropriate, help determine how aggressive therapy needs to be. Intravenous corticosteroids remain the standard initial treatment for severe disease, with close monitoring over the first 72 hours. Lack of improvement by day three should trigger planning for rescue medical therapy or surgery.

The update also highlights the importance of preventing blood clots. Hospitalized patients with IBD have about double the risk of venous thromboembolism compared with other patients, and routine preventive anticoagulation is recommended unless there is a clear contraindication.

For Crohn's disease, management depends heavily on the complication driving admission. As noted in the update, obstruction related to active inflammation may respond to medical therapy, while abscesses usually require antibiotics and drainage, often with input from surgeons and interventional radiologists. Perianal disease is best managed with a combined medical and surgical approach.

Finally, the authors frame discharge planning as part of treatment, not as an afterthought. As best practice advice statement 13 reads: "Stability of treatment response should be achieved before discharge, and a clear discharge transition plan established." According to Dr. Cohen-Mekelburg, who also directs the Inflammatory Bowel Disease Program at VA Ann Arbor Healthcare System, this statement stands out as especially relevant to daily clinical practice "because it addresses the full inpatient journey, including hospital discharge, where many questions often arise about timing of discharge or transition to outpatient care."

Where evidence was limited, the update reflects a combination of published data and the authors' clinical experience. "We realized that while institutions differ in their resources and policies, we generally follow a similar approach to inpatient IBD care," Dr. Cohen-Mekelburg said. "We had more deliberation in making sure we were acknowledging specific scenarios that we are faced with more frequently such as the role of JAK inhibitors for treatment of ulcerative colitis in the inpatient setting or the role of venous thromboembolism prophylaxis on discharge home."

Dr. Cohen-Mekelburg reported having no disclosures. Other authors reported serving as advisors or consultants to, or receiving research support from, several pharmaceutical companies.

Key clinical takeaways

Admit adults with IBD promptly for severe symptoms refractory to outpatient therapy, suspected complications (obstruction, abscess), or significant malnutrition.

Provide supportive care, rule out infections like *C. difficile* and cytomegalovirus, use imaging when complications are suspected, and reassess severe ulcerative colitis within 72 hours to plan rescue therapy or surgery if no improvement.

Give routine VTE prophylaxis due to high clot risk, and ensure stability plus a clear transition back to outpatient care to reduce readmissions.

Task force updates ERCP quality metrics

The indicators are designed primarily for individual endoscopist use but may also support unit- or system-wide initiatives.

By Doug Brunk

Credit: Adobe Stock

A task force from the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG) released an updated set of quality indicators for endoscopic retrograde cholangiopancreatography (ERCP), reflecting new evidence and evolving practice since the prior 2015 update. The document, jointly published in *Gastrointestinal Endoscopy* and *The American Journal of Gastroenterology*, aims to standardize quality improvement efforts for a procedure that remains highly operator dependent and associated with significant morbidity.

Corresponding author Michelle A. Anderson, MD, MSc, a gastroenterologist at Mayo Clinic Arizona in Phoenix, and fellow task force members developed revised indicators spanning the preprocedure, intraprocedure, and postprocedure phases of care. The indicators are designed primarily for individual endoscopist use but may also support unit- or system-wide initiatives. The document outlines 13 ERCP-specific indicators, each paired with a performance target and graded by strength of evidence. A subset was designated as "priority indicators" based on clinical relevance, variability in practice, and feasibility of measurement.

"Important changes to this revision of the ERCP quality indicators document include a more restrictive approach to ERCP indications and a clear endorsement of rectal NSAIDs in average-risk patients with intact ampullary sphincters undergoing ERCP. Moreover, because recent data have confirmed the role of prophylactic pancreatic stents in patients at high risk for post-ERCP pancreatitis (PEP), we have introduced the tracking of this intervention as a new quality indicator. The area of PEP prevention will continue to evolve with emerging evidence about these and other prophylactic interventions," wrote Dr. Anderson and colleagues.

Key preprocedure priorities include ensuring ERCP is performed for an accepted indication (>98%) and that informed consent explicitly addresses ERCP-specific risks. Intraprocedurally, the task force emphasized achieving deep duct cannulation in patients with native papillae (>90%), successful extraction of extrahepatic bile duct stones (>90%), routine documentation of radiation exposure, and near-universal use of rectal indomethacin or diclofenac in patients with an intact papilla to PEP. Documentation and tracking of prophylactic pancreatic stent use in high-risk cases is also strongly endorsed.

Postprocedure indicators focus on outcomes meaningful to patients and health systems, including unplanned hospital visits and unplanned biliary reinterventions within 30 days (each <15%). Recognizing challenges in benchmarking adverse events, the document prioritizes consistent documentation and longitudinal tracking of PEP, bleeding, and cholangitis rather than fixed outcome thresholds.

> *"Because recent data have confirmed the role of prophylactic pancreatic stents in patients at high risk for PEP, we have introduced the tracking of this intervention as a new quality indicator."*
> *- Michelle A. Anderson, MD, MSc*

The task force authors described these indicators not as standards of care or credentialing requirements but rather as a framework to drive continuous quality improvement. Early efforts should target the priority indicators most closely linked to patient safety and value.

"Each provider and/or center should select the most likely indicators to improve clinical care delivery in their practice. High-quality ERCP requires improvement in all the proposed areas, and we hope that this document will serve as a sequential guide along the quality journey," they concluded.

The authors reported having no disclosures.

ASGE updates key guidance on diagnosing and managing GERD in clinical practice

About one-third of U.S. adults are affected by the condition.

By Doug Brunk

The American Society for Gastrointestinal Endoscopy (ASGE) has released an updated clinical practice guideline that reshapes how clinicians should diagnose and manage gastroesophageal reflux disease (GERD), a condition that affects roughly one in three adults in the United States. The guideline, published in *Gastrointestinal Endoscopy*, updates the society's 2014 recommendations and reflects advances in endoscopic techniques, growing concerns about long-term medication use, and emerging patient populations at higher risk for complications.

"Important advances have been made in the endoscopic management of GERD, which were not available a few years ago," one of the study authors, Bashar J. Qumseya, MD, MPH, FASGE, ASGE Standards of Practice Committee Chair and a gastroenterologist at the University of Florida, Division of Gastroenterology, Hepatology & Nutrition, told *GI & Hepatology News*. "Procedures like transoral incisionless fundoplication are changing the way in which gastroenterologists think about and treat GERD. There is also increasing awareness regarding new risk factors for GERD."

One of the most important messages in the new guideline is a more targeted approach to upper endoscopy. The ASGE continues to emphasize that most patients with typical GERD symptoms do not need an endoscopy right away and can be managed initially with medical therapy.

However, endoscopy is strongly recommended for patients with alarm symptoms such as difficulty swallowing, unexplained weight loss, gastrointestinal bleeding, persistent vomiting, or iron deficiency anemia. The guideline also calls for greater use of endoscopy in patients with multiple risk factors for Barrett's esophagus, even if symptoms are mild.

A notable change is the expanded focus on patients who develop reflux after certain procedures. The ASGE now suggests routine endoscopic screening for Barrett's esophagus in patients who have undergone sleeve gastrectomy, starting three years after surgery and repeating every five years, even if they do not have reflux symptoms.

This recommendation reflects growing evidence that this group faces a higher risk of esophagitis and Barrett's esophagus over time. Patients with reflux symptoms after peroral endoscopic myotomy should also be evaluated endoscopically, given the high rates of post-procedure GERD.

Another key theme is careful, standardized documentation during endoscopy. The guideline urges endoscopists to consistently record objective signs of GERD, such as erosive esophagitis and Barrett's esophagus, and to clearly describe gastroesophageal junction anatomy, including hiatal hernia size and flap valve integrity. According to the authors, better documentation can reduce repeat procedures, improve treatment decisions, and support the growing role of endoscopic antireflux therapies.

The guideline also reinforces a balanced approach to treatment. Lifestyle changes such as weight loss, smoking cessation, avoiding late meals, and elevating the head of the bed are recommended for all patients with GERD symptoms. Proton pump inhibitors remain the cornerstone of medical therapy, but the ASGE recommends using the lowest effective dose for the shortest necessary duration, along with regular reassessment. Importantly, the guideline acknowledges patient concerns about long-term PPI use and encourages shared decision-making. In patients with a suboptimal clinical response to PPI therapy, the guideline recommends considering CYP2C19 polymorphism testing and adjusting the PPI dosage accordingly.

For patients with confirmed GERD who wish to avoid chronic medication, the guideline highlights endoscopic options. Transoral incisionless fundoplication may be considered for patients with small hiatal hernias and well-defined anatomy, while combined surgical and endoscopic approaches may be appropriate for those with larger hernias. Although the quality of evidence varies, the ASGE views these therapies as reasonable alternatives for carefully chosen patients.

"Giving patients proton pump inhibitors forever is no longer an-evidence based management approach to patients with GERD," Dr. Qumseya concluded. "Careful evaluation of patients' symptoms, endoscopic findings, and genetic testing should be incorporated to offer the best approach that is tailed to each specific patient."

Bashar Qumseya, MD, MPH, FASGE

Key clinical takeaways

Most patients with typical GERD symptoms can be managed empirically without immediate endoscopy, but those with alarm features or multiple risk factors for Barrett's esophagus should undergo prompt upper endoscopy.

The guideline newly recommends routine Barrett's esophagus screening starting 3 years after sleeve gastrectomy (repeated every 5 years) and endoscopic evaluation for patients with reflux symptoms after peroral endoscopic myotomy.

Endoscopists are urged to standardize documentation of objective GERD findings — including erosive esophagitis, Barrett's esophagus, hiatal hernia size, and flap valve integrity — to improve care and reduce repeat procedures.

PPIs remain first-line therapy, but clinicians should use the lowest effective dose for the shortest duration, reassess regularly, and consider CYP2C19 testing in patients with suboptimal response.

For carefully selected patients with confirmed GERD who wish to avoid chronic medication, endoscopic therapies such as transoral incisionless fundoplication and, when appropriate, combined surgical–endoscopic approaches offer reasonable alternatives.

Dr. Qumseya disclosed that he serves as a consultant for Medtronic, Inc., and Assertio Management, LLC. He has also received food and beverage compensation from Medtronic, Inc., Fujifilm Healthcare Americas Corporation, and Boston Scientific Corporation, as well as speaker fees from Castle Biosciences. Several coauthors reported additional disclosures.

Postoperative Crohn's: What's changed?

The concept of reusing anti-TNF therapy after surgery is gaining traction postoperatively.

By Doug Brunk

Even in the age of advanced medical therapy, surgery remains a fundamental part of Crohn's disease care.

During the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas, Jordan Axelrad, MD, MPH, co-director of the Inflammatory Bowel Disease Center at NYU Langone Health, reviewed new data on who is most likely to relapse after surgery, which therapies may best prevent recurrence, and how postoperative monitoring is evolving.

Although biologics and small molecules have transformed Crohn's disease management, about one in four patients still require intestinal resection at 10 years. "Recurrence can happen very quickly," Dr. Axelrad said. "We can sometimes see histologic changes within one week after a resection." Endoscopic recurrence is often evident within one year, before symptoms develop. Without intervention, this progression can lead to repeat surgery.

Not all patients recur, however. A nationwide cohort study that Dr. Axelrad conducted with Swedish colleagues showed that about 21% of patients with Crohn's disease remained free of medical therapy five years after surgery. Older age and longer disease duration were associated with this lower-risk group, suggesting that some patients may be managed with careful monitoring alone.

Endoscopy remains the cornerstone of postoperative assessment, with the Rutgeerts score guiding risk stratification. Patients with i0 to i2a findings are considered in endoscopic remission, while those with i2b lesions —disease extending beyond the anastomosis — face a significantly higher risk of progression. Data from a U.S. multicenter consortium confirmed that patients with i2b disease are more likely to advance to severe recurrence, reinforcing the need for closer follow-up and earlier treatment escalation.

AGA recommendations have simplified postoperative risk categories. Lower-risk patients tend to be older, nonsmokers undergoing their first surgery with limited bowel resection. "High-risk patients are going to be younger, active smokers, and those who've had a history of surgery for their Crohn's disease," Dr. Axelrad said. Still, he highlighted prospective data showing that recurrence rates approach 50% even among patients classified as low risk. Importantly, medical prophylaxis reduced recurrence in both low- and high-risk groups.

According to Sara Horst, MD, MPH, Professor of Medicine, Gastroenterology, Hepatology, & Nutrition and Vanderbilt University Medical Center, Nashville, who moderated the session, "some data suggests high-risk patients also include those who have been on advanced therapies in the past as well as those with fistulizing or stricturing complications," she told *GI & Hepatology News*.

Anti–tumor necrosis factor (anti-TNF) agents remain the most studied option for postoperative prophylaxis. While antibiotics such as metronidazole have been used historically, many clinicians now favor biologics. Newer data suggest that vedolizumab and ustekinumab perform similarly in preventing recurrence, although patient selection is key. In one analysis conducted at two medical centers, early initiation of anti-TNF therapy — within four weeks of surgery — was associated with the lowest rates of endoscopic recurrence, giving anti-TNF agents a potential advantage when they are safe and appropriate.

The concept of reusing anti-TNF therapy after surgery is also gaining traction. According to Dr. Axelrad, patients who undergo surgery for complications such as strictures, rather than true biologic failure, may still benefit from continuing or restarting anti-TNF treatment. By contrast, he said, data show that patients with clear primary nonresponse before surgery are better candidates for switching drug classes.

Jordan Axelrad, MD, MPH

"The key here is starting advanced therapy in those high-risk patients who need it," Dr. Horst added. "Also, educating our patients on the importance of close monitoring after surgery is extremely important."

Postoperative monitoring strategies are also expanding. A landmark trial showed that colonoscopy at six months, with treatment adjustment based on findings, reduces later recurrence. Biomarkers now play a larger role as well. Updated guidance suggests that patients at low risk, or those receiving prophylactic therapy with fecal calprotectin levels below 50 µg/g, may be able to defer the six-month colonoscopy.

According to Dr. Axelrad, intestinal ultrasound and cross-sectional imaging offer additional, non-invasive ways to detect early recurrence.

He concluded his presentation by noting that postoperative Crohn's disease management starts before the operating room. "Early risk assessment, timely selection of prophylactic therapy, and structured monitoring can help clinicians intervene earlier — and potentially reduce the need for repeat surgery," he said.

Dr. Axelrad disclosed that he has received consultancy fees, honorarium, or advisory board fees from several pharmaceutical companies. He has also received research grants from BioFire Diagnostics, Genentech, Janssen, and Takeda. Dr. Horst disclosed that she is a consultant to Johnson & Johnson, AbbVie, Takeda, Pfizer, and Biocon. She has also received educational grants from AbbVie and Takeda.

Four reasons to add intestinal ultrasound to your practice

"It's really made its way already into the mainstream of IBD care," Dr. Rishika Chugh said.

By Doug Brunk

Rishika Chugh, MD

In the clinical opinion of Rishika Chugh, MD, there are at least four reasons why clinicians who care for patients with inflammatory bowel disease should consider using ultrasound to help guide treatment and management.

It's patient-centric

First, it's patient-centric, she said during the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas. Dr. Chugh, a gastroenterologist at the University of California, San Francisco, shared the story of a young woman with Crohn's disease whose journey through treatment had been long and frustrating. Medications had failed her one by one, and when she arrived at Dr. Chugh's office for another opinion, her symptoms were unclear and her diagnostic workup was delayed by the realities of life: busy schedules, long waiting times, and slow authorizations.

In the past, getting answers often took months. But on that very first visit, Dr. Chugh performed an intestinal ultrasound. In real time, she saw the problem clearly: active disease in the terminal ileum with pre-stenotic bowel dilation.

"I was able to confirm that she had active TI disease, started the authorization process for risankizumab right away, and therefore, even before her labs came back, I was able to get her started on risankizumab in this case," she said. "This case highlights how intestinal ultrasound accelerates IBD care."

Dr. Chugh, who is also education committee chair of the Intestinal Ultrasound Group of the United States and Canada (iUSCAN), added that patients prefer intestinal ultrasound because it doesn't require bowel prep, fasting, diet changes, contrast, or sedation, and it takes only 5-20 to perform, often providing results in real time. "Over and over, patients say they feel more supported, better informed, and more confident in their care," she said.

Other reasons to embrace intestinal ultrasound include the following:

It saves costs

She cited a prospective observational study by Australian researchers in which an IBD nurse used a symptom severity-based protocol to triage 211 episodes of care over the course of 30 weeks. Based on clinical urgency, patients were discussed with their specialist, referred for rapid access intestinal ultrasound, or planned for hospitalization. The study authors estimated that the protocol avoided 20 hospitalizations, 123 urgent IBD clinic reviews, and saved more than $146,000 Australian dollars in health care costs.

It's accurate

According to a review that Dr. Chugh and colleagues published in Current Gastroenterology Reports, ultrasound correlates strongly with endoscopy, biomarkers, and MRI. It detects inflammation, tracks response to therapy within weeks, and reliably excludes active disease when findings are normal. For example, in a prospective study of 407 Crohn's disease patients who underwent intestinal ultrasound or small intestinal contrast ultrasound followed by computer tomography enterography or magnetic resonance enterography, ultrasound showed sensitivity/specificity of 95.3%/93.0% for disease activity and 90.7%/90.5% for extent.

It's the future

For example, the STARDUST substudy used intestinal ultrasound to examine the most affected part of the bowel at the start of treatment, with experts centrally reviewing key measurements in patients treated with ustekinumab. REASON is a phase 3b study focused on healing through the full bowel wall and uses intestinal ultrasound and magnetic enterography to measure how patients respond to guselkumab. VECTORS is a phase 4 randomized study that takes a treat-to-target approach and includes intestinal ultrasound results as part of how response to vedolizumab is assessed.

Intestinal ultrasound as a method of disease monitoring has also made its way into standard of care documents, including a clinical practice update from AGA and a guideline from the European Crohn's and Colitis Organization (ECCP), the European Society of Gastrointestinal and Abdominal Radiology (ESGAR), the European Society of Pathology (ESP), and the International Bowel Ultrasonography Group (IBUS).

"Intestinal ultrasound is the present; it's here," Dr. Chugh concluded. "If you are not incorporating ultrasound into your practice, you may find yourself left behind, because it's really made its way already into the mainstream of IBD care."

Dr. Chugh reported having no relevant disclosures.

Expert spotlights advances in ulcerative colitis treatment

"Appendicectomy is a viable and safe strategy for reducing the relapse rate in patients with UC compared to standard medical therapy alone," Dr. Kara De Felice said.

By Doug Brunk

Credit: Adobe Stock

FDA approval of the IL-23 inhibitor guselkumab has expanded treatment options for patients with moderately to severely active ulcerative colitis (UC), offering greater flexibility through subcutaneous administration, according to Kara De Felice, MD.

"It's been exciting getting a subcutaneous option for our patients with ulcerative colitis," Dr. De Felice, a gastroenterologist at the University of Cincinnati Medical Center, said during the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas.

Data supporting subcutaneous guselkumab were presented from the multicenter ASTRO treat-through-design trial at the 2025 Digestive Disease Week meeting. In the 12-week induction study, 395 patients with moderate-to-severe UC were randomized to receive subcutaneous guselkumab or placebo at weeks 0, 4 and 8, followed by maintenance therapy of either 200 mg every 4 weeks or 100 mg every 8 weeks, or placebo.

The primary endpoint was clinical remission at week 12, with endoscopic improvement as a key secondary endpoint. At week 12, clinical remission was achieved in 26% of patients treated with guselkumab compared with 7% of those receiving placebo. Endoscopic improvement occurred in 36% of guselkumab-treated patients versus 12% in the placebo group.

Additional evidence came from QUASAR, randomized withdrawal design studies which evaluated guselkumab as both induction (intravenous) and maintenance (subcutaneous) therapy in UC. The induction study included 701 patients, with 421 receiving intravenous guselkumab 200 mg and 280 receiving placebo.

Kara De Felice, MD, PhD

At week 12, clinical remission was observed in 23% of patients treated with intravenous guselkumab compared with 8% of those receiving placebo. Endoscopic improvement rates were 27% and 11%, respectively.

"Even though these studies were differently designed and we can't make direct comparisons, I think that we can walk away saying that we have two good choices for our patients in clinic, either giving them subcutaneous or intravenous guselkumab for induction therapy," Dr. De Felice said. Reflecting on my experience, most patients are choosing subcutaneous injections, as they're easier to arrange and patients can probably get to the drug faster instead of waiting to be set up in our infusion center."

Dr. De Felice also highlighted emerging data supporting the use of Janus kinase (JAK) inhibitors in the inpatient management of acute severe UC.

She cited results from the Canadian TRIUMPH study, which evaluated 24 patients treated with tofacitinib 10 mg twice daily for intravenous steroid–refractory disease. By day 7, 58.3% of patients achieved a clinical response, with a mean time to response of 2.4 days. Responders also demonstrated a marked reduction in C-reactive protein within the first two days of treatment compared with nonresponders.

Further evidence was presented from the TACOS trial, which randomized 104 adults with acute severe UC to receive either tofacitinib 10 mg three times daily or placebo for seven days while continuing intravenous corticosteroids.

The primary endpoint was treatment response by day 7, defined as a reduction in the Lichtiger score of more than 3 points with a sustained score below 10 for two consecutive days without rescue therapy. A key secondary endpoint was the need for infliximab or colectomy within 90 days.

At day 7, response rates were 83% in the tofacitinib group compared with 58.8% in the placebo group (odds ratio, 3.42). The need for rescue therapy by day 7 was lower in the tofacitinib arm (odds ratio, 0.27).

"About six patients in the tofacitinib arm did require colectomy by month six, and one patient developed a dural venous sinus thrombosis," said Dr. De Felice, who was not involved in the trial.

Sara Horst, MD, MPH, Professor of Medicine, Gastroenterology, Hepatology, & Nutrition and Vanderbilt University Medical Center, Nashville, who moderated the session, told *GI & Hepatology News* that she is increasingly using JAK inhibitors for acute severe UC. "The key for clinicians is to remember how devastating acute severe UC can be for patients and the high need for colectomy within 6 to 12 months," she said. "Therefore, starting an advanced therapy as soon as possible is key to prevent adverse outcomes."

Dr. De Felice concluded by discussing the potential role of laparoscopic appendicectomy in maintaining remission in UC. In the international, open-label ACCURE trial, 201 patients were randomized to appendicectomy plus standard medical therapy or standard medical therapy alone. At one year, relapse occurred in 36% of patients in the appendicectomy group compared with 56% in the standard care group (P = 0.005).

Adverse events were reported in 11% of patients who underwent appendicectomy and 10% of those in the control group. The most common adverse events were temporary self-limiting postoperative abdominal pain in the appendicectomy group (3%) and skin rash in the control group (3%). Serious adverse events occurred in two patients (2%) in the appendicectomy group and none in the control group. No deaths were reported.

"Appendicectomy is a viable and safe strategy for reducing the relapse rate in patients with UC compared to standard medical therapy alone," Dr. De Felice said.

Dr. Horst cautioned that while the data are encouraging and suggest potential new options for patients, further evidence is needed. "Ideally, a high-quality placebo (aka sham surgery) randomized trial is needed to verify these results," she said.

Dr. De Felice disclosed that she is an honorary speaker for AbbVie, Janssen and Pfizer and serves on AbbVie's advisory board. Dr. Horst disclosed that she is a consultant to Johnson & Johnson, AbbVie, Takeda, Pfizer, and Biocon. She has also received educational grants from AbbVie and Takeda.

MRI-based standard may predict outcomes in perianal Crohn's

The TOpClass definition identifies healing based on three criteria.

By Doug Brunk

Results from a small multicenter study suggest that a strict MRI-based definition of radiological healing may help predict long-term outcomes for patients with perianal fistulizing Crohn's disease, a difficult-to-treat complication of inflammatory bowel disease.

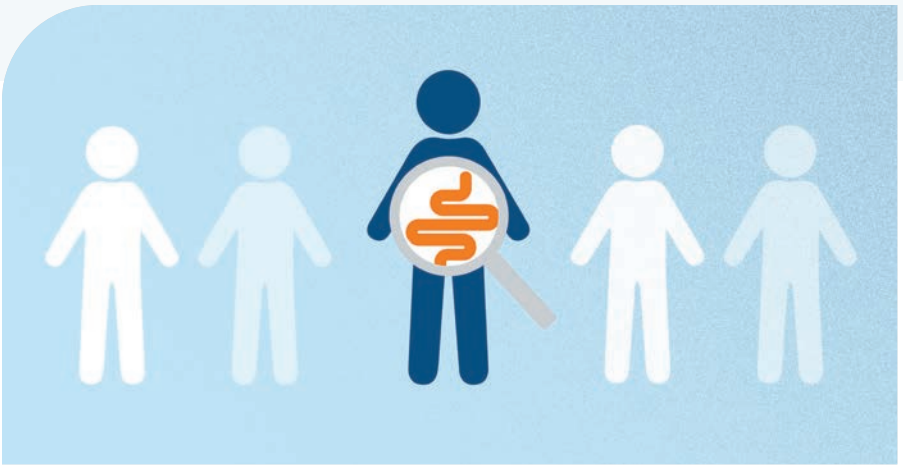
The VALIDATE-PERIANAL study — presented by Sami Samaan, MD, of the Deepak Lab at Washington University School of Medicine in St. Louis, at the 2026 Crohn's & Colitis Congress® in Las Vegas — evaluated whether a consensus-based MRI definition developed by the international TOpClass consortium could be reliably applied in real-world practice and whether it correlated with improved patient outcomes.

According to Dr. Samaan, previous research has shown that clinical closure of perianal fistulas does not always reflect true healing beneath the surface. MRI studies have demonstrated that persistent inflammation may remain even when fistulas appear closed on physical exam, increasing the risk of recurrence. However, until now, there has been no standardized MRI definition of what constitutes true radiological healing.

The TOpClass definition identifies healing based on three criteria: absence of T2 hyperintensity on MRI, a completely fibrotic fistula tract, and lack of contrast enhancement when contrast is used. Experts reached a 95% consensus on this definition.

To test it, researchers conducted a retrospective, multicenter study from 2021 to 2023 using data from Washington University in St. Louis, St. Mark's Hospital in London, and Amsterdam University Medical Center, the Netherlands. Out of 977 patients screened, 40 met inclusion criteria after having MRIs locally reported as healed. Independent expert radiologists then re-reviewed the scans using the TOpClass criteria.

Only 14 patients met the strict definition of radiological healing, highlighting how difficult the endpoint is to achieve. However, outcomes among these patients were markedly better: 93% achieved sustained clinical remission for at least one year, compared with 78% of those who did not meet the criteria for radiological healing. Fistular recurrence at one year was also less frequent in the radiologically healed group (7% vs 22%).



Sami Samaan, MD

Secondary outcomes also favored the radiologically healed group over the non-healed group, including lower rates of fistula-related antibiotic use (7% vs 22%, respectively), seton placement (7% vs 15%), proctectomy (7% vs 11%), return to operating room (30% vs 7%), defunctioning stoma (0% vs 15%), and hospitalizations (7% vs 19%).

The study found excellent inter-reader reliability, with agreement exceeding 95%. "This means that our definition was objective, easy to use, and highly reproducible across different sectors," Dr. Samaan said.

He acknowledged limitations of the study, including its small sample size, retrospective design, and lack of comparison with data on quality of life.

"For future directions, we have ongoing funded work to validate this definition in a larger retrospective and prospective cohort," Dr. Samaan said. "We're also incorporating radiomics and AI in collaboration with biomedical engineers to better understand fistula healing response on MRI."

The researchers reported having no disclosures.

GLP-1 therapy in Crohn's disease: Fewer steroids, hospitalizations

"What stood out most was the consistent association between GLP-1 receptor agonist use and lower steroid dependence."

By Doug Brunk

Glucagon-like peptide-1 receptor (GLP-1) agonists, widely used to treat obesity and diabetes, may also improve key outcomes for patients with Crohn's disease, according to a large real-world study presented during the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, taking place in Las Vegas. "Obesity is now very common among patients with Crohn's disease, yet there is limited guidance on how newer metabolic medications, particularly GLP-1 receptor agonists affect Crohn's-related outcomes," presenting author Nakul Ganju, MD, an internal medicine resident at Howard University Hospital in Washington, DC, told *GI & Hepatology News*. "These medications are being prescribed more frequently for obesity and diabetes, so gastroenterologists are increasingly encountering patients with Crohn's disease who are already taking them. Our study addresses an important and practical question: whether GLP-1 receptor agonists appear safe in this population and whether their use is associated with meaningful clinical outcomes such as steroid dependence and hospitalization."

Nakul Ganju, MD

The researchers used the TriNetX research network to identify adults with Crohn's disease and overweight or obesity who either started a GLP-1 receptor agonist or had no exposure. Patients were matched 1:1 using propensity scores to balance demographics, comorbidities, prior inflammatory bowel disease treatments, healthcare use, and baseline steroid exposure.

After matching, the analysis included 546 GLP-1 receptor agonist users and 546 non-users with similar baseline characteristics. Over 12 months, steroid dependence was significantly lower among GLP-1 users compared with nonusers (52.9% vs 62.8%, respectively).

Hospitalizations were also less common in the GLP-1 group (2.3% vs. 3.7%). Time-to-event analyses showed a lower risk of hospitalization and better persistence on advanced Crohn's therapies among patients receiving GLP-1 treatment (HR 0.74). Rates of major abdominal surgery were similar between groups, with no signal of increased surgical risk.

"What stood out most was the consistent association between GLP-1 receptor agonist use and lower steroid dependence," Dr. Ganju said. "Steroid dependence is something we see commonly in clinical practice and is associated with significant long-term side effects, so seeing a clear reduction was encouraging. We were also reassured by the absence of any signal for increased hospitalization or surgery, which are common concerns with medications that affect gastrointestinal function."

If future studies confirm these results, he added, they could reassure clinicians that GLP-1 receptor agonists can be used safely in certain patients with Crohn's disease who also have obesity or diabetes.

Rather than avoiding these medications out of concern for worsening gastrointestinal disease, providers may feel more comfortable incorporating them into coordinated care," Dr. Ganju said. "Importantly, these agents would remain adjunctive and would not replace standard Crohn's disease therapies."

He emphasized that prospective trials are still needed to better understand causality, identify which patient subgroups may benefit most, and clarify underlying mechanisms.

"As the metabolic profile of patients with Crohn's disease continues to change, research that bridges inflammatory bowel disease and metabolic health will become increasingly important," he said.

The researchers reported having no relevant disclosures.

New Crohn's data spotlight promising therapies

Beyond drugs, interest is growing in diet-based treatments.

By Doug Brunk

Several important developments in Crohn's disease treatment have emerged over the past year, offering clinicians new options and patients renewed hope. During the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas, Ryan C. Ungaro, MD, MS, Associate Professor and of Clinical Research in the Division of Gastroenterology at the Icahn School of Medicine at Mount Sinai, New York, highlighted the growing role of IL-23 inhibitors, the impact of disease location on treatment response, and early signals that diet and digital health tools may help guide care.

Three IL-23 inhibitors are now available, with mirikizumab and guselkumab receiving FDA approval within the past year. In large clinical trials, Dr. Ungaro said, mirikizumab significantly improved symptoms and intestinal healing compared with placebo, both in patients who had never used biologics and in those who had failed prior therapies. When directly compared with ustekinumab, mirikizumab achieved similar clinical remission rates at one year, but was not superior in endoscopic outcomes.

Guselkumab also showed strong results. In the GRAVITI and GALAXI trials, patients treated with guselkumab were more likely to achieve clinical remission and endoscopic improvement than those receiving placebo. "Notably, guselkumab performed similarly whether induction therapy was given intravenously or by injection under the skin, offering flexibility in clinical practice," Dr. Ungaro said. In maintenance studies, guselkumab appeared superior to ustekinumab across several key outcomes.

According to Dr. Ungaro, one common clinical question is whether prior exposure to ustekinumab reduces response to newer IL-23 inhibitors. Trial data presented at the 2025 meeting of the American College of Gastroenterology suggests it does not. Patients who switched from ustekinumab to guselkumab achieved similar response and remission rates as those previously treated with other biologics, supporting IL-23 inhibitors as a viable option even after earlier treatment failure.

Disease location also matters. A large analysis found that most advanced therapies work better in colonic Crohn's disease than in disease affecting the small intestine. Among available options, IL-23 inhibitors and infliximab appeared to have the strongest effects in ileal disease, while JAK inhibitors showed less benefit in that setting. Infliximab, in particular, demonstrated similar healing rates in both ileal and colonic disease. Dr. Ungaro also cited a review paper on combined advanced targeted therapy in IBD.

New data also support vedolizumab for preventing Crohn's disease recurrence after surgery. In a randomized trial known as REPREVIO, patients who received vedolizumab shortly after bowel resection had significantly less endoscopic recurrence than those given placebo.

Beyond drugs, Dr. Ungaro said, interest is growing in diet-based therapies. In the ADAPT trial, which was presented at the 2025 European Crohn's and Colitis Organization Conference in Berlin, 154 patients with mild to moderate Crohn's disease who followed a low-emulsifier diet were more likely to experience symptom improvement and reductions in fecal calprotectin over eight weeks compared with those on an emulsifier-rich diet. While short-term, the findings provide practical dietary guidance that may complement medical therapy.

"Even looking at the fecal-calprotectin response, there was a significant increased rate of fecal-calprotectin decrease in patients who were on the low emulsifier diet," Dr. Ungaro added. "It's intriguing data, [but] I think further longer-term data are needed and it's always important to involve nutritionists when you're able to in these discussions."

Looking ahead, stem cell transplantation is being used for highly refractory disease in specialized centers, wearable devices to predict flares weeks in advance, and even trials aimed at preventing Chron's disease in high-risk individuals. For example, the INTERCEPT project, launched in January 2025, is recruiting 10,000 first-degree relatives of people with Chron's disease in seven European countries. The goal is to confirm a group of biological markers and develop a blood test score that can identify people who are likely to develop Chron's disease and enroll the highest risk individuals in a disease interception trial with vedolizumab.

Ryan C. Ungaro, MD

"This is still in early days, but disease prediction and prevention is very interesting and an exciting area of research," Dr. Ungaro said.

Dr. Ungaro disclosed that he is an advisor to and consultant for AbbVie, Bristol Myers Squibb, Genentech, Janssen, Lilly, Pfizer, and Takeda. He has also received research funding from the Crohn's & Colitis Foundation, AbbVie, Boehringer Ingelheim, Pfizer, Prometheus Laboratories, Department of Defense, the National Institutes of Health, and the Helmsley Foundation.

FMT improves IBD remission, meta-analysis suggests

Researchers evaluated seven trials involving 542 patients with ulcerative colitis or Chron's disease.

By Doug Brunk

Fecal microbiota transplantation (FMT) may help more patients with inflammatory bowel disease (IBD) achieve remission and mucosal healing than standard care alone, according to a new meta-analysis of randomized trials presented during the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, taking place in Las Vegas.


Prince Shah-Riar, MD

"While FMT has established utility in Clostridioides difficile infection, its role in IBD has remained ambiguous due to inconsistent outcomes across smaller trials," presenting author Prince Shah-Riar, MD, an internal medicine resident at DHR Health in Edinburg, Texas, told *GI & Hepatology News*. "Our study helps bridge that evidence gap by identifying significant benefit in both clinical and endoscopic outcomes, suggesting FMT may be a valuable adjunct to standard therapies."

The researchers conducted a systematic review and meta-analysis of randomized controlled trials published between 2020 and 2025. The analysis included seven high-quality trials involving 542 adults with ulcerative colitis or Chron's disease. The main outcomes were clinical remission and mucosal healing.

Overall, patients who received FMT were significantly more likely to enter clinical remission than patients who did not. The pooled analysis showed a 74% higher likelihood of remission with FMT (RR 1.74; P<0.001). Benefits were also seen on endoscopy: 38.2% of patients treated with FMT achieved mucosal healing, compared with 24.6% of controls (HR 1.53; P=0.01).

Rates of serious adverse events were similar between FMT and control groups, suggesting that FMT did not increase the risk of major complications in these trials.

"What stood out was the magnitude of benefit for mucosal healing, which is a harder endpoint to achieve and often correlates with long-term remission," Dr. Shah-Riar said. "We also noted that multi-donor FMT protocols yielded more consistent outcomes, and that patients with lower baseline microbial diversity appeared to respond more robustly. These findings were more nuanced than expected and highlight areas for future precision-medicine approaches."

According to Dr. Shah-Riar, if the study's overall findings are validated in larger trials, FMT could become a more widely accepted adjunctive treatment, particularly in ulcerative colitis, as a bridge therapy or in refractory cases. "It could also stimulate refinement in how we select donors, standardize FMT preparations, and stratify patients based on microbiome profiles or other biomarkers," he said. "Ultimately, it may shift the paradigm from purely immunologic interventions to microbiota-modulating strategies."

The researchers reported having no disclosures.

Upadacitinib in pediatric IBD: 52-week results

Response in those with ulcerative colitis was especially strong.

By Doug Brunk

Credit: Adobe Stock

Upadacitinib, a selective JAK1 inhibitor approved for adults with inflammatory bowel disease (IBD), may offer durable symptom control for children and adolescents with severe disease, according to a single-center study from Boston Children's Hospital.

"This study matters because it provides long-term data for upadacitinib, a therapy already commonly used off-label in pediatric IBD but without established evidence for its safety and efficacy in the pediatric population," lead study author Jennifer Bachand, MD, currently a GI fellow at Stanford University, told *GI & Hepatology News*.

Reporting at the 2026 Crohn's & Colitis Congress®, a partnership between the AGA and the Crohn's & Colitis Foundation, held in Las Vegas, Dr. Bachand and colleagues reviewed outcomes in 48 patients younger than 18 years with Crohn's disease (CD) or ulcerative colitis (UC) who initiated upadacitinib and were followed for one year. Patients were diagnosed with CD or UC at a mean age of 10.9 years and began upadacitinib at a mean age of 14.1 years. Prior advanced therapy failures included anti–tumor necrosis factor agents (98%), ustekinumab (56%), vedolizumab (46%), tofacitinib (15%), and risankizumab (6%).

Jennifer Bachand, MD

At 52 weeks, 81% of patients remained on upadacitinib, suggesting good treatment durability. Among those who continued therapy, 47% of patients with CD and 73% of those with UC achieved corticosteroid-free clinical remission. Inflammatory markers also improved, with 73% of patients demonstrating normalization of C-reactive protein levels. Endoscopic reassessment was available for just over half of the cohort, and 46% of those patients met criteria for endoscopic remission.

"We were surprised by the strong response to upadacitinib in patients who had previously failed tofacitinib, despite both drugs belonging to the same class," Dr. Bachand said. "Six of the seven patients (86%) who had previously failed tofacitinib therapy remained on upadacitinib at 52 weeks, and four (57%) achieved corticosteroid-free remission. This suggests that failure with one JAK inhibitor does not necessarily preclude a response to upadacitinib, although this finding requires further investigation in larger cohorts."

She added that the investigators were also surprised by the incidence of abnormal cholesterol levels, observed in 15% of patients. "More guidance is needed on the management of abnormal cholesterol in pediatric patients in remission on upadacitinib," she said.

Only two patients discontinued treatment because of adverse events, and there were no reports of blood clots, malignancies, or deaths during follow-up. One serious infection was reported.

If larger studies confirm the safety and efficacy of upadacitinib for pediatric IBD, "it could change our treatment algorithm and ultimately lead to FDA approval for pediatric use," Dr. Bachand concluded. "The particularly strong response in our ulcerative colitis cohort suggests it could become a preferred therapy for pediatric UC patients who have failed other advanced treatments. Larger studies are needed to confirm this difference and guide patient selection."

The researchers reported no relevant financial disclosures.

Creeping fat in Crohn's may turn harmful

Even though it is common, the condition has not been studied much.

By Doug Brunk

Creeping fat — the thickened mesenteric adipose tissue seen in Crohn's disease — may start as a protective response to bacterial leakage from the gut but later become a driver of fibrosis and strictures, according to research presented by Suzanne Devkota, PhD.

During the 2026 Crohn's & Colitis Congress®, a partnership of AGA and the Crohn's & Colitis Foundation, held in Las Vegas, Dr. Devkota, who directs the Cedars-Sinai Human Microbiome Research Institute in Los Angeles, described new mechanistic data suggesting that certain gut bacteria can migrate into mesenteric fat, survive there and trigger a cycle of fat expansion, immune activation and fibrosis.

According to Dr. Devkota, creeping fat is most seen in ileal Crohn's disease and is closely linked to strictures. Surgeons have long noted that thick fat wraps only around diseased bowel segments, stopping abruptly where inflammation ends. Even though it is common, the condition has not been studied much.

Importantly, creeping fat is not typical soft adipose tissue. "It is extremely fibrotic," Dr. Devkota said, noting that the fat can be as stiff as the scarred intestinal wall itself. Because it cannot expand normally, it may contribute mechanically to luminal narrowing and stricture formation.

Bacterial translocation as a trigger

Dr. Devkota's lab studies creeping fat through a microbial lens, focusing on how gut bacteria interact with host tissues. In earlier work, her group showed that bacterial translocation — movement of bacteria across the intestinal barrier — occurs even in healthy individuals but is usually harmless because the immune system clears the microbes.

Suzanne Devkota, PhD

In Crohn's disease, however, the bacteria that translocate are different, she said, and clearance appears impaired. One species in particular, *Clostridium innocuum*, was frequently found in mesenteric fat from Crohn's patients, suggesting it may play a role in creeping fat formation.

In unpublished work using human surgical specimens, mouse models and cell culture systems, the researchers found that early mesenteric fat expansion may be beneficial. In animal models, fat expansion appeared to contain bacteria locally and prevent bacterial products from entering the bloodstream.

"These were mice we colonized with a minimal bacterial consortium that included *C. innocuum*," Dr. Devkota told *GI & Hepatology News*. "In these mice we could recover *C. innocuum* from the mesenteric adipose." Similarly, Crohn's patients with creeping fat did not show higher levels of bacterial products in blood compared with healthy controls, despite having a leaky intestinal barrier.

Over time, however, the response becomes maladaptive. Persistent bacteria within the fat drive immune cell infiltration, collagen deposition and progressive fibrosis, creating a self-reinforcing cycle.

Dr. Devkota's team also investigated how *C. innocuum* survives the journey from the gut to fat tissue, an environment very different from the anaerobic intestinal lumen.

One adaptation involves lipid metabolism. When exposed to human creeping fat in the laboratory, *C. innocuum* activated genes involved in beta-oxidation, allowing it to use fat as an energy source. Not all gut bacteria can do this, which may explain why only certain species successfully translocate.

Another adaptation is sporulation. Although *C. innocuum* is classified as a strict anaerobe, the researchers found that exposure to oxygen triggers the bacterium to form spores rather than die. These spores can survive high-oxygen conditions for extended periods and later germinate when they encounter bile acids that signal a lipid-rich environment,

Fat cells are not passive

The research also challenges the idea that adipose tissue is merely a passive target. Adipocytes can sense bacterial products and respond actively. In unpublished cell culture experiments, exposure to *C. innocuum* alone — without hormonal stimulation — caused preadipocytes to differentiate into mature, lipid-filled fat cells.

"This suggests the bacteria are not only consuming lipid but also driving fat expansion," Dr. Devkota said.

Taken together, the findings suggest that creeping fat begins as an attempt to wall off bacterial invasion but eventually contributes to fibrosis and strictures when inflammation persists. The findings also underscore the importance of prevention. "Managing inflammation early and aggressively may be critical to preserve the intestinal barrier and reduce the selection of bacteria adapted to survive outside the gut," Dr. Devkota said.

Her group has completed a large, multi-omic analysis of more than 100 surgical cases, with plans to make the data publicly available. She said that future work will focus on identifying therapeutic targets that interrupt the cycle before fibrosis becomes irreversible.

Dr. Devkota reported having no relevant disclosures.

Study: Acute pancreatitis is not 'one-and-done'

"The reality is that while ~96–98% of patients survive the acute event, a large proportion face clinically meaningful long-term pancreatic consequences that can be missed once they leave the hospital."

By Doug Brunk

The first two years after acute pancreatitis (AP) are the critical window when both pancreatic morphology and endocrine function change most dynamically, interim results from an ongoing prospective study in Hungary showed.

"Acute pancreatitis (AP) is often treated like a 'one-and-done' hospitalization," corresponding author Peter Hegyi, MD, PhD, DSc, of the Institute of Pancreatic Diseases at Semmelweis University, Budapest, Hungary, told *GI & Hepatology News*. "The reality is that while ~96–98% of patients survive the acute event, a large proportion face clinically meaningful long-term pancreatic consequences that can be missed once they leave the hospital. In our cohort, by year 4 the combined burden of prediabetes and diabetes was very high, and the highest incidence of new endocrine deterioration clustered early. That matters because it gives clinicians a clear time horizon for follow-up rather than vague 'as needed' monitoring."

In the Goulash-Plus study, published in *Gastroenterology* as a research letter, investigators at four centers in Hungary aimed to clarify the temporal course and predictors of both morphological and endocrine sequelae following AP. Reporting on 360 patients enrolled to date, they classified participants based on pancreatic morphology into AP, recurrent AP (RAP), early chronic pancreatitis (ECP), or chronic pancreatitis (CP) groups, and according to endocrine status into normal, prediabetes, or diabetes categories. Morphological and endocrine assessments were conducted at baseline and annually during follow-up.

The mean age of patients was 54.5 years and 43% were female. At baseline, 74.7% had a single AP episode, 11.9% had RAP, 6.9% had ECP, and 6.4% had CP. During follow-up, the proportion of patients with RAP, ECP, or CP more than doubled, from 25.3% at baseline to 55.1% at year four. Among patients with a single AP at baseline, 35.1% progressed to RAP, ECP, or CP by year four, with the most rapid morphological changes occurring within the first two years.

Endocrine dysfunction showed similar trends. While 59% of patients had normal glucose metabolism at baseline, the combined prevalence of prediabetes and diabetes reached 76.4% by year four. Notably, among patients with a single AP episode and normal baseline endocrine status, more than half (54.4%) developed prediabetes or diabetes by the fourth year. The most dynamic changes occurred in the first two years post-AP, with statistically significant annual increases in new-onset prediabetes and diabetes.

"What surprised me in the interim analysis was how sharply the curves moved early: both morphologic progression (toward recurrent AP/early chronic pancreatitis/chronic pancreatitis) and endocrine deterioration were front-loaded in the first two years, with a clear deceleration afterward," Dr. Hegyi said. "Clinically, that's a 'lightbulb moment,' because it suggests that if a patient remains stable through that early period, their subsequent risk trajectory may look different than we previously assumed."

He further noted that the clinical implications of the findings to date are that AP should prompt a structured follow-up plan, particularly during the first two years. "Our data support (at minimum) annual assessment of endocrine status (e.g., oral glucose tolerance testing where appropriate) and consideration of imaging-based follow-up to detect morphologic progression during that early window," Dr. Hegyi said. "Importantly, this approach is not about 'testing everyone forever'; it's about focusing attention when the signal is strongest and when early intervention, counseling, or referral is most likely to help."

Dr. Hegyi acknowledged certain limitations of the study, including the interim nature of the findings. "Follow-up is ongoing, and observational data cannot prove causality," he said. "Additionally, the optimal risk-stratification strategy (who needs which test, and how often) still needs refinement as the full cohort matures."

The research was supported by the Hirshberg Foundation, Hungarian Ministry of Innovation and Technology, and the National Research, Development and Innovation Fund.

In an interview with *GI & Hepatology News*, Philip Hart, MD, a gastroenterologist who is director of clinical research for the Division of Gastroenterology, Hepatology, and Nutrition at The Ohio State University, offered his thoughts on the study.

Why is this study important?

Dr. Hart: The paradigm of acute pancreatitis continues to evolve. Historically, it was considered a self-limited acute disease; studies, such as the present one, demonstrate it is an acute disease with important long-term sequelae. This prospective study focuses on recurrence and progression of pancreatitis (described here as morphologic progression) and changes in glycemic status.

Using prospective data, the investigators demonstrated a meaningful risk of clinical events within the first few years following hospitalization. Even amongst patients experiencing their first lifetime episode of acute pancreatitis, clinically meaningful risks were observed, including a 35% risk of recurrent acute pancreatitis at one year. And, over 75% of patients had prediabetes or diabetes by four-years of follow-up.

What are the potential clinical implications of the research?

Dr. Hart: Taken together, these findings support the growing consensus that clinical follow-up after hospital discharge is warranted for all patients with acute pancreatitis. This follow-up should include assessment for persistent symptoms, screening for diabetes (which is now endorsed by the American Diabetes Association), exocrine pancreatic dysfunction, and progression to chronic pancreatitis.

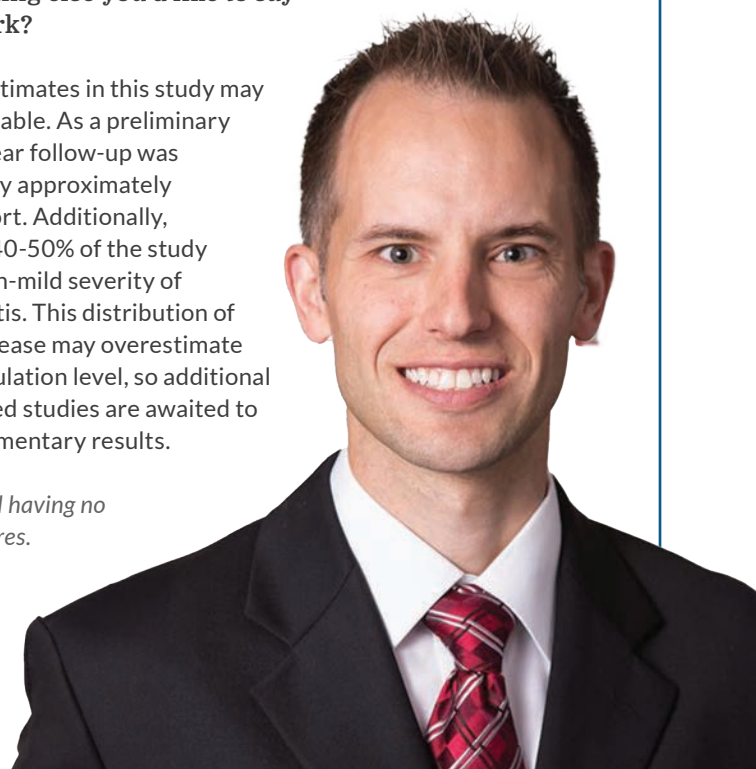
What additional research may be needed/what questions remain unanswered?

Dr. Hart: The investigators presented compelling trends in multiple aspects of disease progression for acute pancreatitis. Future studies are needed to identify clinical, radiographic, laboratory, and genetic markers that can identify individuals at highest risk for progression to enable tailored surveillance and early intervention efforts. The multicenter DREAM study (NCT06401577) in the United States is employing detailed metabolic testing (including standardized oral glucose tolerance testing) that will allow us to look at these various predictors and further understand the mechanisms of diabetes following acute pancreatitis.

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

Dr. Hart: The estimates in this study may not be generalizable. As a preliminary analysis, four-year follow-up was available for only approximately 50% of the cohort. Additionally, approximately 40-50% of the study patients had non-mild severity of acute pancreatitis. This distribution of more severe disease may overestimate risks at the population level, so additional population-based studies are awaited to provide complementary results.

Dr. Hart reported having no relevant disclosures.



Celiac markers unaffected by diet, proteomic analysis reveals

"I was excited to find not just one but four markers that were invariant to diet."

By Doug Brunk

A proteomic analysis of plasma proteins has identified two diet-independent markers for celiac disease, potentially transforming how the condition is diagnosed.

"The results of this study have the potential to significantly impact clinical care," first author Isabel A. Hujoel, MD, of the Division of Gastroenterology at the University of Washington, Seattle, told *GI and Hepatology News*. "Adopting a gluten-free diet without a clear diagnosis of celiac disease is common in the US. Unfortunately, once gluten-free, it is not currently possible to determine if someone has celiac disease without doing a gluten challenge."

A gluten challenge requires consuming a substantial amount of gluten over a prolonged period. Many people are reluctant to do this because of the symptoms that gluten can trigger, which makes it difficult to confirm whether they have celiac disease, said Dr. Hujoel. "Identifying markers for celiac disease that are invariant to diet would allow people to bypass the gluten-challenge and to obtain a proper diagnosis."

Using data from the UK Biobank, the researchers, conducted a proteomic study to identify plasma proteins associated with celiac disease in individuals following a gluten-free diet. They used ICD-10 code K90.0 to identify celiac disease cases and limited the study to individuals who had been diagnosed before their blood samples were collected. They standardized protein levels to reduce extreme values and then compared these levels between individuals with celiac disease on a gluten-free diet and healthy controls, according to their research published in *Gastro Hep Advances*.

A total of 1,044 participants had been diagnosed with celiac disease before proteomic testing. Of these, 141 completed a dietary questionnaire, and 132 reported following a gluten-free diet. Four proteins were significantly elevated in this group: anterior gradient 2, carboxypeptidase A2 (CPA2), integrin subunit beta 7 (ITGB7), and POF1B actin-binding protein (POF1B). However, only two — CPA2 and ITGB7 —appeared to be specific to celiac disease.

"I was excited to find not just one but four markers that were invariant to diet," Dr. Hujoel said. "The ability to diagnose celiac disease in those on a gluten-free diet without requiring a gluten-challenge is one of the most

Isabel Hujoel, MD

common hopes that I hear from patients in my clinical practice. I see many patients in clinic who are frustrated by the lack of available testing to help them obtain a diagnosis without suffering the symptoms of gluten consumption."

Before this discovery, the authors highlighted the HLA-DQ–gluten tetramer as the most promising alternative to the gluten challenge, noting that research indicates it can reliably detect celiac disease even when gluten is not being consumed. "Unfortunately, this test is limited by not being commercially available, requiring a significant volume of blood to perform, and being labor-intensive," wrote Dr. Hujoel and colleagues.

She acknowledged certain limitations of the proteomic analysis, including that gluten-free diet was determined based on survey responses and that celiac disease may have been misclassified through ICD coding. "Our findings are preliminary and only suggest possible markers for celiac disease that are invariant to diet," she emphasized. "Our findings need to be confirmed with further studies and clinical trials."

The authors reported having no relevant disclosures.

JAK inhibitors show superior real-world efficacy in microscopic colitis

"These findings pave the way for dedicated prospective trials and highlight evolving therapeutic strategies."

By Doug Brunk

Janus kinase (JAK) inhibitors provide the strongest effect for patients with microscopic colitis who fail or cannot tolerate budesonide, according to the results of a large multinational real-world study conducted through the ECCO CONFER network.

Bram Verstockt, MD, PhD

Microscopic colitis is a common cause of chronic diarrhea, especially among older adults. Budesonide is considered first-line therapy, but a substantial subset of patients becomes refractory or dependent, leaving clinicians with limited evidence-based options. Although biologics and small molecules are increasingly used off label in this setting, comparative real-world data have been lacking, noted Bram Verstockt, MD, PhD, of the Department of Gastroenterology and Hepatology, University Hospitals Leuven, Belgium, and colleagues.

They retrospectively analyzed outcomes from microscopic colitis patients treated with advanced therapies after budesonide failure or intolerance. The study included 229 treatment cycles administered to 142 patients across multiple international centers. Agents evaluated included anti–tumor necrosis factor (TNF) therapies, vedolizumab, ustekinumab, and JAK inhibitors.

Short-term clinical response was achieved in 95.2% of patients treated with JAK inhibitors, with clinical remission observed in 81%. These outcomes significantly exceeded those seen with anti-TNF agents, vedolizumab, and ustekinumab. The superior efficacy of JAK inhibitors was consistent across analyzed endpoints.

Long-term durability of treatment further set the drug classes apart. Discontinuation occurred in only 23.8% of JAK inhibitor treatment cycles, compared with 56.3% for all other advanced therapies combined. The odds of discontinuation were more than five times higher with non–JAK inhibitor agents (odds ratio, 5.07).

Multivariate analysis identified drug class as the sole independent predictor of therapy continuation, underscoring the importance of treatment selection in this patient population. No other patient or disease factors were linked to long-term persistence.

Despite the availability of advanced medical therapies, 4.2% of patients ultimately required surgical intervention, underscoring that refractory microscopic colitis can still progress despite escalation of treatment.

Advanced therapies, especially JAK inhibitors, are effective options for patients with budesonide-refractory or budesonide-dependent microscopic colitis, noted researchers. "These findings pave the way for dedicated prospective trials and highlight evolving therapeutic strategies," they concluded.

Dr. Verstockt reported receiving research support and/or speaker's fees and consulting fees from several pharmaceutical companies, as did many of his co-authors.

Wearable devices show growing potential in IBD care

"The use of wearables envisions a future where the assessment of disease activity would be ongoing, continuous, and free of clinical visits."

By Doug Brunk

Wearable health technologies — including consumer fitness trackers, experimental biosensor patches, and virtual reality (VR) headsets — are being explored as new tools to monitor disease activity and support patients with inflammatory bowel disease (IBD).

Investigators evaluated 37 studies to assess the impact of the devices on Crohn's disease and ulcerative colitis, in a scoping review published in *Clinical Gastroenterology and Hepatology*.

"The use of wearables envisions a future where the assessment of disease activity would be ongoing, continuous, and free of clinical visits," lead author Vishal Sharma, MD told *GI & Hepatology News*. "The idea is to pick up flares early, even before the clinical symptoms develop. This review finds that there is literature suggesting that this approach is feasible and may provide a convenient way to monitor disease activity in the future," said Dr. Sharma, of the Department of Gastroenterology at the Postgraduate Institute of Medical Education and Research, Chandigarh, India.

Most of the available data reviewed came from wrist-worn fitness trackers and smartwatches, such as Fitbit devices, Apple Watch, and the Oura Ring. Across multiple studies, these devices consistently showed lower physical activity and step counts in patients with active IBD compared with those in remission or healthy controls. Activity levels often improved as patients entered remission or responded to therapy. Several studies also linked moderate-to-vigorous physical activity, measured by trackers, with better bone density, muscle strength, and patient-reported outcomes.

Sleep metrics captured by wearables were another recurring theme. Patients with active disease tended to have poorer sleep efficiency and more disrupted sleep, even when total sleep time was longer. Poor sleep quality was associated with higher disease activity and worse quality of life, reinforcing sleep disturbance as an under-recognized burden of IBD.

Beyond activity and sleep, some studies focused on heart rate and heart rate variability (HRV), measured using consumer devices such as Apple Watch and Fitbit. Changes in HRV and resting heart rate were observed during symptomatic flares and, in some longitudinal studies, even weeks before flares became clinically apparent.

Several studies examined wearable sweat-sensing patches designed to measure inflammatory biomarkers noninvasively. Devices such as IBD Aware and SWEATSENSOR were able to detect C-reactive protein, calprotectin, and cytokines including tumor necrosis factor–α, with moderate to strong correlations to serum levels in small studies. Sweat calprotectin levels tended to be higher in active disease and lower during remission. According to the authors, these devices are still in early development and are largely studied in hospital or research settings, but they represent a promising step toward real-time inflammatory monitoring without blood draws or stool tests.

Other emerging technologies include a smart T-shirt embedded with sensors to capture bowel sounds and VR headsets used for symptom and stress management. In pediatric and adult populations, VR-based interventions reduced anxiety and pain during infusions and promoted relaxation. These findings suggest a role for wearables beyond physiologic monitoring, particularly in addressing the psychological burden of IBD, noted investigators.

Patients in the reviewed studies generally reported positive attitudes toward wearable technologies, especially wrist-worn devices. However, the authors noted that most studies were small, heterogeneous, and exploratory.

"Some of the findings are probably ready for clinical application, [such as] the finding that use of virtual reality-based interventions seem to alleviate the anxiety associated with infusions," Dr. Sharma said. "Other findings like the use of wearables to pre-empt the clinical flares probably would need validation in clinical trials. This is also time for clinical trial organizations to consider use of these wearable based tools for monitoring patients included in clinical trials. Such longitudinal data, if confirmatory, will enable a sea change in the way IBD disease monitoring is performed."

The authors reported having no relevant disclosures.

GI & Hepatology News invited Sumant Inamdar, MD, MPH, an interventional gastroenterologist in the Division of Gastroenterology and Hepatology University of Arkansas for Medical Sciences, Little Rock, to comment on the study.

Why is this study important?

Dr. Inamdar: This study is important because it highlights wearable technology as a potential shift in how we manage inflammatory bowel disease. Presently, IBD care is episodic and based on clinical assessments that capture a single moment in time. Use of wearables could make it more continuous with patient-centered monitoring in real-world settings. In routine practice, clinicians often rely on symptoms, labs, and imaging obtained weeks or months apart, which can miss early physiologic changes that precede a clinical flare. Wearable devices offer the opportunity to passively and objectively track parameters such as physical activity, sleep patterns, heart rate variability, and inflammatory signals over time, providing a more dynamic view of disease activity.

By integrating these real-time data streams with traditional biomarkers and patient-reported outcomes, wearable technologies may help identify subtle changes before patients become overtly symptomatic. This has the potential to enable earlier clinical intervention, reduce unplanned hospitalizations or steroid use, and support more proactive, personalized disease management.

What are the potential clinical implications of the research?

Dr. Inamdar: From a clinical perspective, wearable technologies have the potential to add a new layer of data and information into disease activity that is often missed between clinic visits. Early changes in activity, sleep, or heart rate variability may signal worsening disease before symptoms emerge, enabling earlier follow-up or targeted evaluation rather than reactive care. This type of passive, longitudinal monitoring aligns well with how IBD fluctuates over time and may help clinicians intervene earlier in the disease course.

To make these technologies acceptable, the validation of noninvasive wearable biomarkers, like sweat-based measures of CRP or calprotectin, is essential. This could further transform care by enabling remote disease monitoring and more individualized treatment adjustments. For patients, this could mean fewer urgent visits, reduced reliance on invasive testing, and a greater sense of control over their disease.

What additional research may be needed, and what questions remain unanswered?

Dr. Inamdar: The existing literature demonstrates promising associations between wearable-derived metrics and disease activity, but several critical questions must be addressed before these tools can be meaningfully integrated into routine IBD care. Firstly, large, longitudinal studies are needed to validate wearable signals such as changes in physical activity, sleep, heart rate variability, or sweat-based inflammatory markers, against established clinical outcomes, including endoscopic activity, fecal calprotectin, CRP, and validated disease activity indices. Without this correlation, it remains unclear which wearable signals are truly disease-specific versus which are reflective of nonspecific stress, infection, or comorbid conditions.

Beyond the science, questions remain about how wearable technologies can be effectively implemented in real-world clinical settings. Long-term patient adherence, device fatigue, and usability remain concerns, particularly during periods of clinical remission when perceived benefit may be low. Integration of wearable data into electronic health records and clinical workflows must be seamless and actionable to avoid data overload for clinicians.

Dr. Inamdar reported having no financial disclosures.

Tiny plastics may harm gut and liver health, review finds

Multiple human studies have identified microplastics in stool samples from healthy individuals.

By Doug Brunk

Priyata Dutta, MD

A growing body of research suggests that microscopic plastic particles are not just an environmental concern but may also pose risks to gastrointestinal and liver health. A comprehensive review published in *Clinical Gastroenterology and Hepatology* brings together the latest evidence linking exposure to micro- and nanoplastics (MNPs) with inflammation, gut dysbiosis, liver disease, and possibly gastrointestinal cancers.

"While MNPs are not classified as carcinogens, they can transport toxic substances and heavy metals that increase cancer risk," the study's first author Priyata Dutta, MD, of the department of internal medicine at Trinity Health, Ann Arbor, Michigan, told *GI & Hepatology News*. "The relationship between MNP exposure and health outcomes remains unclear. As plastic pollution increases, understanding the biological effects of MNP is crucial for public health policies."

The review examines how tiny plastic fragments, created as larger plastics break down, enter the human body through food, water, and air. Once ingested, these particles can accumulate in the gastrointestinal tract, where they interact with the gut lining, immune system, and microbiome. Microplastics are defined as particles smaller than 5 millimeters, while nanoplastics are even smaller, measured in billionths of a meter, making them difficult to detect and study.

For the narrative review, Dr. Dutta, senior author David A. Johnson, MD, chief of gastroenterology at Eastern Virginia School of Medicine, Norfolk, and colleagues screened 800 publications (from inception to February 2025) and evaluated 15 human studies, along with relevant animal and laboratory research, retrieved from PubMed, EMBASE, and Cochrane.

They analyzed data from fecal testing, tissue samples, occupational exposure studies, and experimental models to understand how MNPs may affect GI and liver health. In addition, the authors reviewed available methods used to detect these particles, noting wide variation and a lack of standardized testing. "Our aim was to start conversations between clinicians and their patients about this emerging risk," Dr. Dutta explained.

According to the review, multiple human studies have identified microplastics in stool samples from healthy individuals, patients with IBD, and people with high occupational exposure to plastics. Several studies showed higher levels of microplastics in patients with IBD, with concentrations correlating with disease severity. The authors noted that these raise questions about whether plastic exposure contributes to inflammation or whether inflamed intestines retain more particles.

Animal and laboratory studies in the review suggest that microplastics can disrupt the gut microbiome, reducing beneficial bacteria and promoting inflammation. Some plastics may also carry harmful chemicals or heavy metals, potentially amplifying their effects. The review highlights evidence that these particles can damage the gut barrier, trigger immune responses, and increase oxidative stress — processes already known to play a role in chronic GI diseases.

The liver also appears particularly vulnerable. The authors summarize studies showing microplastic accumulation in liver tissue and associations with metabolic dysfunction–associated steatotic liver disease, fibrosis, and cirrhosis. In occupational settings, long-term exposure to certain plastics, such as polyvinyl chloride, has been linked to rare liver cancers, although these findings are based on historical cohorts and specific industrial exposures.

The review also explores emerging concerns about cancer risk, particularly colorectal cancer. While microplastics are not classified as carcinogens, the authors describe experimental data suggesting they may promote tumor growth indirectly by driving chronic inflammation, altering the microbiome, and impairing immune surveillance.

Drs. Dutta and Johnson, for the coauthors, acknowledged limitations of the review, including that most human data come from observational studies, detection methods differ widely, and there is little information on long-term exposure.

"While epidemiological evidence is strongly suggestive, further research employing environmentally relevant exposure levels, mechanistic animal studies as well as longitudinal clinical studies, appropriately balanced for risk assessment, is necessary to more precisely define the risk," Dr. Dutta emphasized. "These findings underscore the urgent need for continued investigation, heightened awareness among healthcare providers and patients, and the development of strategies to mitigate plastic exposures and related adverse health impacts."

Following discussions among the authors, emergent recommendations pending more conclusive evidence would be to begin with small, incremental steps, as outlined below:

- Recognize that thermal extremes accelerate plastic degradation. This includes avoiding cooking and storing food products in heat (e.g. microwave or freezing).
- Avoid or minimize single use plastic exposures (e.g. use reusable water bottles over plastics) as well as liquid commonly prepared with temperature variances (e.g. convenient plastic coffee modules as well as tea bags).
- Avoid or minimize exposure to highly processed/convenience foods, stored for long term exposure within plastics.

"Too much beyond these recommendations will not be helpful for patients at present, and potentially harmful for concerns," Dr. Dutta and her team said. "Our job as clinicians is to make the best recommendations based on current evidence."

The authors reported having no financial disclosures.

"Our aim was to start conversations between clinicians and their patients about this emerging risk."
- Dr. Priyata Dutta

Refining endoscopic surveillance

Dear colleagues,

Screening and surveillance remain foundational to modern endoscopic practice, with colorectal cancer prevention through colonoscopy serving as a central focus for gastroenterologists. Yet beyond average-risk screening, there are several areas of surveillance where practice patterns vary, evidence continues to evolve, and uncertainty persists. In this issue, we turn our attention to two such areas: dysplasia surveillance in inflammatory bowel disease and gastric cancer prevention through the identification and management of gastric intestinal metaplasia.

Dr. Samir A. Shah provides a practical and evidence-based approach to IBD surveillance, highlighting his use of chromoendoscopy with targeted sampling to improve dysplasia detection. He discusses risk stratification, patient selection, and procedural techniques that allow endoscopists to maximize yield while avoiding unnecessary over-surveillance.

Complementing this, Drs. Isiah Gonzalez and Mimi Tan offer a thoughtful framework for the evaluation and surveillance of gastric intestinal metaplasia — an area often encountered incidentally and marked by low endoscopic sensitivity. They outline strategies to improve detection, emphasize systematic gastric mapping, and integrate current U.S. and international guidelines to help clinicians tailor surveillance based on individual risk.

At a time when increasing attention is being paid to the risks and inefficiencies of over-surveillance, these perspectives aim to provide a balanced, pragmatic approach to identifying patients at increased malignancy risk while delivering high-quality, evidence-driven care. We hope these articles help inform and refine your surveillance practices, and we welcome your continued feedback and experience.

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

Gastric intestinal metaplasia surveillance in U.S. practice

By Isaiah T. Gonzalez, MD, and Mimi C. Tan, MD, MPH

Gastric intestinal metaplasia (GIM) often remains outside the primary clinical focus of most gastroenterologists until the diagnosis appears unexpectedly on a pathology report, leaving the clinician uncertain about next steps. To improve detection of GIM, I focus on careful examinations using high-definition white-light endoscopy (HDWLE) and narrow band imaging (NBI). When GIM is suspected on the endoscopic examination, I routinely obtain five gastric biopsies per the Sydney protocol[1] and separate the biopsies into two jars (antrum and gastric body) which allows me to determine the anatomic distribution of GIM without a repeat endoscopy. When the location of GIM is unknown (random biopsies without location specified), repeat endoscopy with systematic gastric mapping biopsies should be performed to risk stratify and determine the surveillance interval. To guide surveillance of GIM, I use the AGA 2025 Clinical Practice Update on Screening and Surveillance in Individuals at Increased Risk for Gastric Cancer in the United States[2] and the 2025 Management of Epithelial Precancerous Conditions and Early Neoplasia of the Stomach (MAPS III) guideline update from the European Society of Gastrointestinal Endoscopy (ESGE). [3]

Gastric biopsies with downstream decisions in mind

GIM and atrophic gastritis are difficult to detect endoscopically, particularly in the United States, where the diagnosis is infrequently encountered. Sensitivity of GIM detection on HDWLE is low (28%); even with NBI, the sensitivity remains suboptimal (53-80%). For this reason, I carefully assess for subtle endoscopic features of GIM and atrophic gastritis, such as cobblestoning/surface irregularity, red-white mucosa, mucosal pallor and greater visibility of submucosal vessels, and gastric fold disappearance while also assessing for the atrophic border per the Kimura-Takemoto classification.[4]

When the mucosa appears suspicious for GIM or atrophy, I obtain a minimum of five biopsies according to the updated Sydney System (lesser curvature and greater curvature of antrum and gastric body along with incisura) and submit the specimens in separately labeled antrum and gastric body jars[1]. This biopsy strategy gives me data on GIM severity and location should GIM be found, and I can then recommend a surveillance interval for endoscopy. This has helped me avoid the scenario of incidental GIM diagnosis on random biopsy histopathology without information on GIM location.

Addressing 'GIM on random gastric biopsy' and unknown GIM extent

A common clinical scenario is one where GIM is diagnosed on random gastric biopsies when the anatomic location of GIM is not known. In such cases, a repeat upper endoscopy with systematic gastric mapping is necessary to determine disease extent and to accurately risk-stratify the patient. Surveillance endoscopy interval and whether surveillance endoscopy is indicated is determined in part by GIM extent and location (antrum-restricted vs corpus-extended).

In this scenario, I repeat upper endoscopy in approximately one year to complete gastric mapping biopsies and risk stratification. This approach allows identification of patients who warrant three-year surveillance due to high-risk features (multifocal, corpus-extended, or incomplete-type GIM) while recognizing that most patients with antrum-restricted GIM do not require further surveillance.[2]

GIM risk stratification

GIM risk stratification involves assessment of the anatomic distribution (antrum-restricted

vs corpus-extended), disease focality (focal vs multifocal), and the histologic severity and subtype (complete vs incomplete). I use the updated Sydney System for gastric mapping biopsies and place biopsies from each location in five separate jars when a GIM diagnosis is already known. Visible lesions are biopsied or removed and placed in separate jars. This approach allows the pathologist to document the Operative Link on Gastritis Assessment (OLGA) or Operative Link on Gastric Intestinal Metaplasia (OLGIM) stage, informed by disease severity and location.[5]

AGA[2] and ESGE[3] support three-year intervals for patients with high-risk features, including moderate to severe atrophy, multifocal or corpus-extended GIM, and/or incomplete-type GIM. Conversely, no surveillance is advised for patients with mild, focal, and/or complete-type GIM, provided *H. pylori* has been eradicated, and there is no family history of gastric cancer. If there is a family history of gastric cancer in a first-degree relative, endoscopic surveillance is recommended in one to two years for high-risk GIM or atrophy and three to five years with mild, focal, or complete GIM.

Primary and secondary prevention of gastric cancer

While much attention is often directed towards endoscopic screening for gastric cancer and precancerous lesions, primary prevention remains critical for long-term gastric cancer control. Primary prevention includes *H. pylori* screening and eradication, smoking cessation, and promotion of healthy dietary habits. Groups at high-risk for gastric cancer should be testing for *H. pylori* even when asymptomatic, including first-generation immigrants from high-incidence regions, non-White racial and ethnic groups, individuals with a first-degree relative with gastric cancer, and those with select hereditary gastrointestinal polyposis or cancer syndromes.[2] All confirmed *H. pylori* infections require treatment with post-treatment eradication testing.

At the same time, it is important to acknowledge the current limitations of gastric cancer screening in the United States. Although mathematical and cost-effectiveness studies suggest that population-wide screen-and-treat strategies may be cost-effective in select high-risk populations, these approaches are not currently endorsed by the USPSTF or routinely covered by payers. Until this changes, the most impactful strategy remains vigilant *H. pylori* testing and eradication based on symptoms or risk factors combined with high-quality endoscopic examinations.

Practical approach to gastric intestinal metaplasia (GIM) in U.S. practice

When GIM appears on a pathology report

1. Confirm and eradicate H. pylori.
- Test all patients with GIM if status is unknown.
- Treat confirmed infection with guideline-concordant therapy.
- Document eradication with post-treatment testing.
- *H. pylori* eradication remains the most effective gastric cancer prevention strategy.

2. Determine anatomic extent.
If GIM was diagnosed on random biopsies without documented location, repeat upper endoscopy with systematic gastric mapping is recommended to define disease extent and guide surveillance.

Endoscopic examination: What to look for

Detection of GIM can be subtle, particularly in low-prevalence U.S. practice. On HD white-light endoscopy and narrow band imaging, assess carefully for:
- Cobblestone or irregular mucosa
- Patchy red-white discoloration
- Mucosal pallor
- Increased visibility of submucosal vessels
- Loss of gastric folds
- Atrophic border (Kimura-Takemoto classification)
- Light blue crest sign on NBI

Suspicion should lower the threshold for systematic biopsies.

Gastric mapping: Updated Sydney Protocol

Minimum five biopsies:
1. Lesser curvature, antrum
2. Greater curvature, antrum
3. Lesser curvature, corpus
4. Greater curvature, corpus
5. Incisura

Specimen handling
- At minimum, separate antrum and corpus into different jars.
- If GIM is already known, consider five separately labeled jars to allow precise staging.
- Visible lesions should be biopsied or resected separately.

This approach enables OLGA/OLGIM staging and avoids repeat procedures due to incomplete mapping.

Risk stratification: Who needs surveillance?

Risk assessment should include:
Extent: antrum-restricted vs. corpus-extended
- **Focality:** focal vs. multifocal
- **Histology:** complete vs. incomplete subtype
- **Severity of atrophy**
- **Family history** of gastric cancer

Surveillance recommendations (AGA 2025 and MAPS III):

- Moderate to severe atrophy: every 3 years
- Multifocal or corpus-extended GIM: every 3 years
- Incomplete-type GIM: every 3 years
- High-risk features + first-degree relative: every 1–2 years
- Mild, focal, complete-type GIM (no family history, H. pylori eradicated): no surveillance

Most patients with antrum-restricted GIM do not require ongoing endoscopic surveillance.

Primary prevention matters

High-risk individuals should be tested for H. pylori even if asymptomatic, including:
First-generation immigrants from high-incidence regions
- Non-White racial/ethnic groups at increased risk
- Individuals with a first-degree relative with gastric cancer
- Patients with hereditary gastrointestinal cancer syndromes

While population-wide screening is not currently endorsed or broadly reimbursed in the U.S., targeted testing and eradication combined with high-quality endoscopic examination remain the most impactful strategies for gastric cancer prevention.

Isaiah T. Gonzales, MD, is a physician in the Department of Medicine at Baylor College of Medicine in Houston, Texas.

Mimi C. Tan, MD, MP, is a physician in the Section of Gastroenterology and Hepatology within the Department of Medicine at Baylor College of Medicine in Houston, Texas.

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Introduction to IBD dysplasia surveillance

By Samir A. Shah, MD

IBD patients have an elevated risk of colorectal cancer. Population based studies put the overall risk of colorectal cancer at about two times higher than that of the general population (lower than the purported risk in the 2001 meta-analysis of 8% by 20 years, and 18% by 30 years)[1].

Risk factors include extent of colonic disease, number of years of disease, primary sclerosing cholangitis (PSC), family history of colorectal cancer (especially age < 50), degree of endoscopic/histologic inflammation, male gender, presence of post-inflammatory pseudopolyps, and history of previous dysplasia.

The paradigm for surveillance in IBD has changed from multiple random biopsies and annual colonoscopies with standard-definition scopes in the 1990s to the use of HD scopes with chromoendoscopy (dye spray or virtual), targeted biopsies, and longer intervals in between determined by findings and risk stratification.

The optimal approach to dysplasia detection and colorectal cancer prevention in IBD continues to be debated. However, a strong case can be made for chromoendoscopy with targeted biopsies as the standard of care for IBD surveillance in 2026.

When to initiate surveillance

Surveillance colonoscopy should begin eight years after IBD diagnosis for patients with colonic disease extending beyond the rectum for ulcerative colitis and at least one-third of the colon involved for Crohn's disease.[2-5,8,10] For patients with concomitant PSC, surveillance should start at diagnosis, regardless of disease duration or extent reflecting the substantially elevated cancer risk in this population.[2-5, 10, 14]

Optimizing conditions for dysplasia detection

The foundation of effective surveillance requires optimizing multiple procedural factors: (1) achieving disease remission before surveillance, as active inflammation significantly impairs dysplasia detection; (2) using high-definition (HD) scopes with excellent bowel preparation, along with meticulous washing and inspection of all colorectal mucosa; and (3) performing a second look, preferably with chromoendoscopy.

The role of chromoendoscopy

Chromoendoscopy maximizes dysplasia detection. The ASGE recommends chromoendoscopy with targeted biopsies as the preferred surveillance technique.[4-5] Dye chromoendoscopy should be considered in all IBD patients undergoing surveillance, but especially in higher risk patients such as patients PSC or with prior invisible dysplasia.[2-5,14]

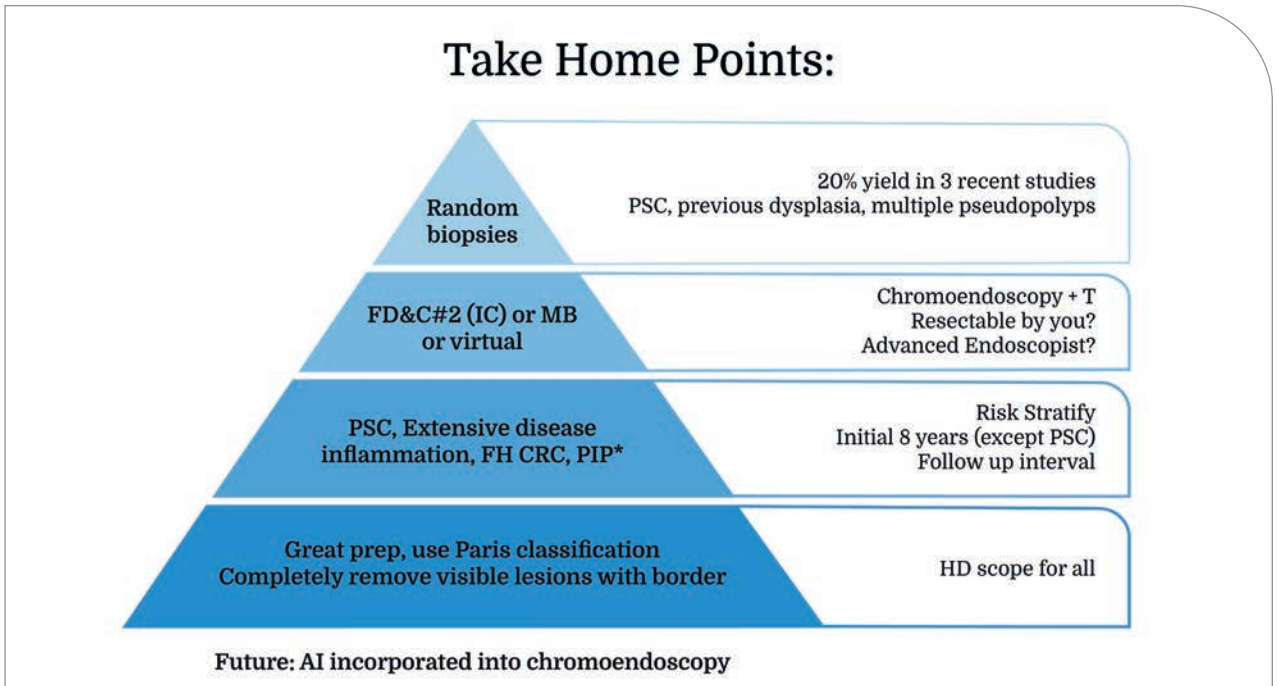
A 2024 meta-analysis demonstrated that dye chromoendoscopy detected significantly more patients with dysplasia than HD white-light endoscopy (18.8% vs 9.4%, OR 1.94), with high certainty of evidence.7 This translates to nearly double the dysplasia detection rate, representing a clinically meaningful improvement in patient outcomes.

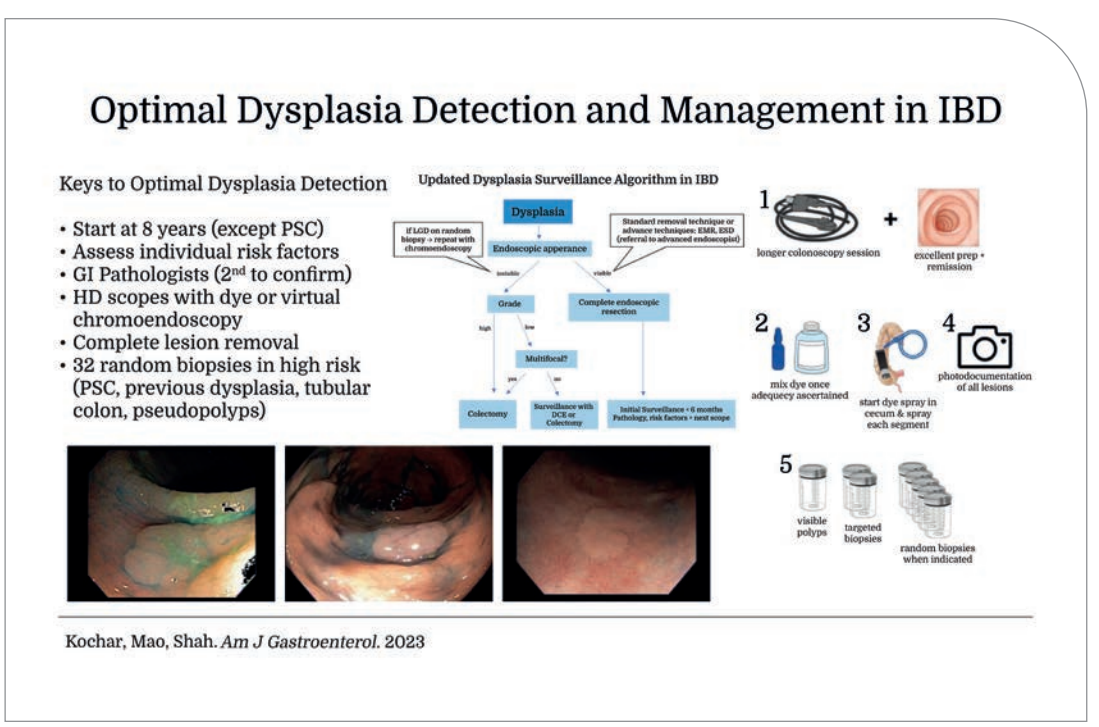
A 2026 meta-analysis of studies using HD scopes found that virtual chromoendoscopy was not inferior to dye chromoendoscopy. Thus, the endoscopist can choose either virtual or dye chromoendoscopy.

Virtual chromoendoscopy — including narrow-band imaging, Pentax Medical i-scan, and Fuji intelligent color enhancement — enhances vascular and surface architecture without requiring dye application, offering practical advantages in busy endoscopy units. The ACG-ASGE joint quality indicators recommend HD colonoscopy complemented with one modality of chromoendoscopy, with targeted biopsy sampling of suspicious areas.[9]

My personal preference is dye chromoendoscopy over virtual. I believe that dye chromoendoscopy is well within the wheelhouse of endoscopists who perform screening and surveillance colonoscopies (all of my partners utilize dye chromoendoscopy in our private practice). I incorporated dye-spray chromoendoscopy in my practice shortly after Professor Ralf Keisslich discussed his landmark 2003 publication[13] showing the superior yield of chromoendoscopy at GI grand round at Brown University in 2024.

Dye spray requires an excellent prep, resulting in a more thorough second look, as the endoscopist can see where the dye went and did not go and is forced to irrigate unstained areas





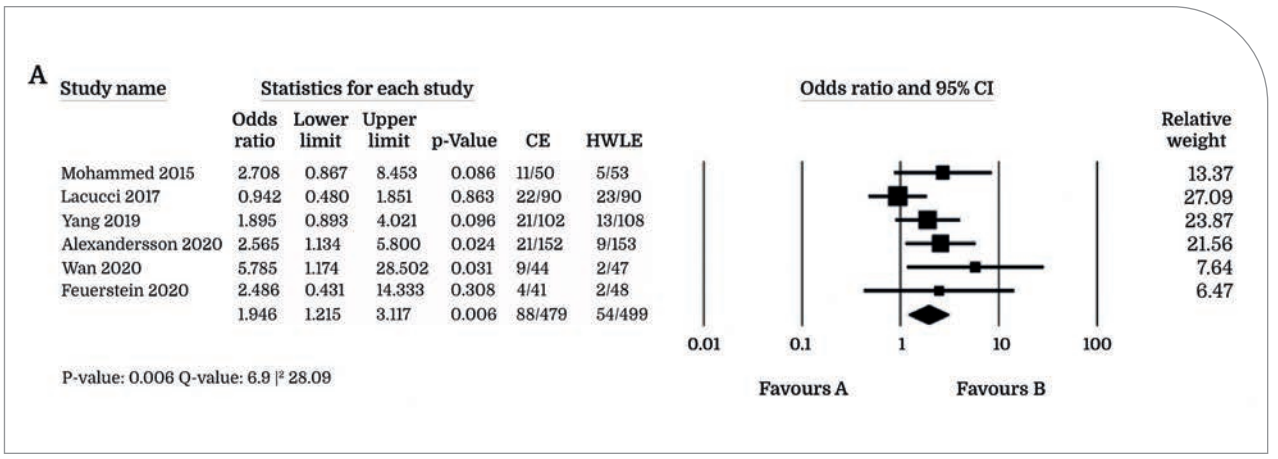
and suction up puddles of excess dye for optimal visualization. With virtual chromoendoscopy, time pressure can make the second look too quick and incomplete. Either methylene blue or FD&C Blue No. 2 (a synthetic equivalent of indigo carmine) can be used and efficiently delivered using the flushing apparatus.

I prefer FD&C Blue No. 2 mixed to a concentration of 0.1%, which I use routinely in our outpatient ASC. At the hospital, I use a very dilute concentration of 0.05% methylene blue (50 mg/10 mL in 1 liter of sterile water). We conducted a retrospective, uncontrolled comparison of chromoendoscopy to white light endoscopy (WLE) in my patients between January 2005 and August 2012 and reported 25 dysplastic lesions in 64 procedures with chromoendoscopy (39.1%) versus only 8 in 120 procedures (6.9%) with WLE ($p < 0.001$, a fivefold higher yield).[15]

This changed my practice to use this technique for all surveillance colonoscopies in IBD and now also for patients with serrated polyposis syndrome (SPS).

A few caveats: Do not use dye spray if the prep is not excellent (Boston Bowel Preparation Score = 9) or if there is significant inflammation. Wear scrubs and old sneakers and warn staff and patients to wear clothes they do not mind getting stained with blue dye. I schedule these cases for 45 minutes in our outpatient center and one hour in the hospital.

Our approach to incorporating chromoendoscopy into practice is depicted in the second panel, along with an algorithm for clinicians to follow. [14]



Are biopsies still needed?

When chromoendoscopy (dye-spray or virtual) is performed with high-definition endoscopy, targeted biopsies of suspicious lesions are sufficient as most dysplastic lesions are visible.[4] However, non-targeted biopsies should still be considered in high-risk patients such as those with prior invisible dysplasia, multiple post-inflammatory pseudo-polyps, or primary sclerosing cholangitis.[4,5,14]

Without chromoendoscopy, extensive non-targeted biopsies should be done approximately four adequately spaced biopsies every 10 cm from flat colorectal mucosa, totaling at least 32 samples.[4,7] This labor-intensive, costly and low yield approach underscores the efficiency gains achievable with chromoendoscopy-guided surveillance.

Targeted biopsies dramatically outperform random sampling, with dysplasia found in 17.3% of targeted biopsies versus only 0.33% of random biopsies in comparative studies.[3] This 50-fold difference emphasizes the importance of enhanced visualization techniques.

Lesion characterization and management

All visible precancerous lesions should be described using the modified Paris Classification. Documentation should include size, morphology, border clarity, presence of ulceration, location, and relationship to areas of current or past colitis.

All clearly delineated dysplastic lesions without stigmata of invasive cancer or significant submucosal fibrosis should be considered for endoscopic resection. Endoscopic resection is preferred over biopsies when lesions are clearly demarcated. When resectability is uncertain or beyond the skill set of the endoscopist, referral to a specialized advanced endoscopist and/or IBD center is recommended.

Surveillance intervals and risk stratification

After negative screening colonoscopy, surveillance intervals range from one to five years based on risk stratification.[2-5] High-risk patients — including those with prior dysplasia, strictures, primary sclerosing cholangitis, or extensive colitis with severe inflammation — require annual surveillance.[2-4,7,9] Intermediate-risk patients with extensive colitis and mild-to-moderate inflammation or family history of colorectal cancer should undergo surveillance every two to three years[1-4,9] Low-risk patients with limited disease extent and minimal inflammation may extend to 5-year intervals.[1,9]

Future directions and emerging technologies

Artificial intelligence-assisted detection systems show promise for enhancing surveillance performance. Computer-aided models have demonstrated 95% sensitivity and 99% specificity for detecting colorectal lesions in IBD patients.[10-11]

Conclusions

Effective IBD surveillance requires integrating multiple evidence-based strategies: initiating surveillance at appropriate intervals, optimizing procedural conditions, employing chromoendoscopy, performing targeted biopsies of suspicious lesions, and risk-stratifying patients for appropriate follow-up intervals.

While chromoendoscopy remains the preferred technique for maximizing dysplasia detection yield, high-definition white-light endoscopy with meticulous technique represents an acceptable alternative when chromoendoscopy expertise is unavailable.

Emerging technologies, including artificial intelligence and advanced imaging modalities, promise further improvements in dysplasia detection and patient outcomes.

Samir A. Shah, MD, is former chief of gastroenterology at The Miriam Hospital in Providence, RI. He is currently a clinical professor of medicine at The Warren Alpert School of Medicine at Brown University. He reports disclosures as a speaker for AbbVie and JNJ, a consultant for Roche Information Systems, and an advisory board member for Pfizer.

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Integrating mind and gut: Dr. Megan Riehl on the future of GI psychology

Exploring the evolving role of behavioral health in gastroenterology

By Sierra Rendon

"I won't promise a cure, but our goal is to reduce the severity, frequency, and duration of symptoms while building confidence in a toolbox of skills to manage challenges."

As the science of the brain–gut connection continues to reshape how gastrointestinal disorders are understood and treated, few leaders have been more influential in advancing integrated psychological care than Megan Riehl, PsyD, AGAF. A nationally recognized expert at the intersection of psychology and gastroenterology, Dr. Riehl is an Associate Professor of Medicine and Clinical Director of the GI Behavioral Health Program at the University of Michigan. She also holds key leadership roles within Michigan Medicine focused on clinician wellbeing and serves on the national Board of Trustees for the Crohn's & Colitis Foundation.

Dr. Riehl's path into GI psychology was shaped early by her passion for integrated care and her interest in the relationship between emotional and physical health. After specialized fellowship training at Northwestern — then the only program in the country offering GI behavioral health training within a Division of Gastroenterology — she went on to help build one of the nation's leading GI Behavioral Health programs at Michigan. Today, she works as an embedded member of multidisciplinary GI teams, helping patients better understand their symptoms, build practical coping skills, and improve both outcomes and quality of life.

Beyond the clinic, Dr. Riehl is deeply committed to education, access, and community-building within the field. She is the co-author of the book *Mind Your Gut: The Science-Based, Whole-Body Guide to Living Well with IBS* co-host of *The Gut Health Podcast*, and a strong advocate for expanding training opportunities and insurance coverage for GI psychology services. In this month's Member Spotlight, Dr. Riehl shares insights on the evolving role of GI psychologists, common misconceptions about the brain–gut connection, and why integrated psychological care is becoming an essential pillar of modern gastroenterology.

What first drew you to the intersection of psychology and gastroenterology, and how did that path shape your career?

Dr. Riehl: I was first drawn to behavioral health during my internship, where I provided mental health services to individuals seeking medical care at a community health center in Chicago. I quickly realized how much I enjoyed working as part of an integrated care team and having conversations about the bidirectional relationship between emotional and physical health. Through what felt like a serendipitous path, I had the opportunity to receive training and mentorship from two leaders in the field, Drs. Laurie Keefer and Sarah Kinsinger, who both helped support my early work and passion for this specialty. The enthusiasm and support of Dr. Bill Chey at the University of Michigan further inspired me to take an early-career leap to help build the GI Behavioral Health Program.

For readers who may be unfamiliar with the role, how does a GI-specific psychologist differ from a general mental health provider?

Dr. Riehl: GI psychologists are trained within gastroenterology settings to address disorders of gut–brain interaction and other digestive diseases using evidence-based brain–gut behavioral therapies. We work as integrated members of multidisciplinary GI teams to target symptom severity, treatment adherence, and quality of life by directly modulating brain–gut communication. At the same time, we often encourage patients to work with a general mental health provider for broader mental health needs, such as mood management, trauma, or eating disorders. Addressing these needs alongside GI-focused care ensures treatment is more effective and helps patients access the right type of support for their condition.

Why is integrated psychological care so critical for patients with gastrointestinal disorders, both in terms of outcomes and quality of life?

Dr. Riehl: Gastrointestinal disorders are inherently biopsychosocial, shaped by physiology, the nervous system, behavior, and lived experience. Integrated psychological care addresses these dimensions together rather than in isolation. When behavioral health is embedded within gastroenterology, patients better understand how symptoms, stress, and behaviors interact and learn strategies to manage symptoms and improve overall health. Integrated care also validates patients' experiences and reduces stigma by framing psychological intervention as a core part of evidence-based GI treatment. By fostering a trusted, collaborative therapeutic team, we can intervene earlier, support patients through relapsing and remitting conditions, and improve both clinical outcomes and quality of life.

Below: Dr. Riehl with her family.
Top Right: Dr. Riehl attends DDW 2025.
Bottom Right: Dr. Riehl with friends and colleagues.

What are some of the most common misconceptions patients — or even clinicians — have about the brain–gut connection?

Dr. Riehl: We move beyond symptom-focused care to skill-building and long-term management. I often tell patients I won't promise a cure, but our goal is to reduce the severity, frequency, and duration of symptoms, as well as associated anxiety, while building confidence in a toolbox of skills to manage challenges. Patients learn evidence-based strategies to regulate symptoms, manage stress, and improve daily functioning, often addressing root causes through the brain–gut connection. This proactive approach improves outcomes, increases satisfaction, and can reduce unnecessary healthcare use. Many patients wish they had access to a GI psychologist sooner!

You've been a strong advocate for expanding access to GI psychology. What gaps do you still see in the field, and what needs to happen next?

Dr. Riehl: Education is truly my passion, and it drives much of my work — from my book and podcast to collaborations with digital health companies — all aimed at expanding access to the valuable care GI psychologists provide. While progress has been made, gaps remain. We need more training opportunities for the next generation of GI psychologists and earlier exposure for mental health providers to the diverse career paths within gastropsychology. Another major barrier is variability in insurance coverage for both GI psychology services and evidence-based digital products. Increasing coverage would greatly improve access to care and has the potential to reduce overall healthcare costs by improving symptom management and decreasing reliance on more invasive or costly interventions. Continued advocacy, education, and research will be essential to closing these gaps and moving the field forward.

As both a clinician and an author, how do you approach translating complex brain–gut science into practical, empowering guidance for patients?

Dr. Riehl:I start from the belief that patients don't need less science; they need a better, more empathetic translation of it. I listen closely to how symptoms show up in daily life and what feels most confusing or discouraging to the patient. Then I reverse-engineer the science into clear, human language that explains why symptoms happen, without implying blame or inevitability.

I focus on three things: validation, mechanism, and agency. First, I validate that symptoms are real and biologically driven. Next, I explain the brain–gut mechanisms in simple, accurate terms — how the nervous system, immune signaling, and prior experiences shape gut function and pain. Finally, I translate that understanding into practical tools patients can use, emphasizing skills that restore a sense of control and safety in the body. The goal is to replace fear with understanding and helplessness with confidence, so patients feel informed, empowered, and active in their care rather than overwhelmed or stuck.

You've helped bring GI psychologists together through professional gatherings, including an upcoming meet up at AGA Central during Digestive Disease Week® (DDW). Why is community-building within this specialty so important?

Dr. Riehl: For years, GI psychologists have often worked independently, developing programs within medical settings. While this independence allows for creativity and growth, it can also feel isolating. Networking with physician champions is important for building referral networks and multidisciplinary teams, but connection among GI psychologists is essential for professional growth, mentorship, and sponsorship. Time together also creates opportunities for collaboration in research and innovation, helping the field advance together. It's always inspiring to reconnect with colleagues at DDW, hear about work happening around the world, and watch our meet up continue to grow.

Looking ahead, what excites you most about the future of GI psychology and its role in improving patient care?

Dr. Riehl: While a definitive medical diagnosis remains essential, GI psychologists are increasingly taking a central role in shaping patient care. More patients are seeking us out early, recognizing the importance of brain–gut behavioral therapies, and our evidence-based treatments are gaining visibility and credibility. I'm thrilled to see GI psychologists leading research and innovation that tackle the complexities of digestive diseases, while also being recognized in leadership roles to promote more holistic, integrated care. The field is evolving quickly, and it's inspiring to watch how our work is improving outcomes, empowering patients, and creating new opportunities for collaboration. It's an exciting time to be part of GI psychology!

Lightning round

Who inspires you and why?

People who actively seek joy, even in the midst of life's challenges.

What are you excited about working on right now?

The Gut Health Podcast with Kate Scarlata.

Best piece of advice you've given or received?

Listen to your gut.

Favorite quote or words to live by?

You can do hard things, and you don't have to do them alone.

What is your favorite GI organ and why?

The brain! It runs the show!

Favorite way to spend a day off?

An excellent cup of coffee, time outside, and a delicious meal with loved ones.

Best way to unwind after work?

Laughing with my kids and exercising.

Favorite AGA memory?

Any AGA Women in GI event!

If you could have dinner with anyone, who would it be and why?

The Obamas. They embody leadership, empathy, and vision.

What do you want to learn more about?

Brain–gut microbiome insights.

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