Take-Home Pearls: What Did We Learn Today?

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ACG PG Course 2025

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Session 1A: Clinical Conundrums in Everyday Gastroenterology

Evolving Perspectives on Colon Cancer Screening Methods

- **Start at 45** Guidelines agree, but <60% of eligible adults are screened. We must close this gap
- **New Options Rising** Stool & blood-based tests (mtsDNA 2.0, mtRNA, ctDNA) show strong sensitivity for CRC — but cost, intervals & false positives need careful study
- **Bigger Pie, Not a Shift** Colonoscopy stays key, while new tests expand reach to the unscreened

👉 **Offer CRC screening starting at age 45 and emphasize adherence — with new stool and blood-based tests expanding options, but colonoscopy remains the gold standard for prevention**

Navigating Therapies in IBD: Strategic Positioning of Emerging Drugs

- **New drugs expand options** — the therapeutic ceiling isn't broken yet.
- **Balance matters** — efficacy, safety, and access guide real-world choice. "newer" does not always mean "better"
- **Stay strategic** — treat-to-target with proactive monitoring

👉 **Next time I see an IBD patient, I'll choose therapy based on efficacy, safety, and access—and stay committed to a treat-to-target strategy with close monitoring**

Step-up versus Top-down Therapy in Eosinophilic Esophagitis

- **Shared decision-making** – consider patient preferences & comorbidities
- **Step-up** – start with PPI or less restrictive elimination diet (dairy +/- wheat)
- **Top-down** – early steroids or dupilumab in severe disease or concurrent atopic disorders

☞ **I will offer step-up or top-down therapy based on my patient's preference, lifestyle and comorbidities**

Functional Dyspepsia & Idiopathic Gastroparesis: When Is Motility Testing Needed?

- **Recognize overlap** – treat the predominant symptom
- **Let symptoms be your guide** – choose tests based on symptoms but don't over test
- **Augmentation therapy** – think beyond prokinetics and consider combining therapies with different MOAs

☞ **Next time I see a patient with dyspepsia, I will let the predominant symptom(s) guide my treatment and test those refractory to empiric therapy**

Session 1B: Clinical Guidelines in Action: Practical Applications

Acute Pancreatitis: Implementing Clinical Guidelines for Optimal Patient Outcomes

- **Identify moderate-severe disease early** – older patients with higher BMI and SIRS features at higher risk
- **Avoid aggressive IV hydration** – choose moderate hydration with lactated ringers 10 mL/kg bolus follow by 1.5 mL/kg/hr
- **Enteral nutrition** – Avoid TPN. Initiate enteral nutrition early for moderate to severe disease.

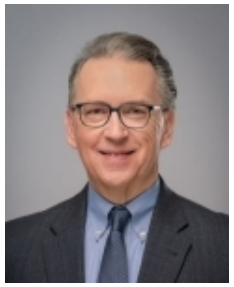
☞ **I will use lactated ringers and start nasojejunal enteral nutrition early in patients with moderate to severe acute pancreatitis**

Malnutrition and Nutritional Support in Liver Disease

- **Do NOT restrict protein** – even in patients with hepatic encephalopathy, aim for 0.5-0.7 g/lb body weight of protein per day
- **Late evening snacks** – prescribe a late evening snack ≥ 210 kcal each night
- **Avoid sugar** – limit fructose and sucrose to reduce hepatic steatosis

☞ **I will advise patients with chronic liver disease to limit sugar and salt and eat more plant-based protein**

Quality Assurance in Endoscopy: Metrics and Applications



- **Define quality** — bowel prep, ≥95% cecal intubation, ≥35% ADR, ≥6% SSL rate
- **Slow down** — ≥8-minute withdrawal with careful inspection
- **Prioritize safety** — aim for ≥90% adequate prep; it's a system responsibility

☞ **Next time I scope, I'll slow down, document metrics, and own quality from prep to withdrawal**

ACG Clinical Guideline for the Treatment of *H. pylori*: In With the New, Out With the Old

- **Avoid empiric clarithro/levofloxacin** — use only if susceptibility proven
- **First-line = Optimized BQT** (PPI + bismuth + tetracycline + metronidazole x14d); rifabutin triple or PCAB-based are alternatives.
- **Always confirm eradication** — UBT, stool antigen, or biopsy ≥4 weeks post-therapy

👉 **Treat right the first time, optimize dosing, and confirm eradication**

Symposium A: Microbiome Therapeutics: Separating Science From Pseudoscience

Nonprescription Therapeutics: Making Heads or Tails of Prebiotics, Probiotics, Synbiotics, and Postbiotics

- **Definitions:** Probiotics = live bugs, Prebiotics = “bug food,” Synbiotics = both, Postbiotics = inactive microbial products
- **Evidence is modest & condition-specific** — small benefits in AAD, pouchitis, NEC
- **Safety & cost matter** — mostly mild AEs, but rare infections in high-risk groups, and usually not covered by insurance

👉 **Consider probiotics only in select situations. For most GI conditions, evidence is weak, and the biggest adverse effect may be on the wallet**

Manipulating the Microbiome for the Treatment of Recurrent *Clostridioides difficile* Colitis

- **Diagnosis = clinical + tests** — interpret GDH/PCR/toxin carefully; avoid “test for cure”
- **Fidaxomicin > vancomycin** for reducing recurrence, but relapses still occur
- **FDA-approved microbiome therapies** outperform unregulated FMT

☞ **For recurrent *C. difficile*, think beyond antibiotics — fidaxomicin first if available, and microbiome-based therapies for prevention after multiple episodes**

The Who, What, and How of Small Intestinal Bacterial Overgrowth

- **SIBO is hard to define** — breath tests have limits, false +/– common.
- **Test selectively** — only in symptomatic patients with risk factors.
- **Treatment = antibiotics (rifaximin)** — weak evidence for retreatment, diet, probiotics, FMT

👉 Test and treat SIBO cautiously — focus on symptoms + risk factors and use shared decision-making

Symposium B: What to Expect When Your Patient Is Expecting: Navigating Gastroenterology Challenges in Pregnancy

Expecting and Inspecting: Contending with Endoscopy in Pregnancy

- **Anesthesia does not cause congenital abnormalities** – focus on avoiding hypoxia, hypotension, acidosis and hyperventilation
- **Optimize procedure timing and patient positioning** – defer nonurgent but necessary procedures to the 2nd trimester and position patients left lateral or left pelvic tilt
- **Prioritize patient safety** – multidisciplinary management to prioritize maternal and fetal safety

☞ **I will work with a multidisciplinary team to optimize safety in a pregnant patient who needs endoscopy during pregnancy rather than unnecessarily delaying the procedure**

Taming the Flames: Navigating Care and Therapeutic Safety in IBD and Pregnancy

- **Impaired fertility in IBD** – early preconception counseling improves outcomes
- **Active disease more harmful than medications** – continue preconception medications known to be safe in pregnancy to maintain remission. Avoid JAK inhibitors and S1P agonists (for now)
- **Chestfeeding possible on biologics** – no absolute contraindications in patients on biologics, thiopurines and mesalamine

☞ **In patients with IBD, I will prioritize disease remission and nutrition to improve fertility and pregnancy outcomes**

Bump in the Road: Grappling with Constipation and IBS During Pregnancy

- **Constipation common in pregnancy** – fiber, magnesium, PEG and lactulose generally safe and low risk
- **Avoid stimulant laxatives** – use bisacodyl or senna with caution due to lack of evidence. Lubiprostone can be used if benefits outweigh risks
- **Neuromodulators can be continued** – SSRIs (sertraline or escitalopram) preferred neuromodulator during pregnancy.

☞ **In patients with IBS who are stable on therapy, I will develop a shared pregnancy plan to avoid unnecessarily discontinuing medications and causing symptom flares**

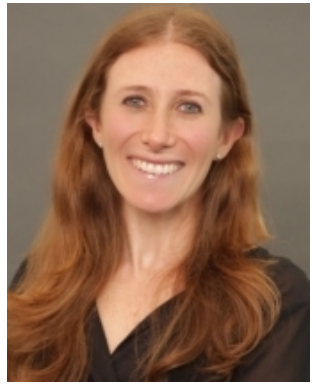
Symposium C: Obesity and Metabolic Mayhem: Unlocking the Role of Gastroenterologists

The Gastroenterologist's Role in Managing the Metabolic Dysfunction in MAFLD

- **MASLD common, focus on fibrosis** – fibrosis associated with increased morbidity and mortality
- **Treat F2/F3 fibrosis** – GLP1-RA and resmetirom available in the US
- **Lifestyle interventions for all** – optimize cardiometabolic factors and remember moderate alcohol consumption increases fibrosis risk in patients with MASLD

☞ **When I see a patient with "steatosis" on imaging, I will assess BMI, fasting glucose & lipids and BP to screen for MAFLD and assess fibrosis risk (e.g. FIB-4).**

Paging Dr. GI: Managing Complications of Bariatric Surgery



- **Marginal ulcers** – high dose open capsule PPI +/- sucralfate, smoking cessation, discontinue NSAIDS, test and treat *H. pylori*
- **GJ anastomotic stricture** – careful dilation with goal of symptomatic improvement. Do not exceed 15 mm
- **Sleeve stenosis** – diagnosis often delayed and requires high index of suspicion

☞ **When I see a patient with prior bariatric surgery, I will review the operative report and become familiar with the anatomy to help guide diagnosis & management**

The Hidden Costs of Anti-Obesity Medications: Navigating Side Effects in the Quest for Weight Loss

- **GI side effects common with GLP-1 RA** – most symptoms improve over time
- **Management of side effects** – dose reduction or slower titration, anti-emetics, bowel regimen, prokinetics
- **Endoscopy considerations** – risk of aspiration low, can consider clear liquid diet pre-procedure and assess risk for inadequate bowel preparation

👉 **When I see a patient who is benefiting from but experiencing GI side effects from GLP-1RA therapy, I will discontinue the therapy only as a last resort**

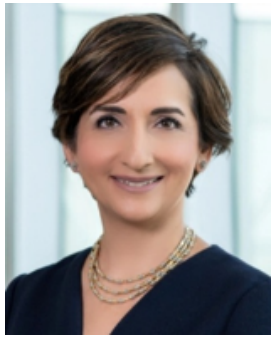
Session 1C: Hindgut Highlights: Emerging Trends and Clinical Practices

Getting to the Bottom of It: Conquering Benign Anorectal Disorders

- **Always do a DRE** – inspect the perineum, assess perianal sensation and anocutaneous reflex and perform digital maneuvers
- **Dyssynergic defecation** – accurately diagnose with an abnormal anorectal manometry and balloon expulsion test
- **Biofeedback therapy** – biofeedback therapy is first line for dyssynergic defecation and fecal incontinence

☞ I will use the history, detailed stool diary and ”enhanced” digital rectal exam to accurately diagnose anorectal disorders and characterize the severity of symptoms

Striking the Balance: Treatment Selection Based on Disease Severity in UC



- **Assess severity, not just activity** — guides early, appropriate therapy
- **Start advanced therapy early** in aggressive disease, avoid prolonged step-up
- **Balance efficacy & safety** — tailor choice to patient profile and risks

👉 **In UC, match treatment intensity to disease severity early, and personalize therapy by balancing disease risk with treatment risk**

Mastering Perianal Fistulas in Crohn's Disease: Approach to Evaluation and Management

- **Drain first** — control abscess with EUA/seton before medical therapy
- **Anti-TNFs = first-line** for complex pCD; add antibiotics, optimize troughs
- **Multidisciplinary care** — combine surgery, biologics, and emerging adjuncts

☞ For perianal Crohn’s, think “drain, drug, and team-up” — control the abscess, start biologics, and work closely with surgeons

See You Tomorrow

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