Take-Home Pearls: What Did We Learn Today?

SUNDAY, OCTOBER 26, 2025

ACG PG Course 2025

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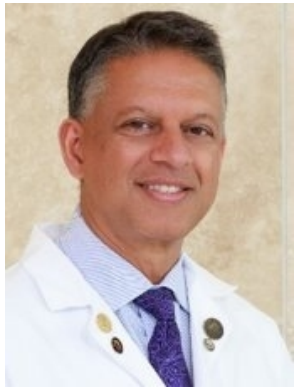
Session 2A: Foregut Focus: New Trends and Best Practices in Care

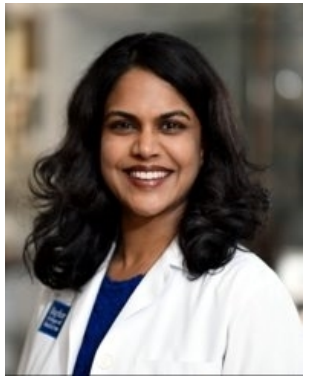
Grappling With GERD: New Frontiers in GERD Diagnostics and Therapeutics



- **Factors associated with PPI nonresponse** — suboptimal dosing, regurgitation predominant symptoms, superimposed behavioral syndromes
- **Consider PCABs** — severe erosive esophagitis (LA C/D), PPI nonresponders, patients with esophageal/gastric dysmotility, NERD
- **Endoscopic and surgical anti-reflux therapies** — increasing options available for patients with large hiatal hernia, refractory to medical therapy or patient preference

☞ **Practice Pearl: Perform esophageal physiology testing to confirm the diagnosis of GERD in patients with atypical symptoms and those not responding to therapy**

Getting Unstuck: Positioning of Esophageal Motility Testing in Patients with Esophageal Motility Disorders



- **High quality endoscopy** — assess and document **C**ontents, **A**natomy of the lumen, **R**esistance at LES, evidence of **S**tasis (i.e. Candidiasis) and retroflexion view of the hiatus
- **Assess primary esophageal symptom** — let the symptoms guide your diagnostic approach
- **Avoid over diagnosing EGJOO** — diagnosis requires abnormal IRP both supine AND upright, clinically relevant symptoms and additional supportive evidence

☞ **Practice Pearl: No one test is perfect — esophageal manometry, FLIP panometry and timed barium esophagram are complimentary**

Besting Barrett’s: Advances in the Diagnosis and Treatment of Barrett’s Esophagus

- **Screen smart** — use risk-based criteria; consider non-endoscopic options
- **Scope well** — high-quality EGD, 3–5 yr intervals; avoid repeat negatives
- **Treat right** — resect nodules (EMR/ESD), ablate flat

👉 **Practice Pearl: Barrett’s success = smart screening, precise scoping, and targeted therapy**

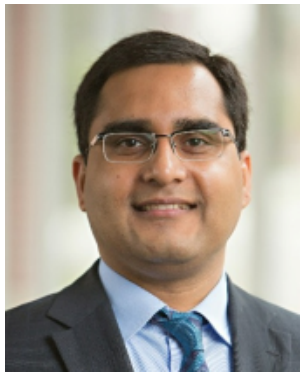
Stomach This: Approach to Precancerous Gastric Lesions

- **Do high-quality endoscopy** — use HD + image-enhanced scopes, 6-station photo-docs, and Sydney protocol biopsies
- **Collaborate with pathology** — report *H. pylori*, severity (CAG/GIM), and subtype (complete vs incomplete)
- **Survey smart** — only moderate- or high-risk cases need 3-year surveillance; low-risk shouldn’t be routinely followed

☞ **Good visualization, good biopsies, and good teamwork prevent missed gastric cancer**

Session 2B: Hospital Medicine and Gastroenterology: Integrated Care for Better Outcomes

Acute Severe Ulcerative Colitis: Optimizing Inpatient Management for Improved Outcomes



- **Diagnose early, act fast** — IV steroids (60 mg × 3–5 days) remain first-line; assess response by Day 3
- **Identify non responders quickly** — use Oxford or ADMIT-ASC scores; plan rescue with infliximab, cyclosporine, or JAK inhibitor
- **Comprehensive care saves colons** — rule out C. diff / CMV, provide VTE prophylaxis, nutrition, and early surgical input

👉 **ASUC success = Early recognition, timely rescue, and team-based care**

Diverticular Disease: Unpacking the Pockets of Mystery and Navigating Effective Management

- **Antibiotics not routine** — reserve for high-risk or complicated diverticulitis (immunocompromised, frail, severe CT findings)
- **Colonoscopy only after complicated cases** — or if not up to date with screening
- **Prevention = lifestyle** — high fiber, normal BMI, physical activity, low red meat; surgery helps select recurrent cases

☞ **Diverticulitis care is evolving — less antibiotics, more lifestyle, smarter follow-up**

Cancer Immunotherapy Related Gastrointestinal Toxicities

- **Early diagnosis matters** — use stool biomarkers (calprotectin, lactoferrin) and early endoscopy to grade severity
- **Steroid-refractory colitis needs targeted rescue** — infliximab or vedolizumab are first-line selective immunosuppressive therapies
- **Refractory cases respond to JAK/IL-12/23 blockade or FMT** — ustekinumab, tofacitinib, and microbiome therapy show promising results

☞ **ICI colitis is treatable — diagnose early, personalize rescue, and restore gut balance without halting cancer control**

Balancing Act: Managing Active Bleeding and Risk of Thrombosis in the Hospital

- **Triage** — limit use of reversal agents to life-threatening bleeding and resume therapy immediately after hemostasis (< 24 hours)
- **Endoscopic hemostasis** — thermal and mechanical modalities safe and effective
- **The heart always wins** — avoid discontinuation of cardiac ASA and prolonged discontinuation of antithrombotic therapy > 48-72 hours

👉 **Steps to prevent future GI bleeding: optimize PPI therapy, switch rivaroxaban to apixaban, test and treat *H. pylori* and absolutely avoid NSAIDs**

Managing Cirrhosis and Its Complications: Inpatient Strategies for Optimal Care

- **Infection until proven otherwise** — hospitalized patients may not manifest usual signs of infection. Clues include altered mental status, AKI or mild leukocytosis
- **Complications come as a package deal** — infection, AKI, hepatic encephalopathy, GI bleeding, malnutrition
- **Refer early**— refer/initiate liver transplant evaluation

☞ **Next time I see a hospitalized patient with cirrhosis, I will assume the patient is infected, start broad spectrum antibiotics early and conduct a thorough evaluation**

Symposium D: Integrative Approaches in Gastroenterology: Exploring Complementary and Alternative Therapies

CAM and Other Unconventional Avenues for IBD Relief

- **Integrative care is patient-driven** — up to 40% of IBD patients seek complementary therapies
- **Evidence is variable** — curcumin ± Qingdai, vitamin D, and omega-3s show modest benefit; cannabis improves symptoms but *not* inflammation
- **Whole-person wellness matters** — sleep, stress reduction, movement, and toxin avoidance can support remission and quality of life

👉 **Next time I see an IBD patient, I'll ask about supplements and lifestyle habits, discuss what's evidence-based, and align integrative options with their treatment goals**

CAM Secrets: Transforming Functional GI Disorders

- **Mind–gut therapies help** — hypnotherapy and CBT improve IBS symptoms and QoL
- **Cannabis & VR emerging** — promising but limited evidence.
- **Integrative care works** — combine evidence-based CAM with standard therapy

👉 **Next time I see a patient with functional GI symptoms, I'll ask about their stress, sleep, and interest in mind–body therapies — and consider adding hypnotherapy or CBT alongside standard care**

Digital Dilemmas: How to Help Patients Choose the Right GI Behavioral Health Digital Therapeutic

- **Digital therapeutics widen access** — CBT and gut hypnotherapy apps (e.g., Mahana, Regulora) deliver care remotely
- **Hybrid platforms add support** — virtual models (Oshi, Cara Care, Trellus) blend tracking, coaching, and care
- **Match tool to patient** — tailor by symptoms, comorbidities, and digital comfort

☞ **Next time I see a DGBI patient open to nonpharmacologic care, I'll recommend a vetted digital CBT or hybrid program tailored to their needs and access**

DGBI=Disorders of Gut–Brain Interaction

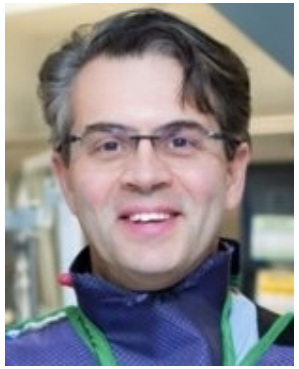
Symposium E: The Surprise Package: Decoding Incidentalomas in Gastroenterology

Spotlight on Liver Lesions: Uncovering the Mystery of Focal Findings

- **Suspect HCC with underlying cirrhosis** — any cyst in a patient with cirrhosis requires further evaluation
- **Beware of complex cysts**— refer for multidisciplinary discussion and surveillance imaging
- **Biopsy if atypical features** — adenomas with atypical features, especially in women, require biopsy to confirm

☞ Next time I see a patient with an isolated liver lesion on ultrasound, I will order a CT or MRI to better characterize the lesion and stratify risk for progression

Cysts With A Twist: Unraveling the Mysteries of Pancreatic Lesions



- **EUS-FNA intermediate risk** — CA 19-9, HgA1c, pancreatitis, abdominal pain, weight loss, worrisome features on imaging
- **Surveillance low risk < 1 cm** — MRI, CA 19-9, HgA1c every 2 years, consider stopping after > 5 years
- **Cyst ablation** — consider ablation for high risk IPMNs or MCNs; borderline surgical candidates

👉 **Next time I see a patient with a pancreatic cyst, I will add CA 19-9 and HgA1c to their MRI as part of the surveillance protocol**

“Beneath the Surface”: Decoding Submucosal GI Lesions

- **Avoid bite-on-bite biopsies**— EUS to confirm nonvascular lesion, avoid “blind” bite-on-bite biopsies
- **EUS solid nonlipomatous lesions** — nonlipomatous (hypo- or anechoic) subepithelial lesions should be referred for EUS and tissue sampling (FNB or FNA)
- **The GISTs** — gastric GISTs > 2 cm and ALL nongastric GISTs should be referred for resection

☞ **Next time I see a subepithelial lesion on endoscopy or colonoscopy, I will refer for EUS and refrain from the urge to take a bite-on-bite biopsy**

Symposium F: Autoimmune GI Disorders

Mysteries Revealed: Unraveling Eosinophilic Gastroenteropathies

- **Think EGID early** — chronic GI symptoms + mucosal eosinophilia = suspect EGID, not IBS
- **Diagnose with biopsies** — histology and DDx review are essential; involve pathology if unclear
- **Treat, then transition** — steroids work first-line, but new biologics (anti–IL-5, IL-13, IL-4R) show promise

☞ **Next time I see unexplained GI inflammation with eosinophilia, I'll biopsy widely, rule out mimics, and consider EGID in the differential**

Grains of Truth: Update on the Diagnosis and Management of Celiac Disease

- **Test smart** — TTG IgA (plus total IgA) is the best screen; biopsy needed unless TTG IgA >10× ULN with high suspicion
- **Screen relatives** — first-degree family members carry 10–20% risk
- **Treat & monitor** — lifelong gluten-free diet, dietitian support, follow TTG IgA for adherence

☞ **Next time I suspect celiac, I'll confirm with serology + biopsy (if needed), educate on GFD, and check family risk**

Unlocking the Liver: Decoding Autoimmune Liver Diseases

- **AIH needs biopsy + immunosuppression** — prednisone ± azathioprine; MMF or tacrolimus if refractory
- **PBC starts with UDCA** — add bezafibrate or seladelpar if ALP stays >1.67× ULN
- **ICI liver injury** — hold drug, start steroids, add MMF if severe or refractory

☞ Next time I see abnormal LFTs with autoimmune pattern, I'll confirm with biopsy, tailor immunosuppression, and monitor closely for overlap

Session 2C: Innovations in Gastroenterology: Shaping the Future of Digestive Health

Advances in Diagnostic Strategies for Inflammatory Bowel Disease

- **IBD diagnosis is evolving** — endoscopy remains gold standard; IUS, MRE, and biomarkers enhance precision
- **Tight control works** — use calprotectin, CRP, and imaging to guide treat-to-target care
- **Precision medicine is next** — genetic and predictive biomarkers may personalize therapy and prevent relapse

👉 **Next time I manage an IBD patient, I'll use noninvasive tools for monitoring and tailor therapy using risk and biomarker data**

AI in GI: What You Need to Know to Not Be Obsolete

- **AI is accelerating** — exponential growth across endoscopy, imaging, and clinical decision support.
- **Adoption curve matters** — innovators lead, laggards risk being left behind
- **AI augments, not replaces** — gastroenterologists who integrate AI will elevate precision and efficiency

👉 I'll will keep exploring and learning about AI tools that enhance and streamline workflow in my practice

Gadgets and Gizmos: New Tools for the Evaluation of Patients with GI Motility Disorders

- **Testing in DGBI is evolving** — newer technology can help clarify the diagnosis in patients with atypical presentations
- **Personalized medicine through physiology** — understanding pathophysiology can guide therapy
- **Just because you can, doesn't mean you should** — avoid exhaustive testing in everyone

☞ **I will become familiar with new technology and consider how to apply them in my clinical practice**

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