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In this issue

A Pivotal Moment for Global Gastroenterology

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It is with great honor, sincere gratitude, and a deep sense of responsibility that I assume the Presidency of the World Gastroenterology Organisation. I begin this journey with profound respect for the distinguished leaders who have guided WGO over the years, and with appreciation for the unwavering dedication of our Governing Council, our member societies, our global partners, and the countless colleagues and volunteers who have built and sustained this remarkable organization. Their leadership, vision, and commitment have laid the foundation for our continued growth.

We stand today at a pivotal and inspiring moment for global gastroenterology and for our organization. Rapid scientific advancement, new educational paradigms, evolving healthcare challenges, and the imperative for equitable access to care call upon us to respond with creativity, collaboration, and purpose. At the same time, we are mindful that we operate in a world of finite financial resources, which requires us to prioritize wisely, innovate responsibly, and ensure that every initiative delivers real value and lasting impact. The strength of WGO has always resided in its truly global spirit — uniting regions, sharing knowledge across cultures, fostering professional development, and supporting clinicians and patients in every corner of the world.

Over the next two years, our work will be shaped around four central pillars — Belonging, Excellence, Sustainability, and Transparency (BEST).

Belonging – strengthening inclusion, community, and engagement across our member societies and the global gastroenterology community.

Excellence – advancing high-quality education, training, innovation, and clinical care through modern, accessible, and impactful programs.

Sustainability – ensuring the long-term financial strength, institutional stability, and operational resilience of WGO, developing responsible funding models, strengthening partnerships, and investing wisely in programs that guarantee continuity, impact, and growth.

Transparency – reinforcing trust, accountability, and open, transparent governance throughout all aspects of our work.

As a first and essential step, we will focus on developing a comprehensive Strategic

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Prof. Olano poses alongside several WGO Past Presidents, along with President-Elect, Prof. Vivek Kaul (far left), and Train the Trainers Committee Chair, Prof. Wojciech Marlicz (far right).

Plan to guide WGO over the coming years. This plan will be forward-looking, inclusive, pragmatic, and firmly anchored in our mission and values, ensuring that our programs, partnerships, governance, and financial structure are aligned with a strong and sustainable future.

This will be a time of shared effort, constructive dialogue, and collective ambition. I warmly invite our members, partners, and colleagues to join us, contribute ideas, and work together as we continue to build a stronger, more innovative, more inclusive, and truly global WGO.

Thank you for your trust. Together, we will shape what comes next.

Carolina Olano
WGO President

Prof. Olano poses with a bouquet on behalf of the Uruguayan Society of Gastroenterology, presented to her after being ratified as President at the 2025 WGO General Assembly in Melbourne, Australia.

Welcome *e-WGN*'s New Co-Editor

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Dear colleagues,

Welcome to the first 2026 issue of *e-WGN*.

As we transition into a new term for the WGO, we express our gratitude to Past President, Professor Geoffrey Metz (Australia) who has led WGO with wisdom, grace, and a steadfast commitment to the organization's global mission over the last two years. Let us now welcome WGO's new President, Professor Carolina Olano (Uruguay). As a world-renowned expert and a tireless advocate for academic excellence, Professor Olano brings dynamic energy and a visionary roadmap for the future. We also welcome the new Governing Council and committee members of WGO as detailed later in this issue.

Regarding our editorial team, we thank Professor Mahesh Goenka (India) for his invaluable service as Co-Editor-in-Chief and look forward to his continued guidance and support for the publication. It is my pleasure to introduce our new co-editor, Associate Professor Dao Viet Hang, MD, PhD. Dr. Hang is the Director of the Endoscopy Center at Hanoi Medical University Hospital and a Senior Researcher. In addition, she serves as Vice General Secretariat for both the Vietnam Association of Gastroenterology (VNAGE) and the Vietnam Association for the Study of Liver Diseases (VASLD).

As we embark on this new editorial year, our global community continues to witness an extraordinary acceleration in the transition from generalized care to "precision" medicine.

Our Expert Point of View articles for this issue focus on three areas where the molecular understanding of disease is fundamentally changing how we treat our patients.

The first EPOV addresses the new era for Alcohol-Associated Hepatitis (AH) which has long suffered from a lack of therapeutic innovation. Prof. Nancy Reau, Dr. Jonathan Lee, and Dr. Zoë Post emphasize that we are finally moving beyond the "steroid-only" era towards promising modulators like Larsucosterol (DUR-928) and Fecal Microbiota Transplantation (FMT), showing significant potential to lower the 50% 90-day mortality rate that has plagued this patient population for decades.

"Challenge of Dissociation in Crohn's Disease" is the title of the second EPOV. Drs. Atteyat Semeya, Rehab Ahmed, and Raafat Saad provide a critical analysis of the clinical-endoscopic-histologic dissociation in IBD, especially in Crohn's disease. By advocating for a Treat-to-Target paradigm, the authors challenge us to dive beyond symptom control and aim for "deep remission" as the only way to prevent irreversible structural damage in Crohn's disease.

With global prevalence projected to rise sharply through 2037, Dr. David T. Dulaney explores the "treatment gap" in Eosinophilic Esophagitis throughout the third EPOV. The recent approval of Dupilumab represents a milestone in therapy, as it is the first biologic to successfully target the core type 2 inflammatory drivers of the disease. Furthermore, the analysis of investigational therapies like Cendakimab and Etrasimod suggests that the future of esophageal health lies in highly specific, molecularly guided interventions.

In a reflection for International Women's Day 2026, Prof. Lubna Kamani and Alizeh Arshad deconstruct the "Myth of Merit" in academia. They argue that systemic barriers create an accumulated disadvantage for women, necessitating a fundamental restructuring of how institutions evaluate and promote talent through the #GiveToGain philosophy.

WGO News is very vibrant and diverse! Global reports further demonstrate the power of collaboration and the rapid adoption of technology

across the globe:

Co-hosted by the New Zealand Society of Gastroenterology and the New Zealand Gastroenterology Nurses' College, the 2025 Annual Scientific Meeting (ASM 2025) stood as a premier showcase of international collaboration. The event not only fostered world-class scientific exchange but also championed community spirit through initiatives like the charity Fun Run for Crohn's & Colitis New Zealand.

Dr. Juan David Linare and colleagues provided a warm reflection on a landmark successful gastroenterology conference in Barranquilla, Colombia. In a standout collaboration with WGO, global experts provided critical updates on high-prevalence conditions and advanced endoscopic techniques, as well as extensive research. A centerpiece of the event was the WGO-ACG Symposium, where international leaders including WGO President Dr. Carolina Olano, Dr. José María Sanguinetti, and Dr. Luis Carlos Sabbagh shared cutting-edge updates on IBS, intestinal failure, and advanced endosonographic biliary drainage.

APDW 2025 in Singapore gathered over 3,000 delegates united under the theme, "Innovate, Integrate, Invigorate." Dr. Stephen Tsao, president of APDW 2025, reported that the congress solidified Singapore as a hub for AI, robotics, and microbiome science, emphasizing a holistic future for integrated patient care.

In this update, Dr. Áureo de Almeida Delgado, President of the Brazilian Federation of Gastroenterology, reflects on the record-breaking success of SBAD 2025. Held in São Paulo, the event gathered 5,500 specialists to address the unique epidemiological challenges of Brazil, particularly the seasonal spike in digestive emergencies.

Drawing nearly 2,000 participants from 47 countries, the KDDW 2025 meeting in South Korea focused on the "bench-to-bedside" evolution of gastroenterology, specifically the clinical integration of AI, precision medicine, and digital healthcare, in addition to building inter-society partnerships to reduce global health disparities.

During the AHPBCC 2025 in Johannesburg, over 200 experts united to bridge laboratory research and clinical practice for African hepatobiliary cancers. Biomedical scientist Samuel Jere highlighted the essential role of genomics and T-cell proteomics in advancing early detection and personalized treatment protocols on the African continent.

We cordially invite you to share your recent publications, success stories, society news and activities, as well as your experience with WGO courses and committees for future issues of *e-WGN*. Follow WGO social media pages for updates!

Sincerely,

Dr. Nancy Fanous, Egypt
Dr. Dao Viet Hang, Vietnam

Alcohol-Associated Hepatitis: Current Guidelines and Promising Emerging Therapies

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Introduction

Alcohol-associated hepatitis (AH) is a subset of alcohol-related liver disease characterized by acute liver inflammation in the setting of significant alcohol use. It is associated with significant morbidity and a 90-day mortality rate ranging as high as 30-50%.[1, 2] The clinical manifestations of AH can vary from the rapid onset of jaundice to acute-on-chronic liver failure, particularly in patients with underlying liver pathology or alcohol use disorder (AUD). Female sex, and increased body mass index (BMI) remain the most established risk factors for the development of AH. While heavy alcohol consumption is commonly observed amongst patients who develop AH, the exact thresholds for amount and duration of alcohol use are still unknown. One recent systematic review estimated the prevalence of AH to be approximately 3.5% in unselected populations.[3] However, the highest incidence rates in the United States are found amongst individuals aged 40-59, with a startling increase in incidence being observed amongst young adults aged 20-39 years in recent years.[4]

The diagnosis of AH is based upon clinical history, physical examination, and laboratory evaluation. The most widely accepted diagnostic criteria proposed by a consortium of experts from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is summarized in **Table 1**.[5]

Liver biopsy can further confirm the diagnosis if uncertainty exists. Several scoring systems based upon histological findings have been observed to have prognostic value, with the presence of cirrhosis conferring a worse prognosis.[6]

Once diagnosed, AH is further classified based on severity and a patient's likelihood to benefit from pharmacologic therapy. Current guidelines recommend using the well-validated Model for End-Stage Liver Disease (MELD) or Maddrey discrimination function (DF) scores for assessing

Table 1. NIAAA diagnostic criteria for AH

NIAAA diagnostic criteria	Alcoholic hepatitis
Onset of jaundice	Within prior 8 weeks
History of alcohol use	Ongoing consumption of >40 (roughly 3 standard drinks) in females or 60 (roughly 4 standard drinks) g alcohol/day in males for ≥6 months, with <60 days of abstinence before onset of jaundice
Transaminases	AST > 50, AST/ALT > 1.5, and both values < 400 IU/L
Serum bilirubin levels	Serum total bilirubin level >3.0 mg/dL
Confounding factors	Absence of confounding factors (ischemic hepatitis, metabolic liver disease, DILI, uncertain alcohol use assessment, atypical laboratory findings)

AST = aspartate transaminase; ALT = alanine transaminase; IU = international units; DILI = drug induced liver injury

disease severity and risk stratification.[7] Severe AH is defined as a MELD ≥21 or DF >32 and is associated with significant short-term mortality (30% at 1-month, 30-50% at 90 days, and >50% past 1 year).[8] The majority of existing and ongoing studies on AH prognosis and future therapies have been developed in patients meeting these thresholds. Conversely, patients with MELD <21 or DF <32 are traditionally classified as having "non-severe" or "moderate" AH. Mortality in patients with moderate AH has been observed to be as high as 3-7% at 1-3 months and 13-20% at the 1-year mark.[9] This represents an overlooked population whose incidence is likely underestimated given many of these patients often present with mild symptoms that might not necessarily warrant hospitalization.

Our understanding of the diagnosis and pathogenesis of AH continues to evolve. However, there remains a paucity of effective therapies tailored towards its treatment, leaving alcohol abstinence and nutritional support as the long-term bedrocks of therapy. In severe AH, glucocorticoids have been found to improve 30-day mortality without improvement in longer term mortality.[10] A recent study consisting of a large international cohort of 3380 patients revealed glucocorticoid therapy improved 30-day mortality in AH patients with MELD >20, with an even greater survival benefit being observed in patients with MELD scores of 25-39.[11] Unfortunately, glucocorticoids remain a crude and imperfect therapeutic tool, often predisposing patients to increased infections and other well-documented side effects. There is also no conclusive evidence that glucocorticoids significantly improve survival in AH patients beyond 1 month. In this review, we will summarize the current management of AH and discuss novel therapies currently under investigation in which preliminary results from randomized clinical trials (RCTs) have shown benefit.

CURRENT MANAGEMENT GUIDELINES

A summary of the most recent society guidelines for the management of AH is summarized in **Table 2**.[12-14]

Alcohol abstinence

Alcohol abstinence remains the cornerstone of long-term AH management given its main pathophysiologic mechanism is related to liver toxicity from excessive alcohol consumption. Although there is a lack of survival data in severe AH patients, abstinence has been found to be independently associated with long-term prognosis in moderate AH and is the only inter-

Table 2. Summary of society guidelines for the management of AH

Management Component	AASLD (2020)	EASL (2018)	ACG (2024)
Disease Severity Definition	Severe AH: MDF ≥32 or MELD >20	Severe AH: MDF ≥32 or MELD >20	Severe AH: MELD >20
Corticosteroid Therapy	Prednisolone 40 mg/day for severe AH without contraindications; maximum benefit at MELD 25-39	Prednisolone 40 mg/day for severe AH	Corticosteroid therapy for severe AH (MELD >20) if no contraindications; maximum benefit at MELD 25-39; careful consideration if MELD >50
Response Assessment	Lille score at day 7 to identify nonresponders and guide treatment course	Lille score at day 7; continue if <0.45, discontinue if nonresponder	Lille score at day 7 or day 4; discontinue corticosteroids if Lille >0.45
N-Acetylcysteine	Addition of IV NAC to prednisolone may improve 30-day survival	NAC with prednisolone improved 1-month survival but not 6-month survival	IV NAC as adjuvant to corticosteroids (strong recommendation)
Nutritional Support	Malnutrition should be addressed and treated, preferably with enteral nutrition	35-40 kcal/kg/day with 1.5 g protein/kg/day	Oral nutritional supplements for malnourished patients; enteral nutrition if unable to meet requirements despite supplements; goal 35 kcal/kg/day with 1.2-1.5 g protein/kg/day
Early Liver Transplantation	May be considered in carefully selected patients with favorable psychosocial profiles in severe AH not responding to medical therapy	Consider for select patients with severe AH not responding to medical therapy	Consider for highly selected patients unresponsive to medical management with high mortality risk, according to regional/institutional protocols
Abstinence	Key to long-term survival; use AUD treatment methods	Recommended in all patients with AH	Sustained abstinence associated with long-term survival; offer integrated multidisciplinary care with behavioral/pharmacotherapy
References	[12]	[13]	[14]

vention thus far to increase 6-month survival.[15] Many patients diagnosed with severe AH also concurrently suffer from significant alcohol use disorder (AUD). High rates of relapse of alcohol consumption shortly after recovery from AH are common complications that place patients at high-risk for repeated episodes of AH and thus worsen both short- and long-term prognosis. Despite this clinical challenge, achieving complete alcohol abstinence remains the goal for all AH and AUD patients.

Integrated addiction treatment incorporating motivational interviewing, pharmacological therapies, and cognitive behavioral therapy (CBT) have become the mainstay of helping patients achieve alcohol abstinence.[16] Naltrexone, disulfiram, and acamprosate remain the only US Food and Drug Administration (FDA)-approved pharmacologic drugs available to treat AUD in the outpatient setting. However, patients with severe AH associated with significant liver dysfunction are likely not great candidates for these drugs. Additionally, despite their efficacy, only 10% of those with AUD receive any form of treatment, and less than 1% of those with AUD receive any FDA-approved medications.[16] Other pharmacologic therapies such as gabapentin, baclofen and topiramate are currently prescribed off-label and remain under investigation.

Nutritional support

There is a high prevalence of malnutrition among patients with AH, with recent literature finding almost all patients with severe AH possessing some component of malnourishment.[17] The degree of malnutrition often correlates with the clinical severity of liver dysfunction and increases the risk of infections and death, especially in patients with concomitant decompensated liver failure. Thus, early assessment of nutritional status and ensuring adequate caloric, protein, vitamin, and electrolyte intake to prevent progression to sarcopenia are essential to overall AH treatment.

Oral and enteral nutritional support are preferred in all patients with AH regardless of severity. Patients with severe AH often present with extremely poor oral intake and inadequate caloric and protein goals. Updated guidelines recommend a high-protein, high-energy diet consisting of 1.2-1.5 g/kg protein and 35-40 Kcal /kg calories per day.[18]

Liver transplantation

Patients with severe AH unresponsive to medical therapy were historically deemed ineligible for liver transplantation due to the lack of a minimum duration of sobriety. However, a 2011 landmark study by Mathurin et al. completely shifted this paradigm when it demonstrated early liver transplantation significantly improved 6-month survival post-transplant compared to a historical cohort (77% vs 23%).[19] The previous "6 months of sobriety" rule was subsequently rejected due to the lack of supporting scientific evidence and clear survival benefit from early liver transplantation that has been replicated in follow-up studies.[20] Current consensus formerly recognizes severe refractory AH as an indication for liver transplantation with considerations for social status, presence of active substance use, and disease insight, among other factors.

PROMISING NOVEL THERAPIES UNDER INVESTIGATION

Numerous studies in recent years have sought to investigate the efficacy of several biological molecules in the treatment of AH. The results of these studies are summarized in **Table 3**.

Liver regeneration stimulation

DUR-928

DUR-928 acts as an epigenetic modulator that regulates the expression of multiple clusters of master genes involved in down-regulating lipotoxicity, stabilizes mitochondria, and reduces inflammatory and stress responses. A recent phase IIa, multicenter, open label, dose escalation trial in 19 AH patients found notable reductions in serum bilirubin levels at days 7 and 28 and MELD scores at day 28 with no reported adverse events.[21] Additionally, Lille scores from 8 subjects with severe AH who received 30 or 90 mg DUR-928 were statistically significantly lower ($p < 0.01$) than those from subjects with severe AH treated with standard of care from a contemporaneous study. DUR-928 represents arguably the most promising novel therapy to date, and its therapeutic potential continues to be evaluated in an ongoing phase 2b, multicenter, randomized, double-blinded, placebo-controlled trial (AHFIRM, NCT04563026).

Granulocyte colony-stimulating factor (G-CSF)

G-CSF is a glycoprotein that stimulates the bone marrow to mobilize hematopoietic CD34+ stem cells into the bloodstream. Animal models had previously demonstrated the potential for G-CSF administration to induce liver regeneration and improve survival. A recent meta-analysis of 7 RCTs (n=336) showed a 90-day survival benefit (OR 0.28, 95% CI: 0.09–0.88; $p = 0.03$) and reduced risk of developing infections in patients receiving G-CSF compared to placebo or pentoxifylline.[22] However, despite its excellent safety profile, definite conclusions regarding the usefulness of G-CSF in AH cannot be made, as high heterogeneity was observed in the overall analysis caused by conflicting results between the Asian and European studies.

Inflammation amelioration

Interleukin (IL)-22

IL-22 plays a crucial role in hepatoprotection through its anti-apoptotic, regenerative, and anti-fibrotic effects. Its effects are mediated predominantly through the STAT3 signaling pathway and helps reduce hepatic injury by decreasing production of proinflammatory cytokines (e.g. tumor necrosis factor-α, IL-6) and ameliorating oxidative stress. A phase IIb trial studying the use of F-652 (an IL-22 analog) in 18 AH patients demonstrated a significant decrease in MELD score, proinflammatory cytokine markers, and serum aminotransferases while also observing an increase in hepatic regeneration markers at days 28 and 42 from baseline ($p < 0.05$).[23] Ongoing clinical trials continue to evaluate the safety and efficacy of IL-22 analogs, but preliminary results are promising, especially with no significant associated adverse effects being reported thus far.

Infliximab

Infliximab is a TNF-α inhibitor that has been commonly used to treat chronic inflammatory pathologies such as rheumatic arthritis and inflammatory bowel disease. One systematic review of five studies found that 1-month mortality ranged from

Table 3. Overview of pharmacological therapies under investigation for treatment of AH

Therapy	Mechanism of action	Study type	Number of participants	Outcome	Trial reference
Liver regeneration stimulation					
DUR-928 (Larsucosterol)	Epigenetic modulation involved in down-regulation of lipotoxicity, mitochondrial stabilization, and inflammatory/stress reduction.	Phase 2a RCT	19	Notable declines in serum bilirubin levels and MELD scores at day 28. Lower Lille scores (p<0.01) in severe AH compared to standard of care.	21
Granulocyte colony-stimulating factor (G-CSF)	Stimulates bone marrow to mobilize CD34+ stem cells that can induce liver regeneration.	Meta-analysis	396	90-day survival benefit (OR 0.28, 95% CI: 0.09–0.88; p = 0.03) and reduced infection risk in patients receiving G-CSF compared to placebo or pentoxifylline.	22
Inflammation amelioration					
Interleukin (IL)-22	Decreases production of proinflammatory cytokines and ameliorates oxidative stress.	Phase 2 RCT	18	Significant decrease in MELD score, proinflammatory cytokine markers, and serum aminotransferases while also observing an increase in hepatic regeneration markers at days 28 and 42 from baseline (p < 0.05).	23
Infliximab	↓ tumor necrosis factor-α (TNF-α) inflammation	Systematic review	70	1-month mortality ranged from 10% to 17% in patients with severe AH who received a single dose of infliximab with or without prednisone.	24
Anakinra	IL-1 receptor inhibitor,↓ inflammation and liver injury	Phase IIb RCT	73	Trial stopped early after a prespecified interim analysis showed prednisone was associated with higher 90-day overall survival (90% vs. 70%, p = 0.018) and transplant-free survival (88% vs. 64%, p = 0.004).	25
Anti-oxidants					
Metadoxine	Antioxidant and antifibrotic. Inhibits hepatic steatosis	RCT	135	Significantly improved 3- (68.6% vs 20%, p = 0.0001) and 6-month survival rate (48.6% vs 20%, p = 0.003) compared to prednisone therapy.	26
Gut-liver axis					
Fecal microbiota transplantation (FMT)	Improvement of gut microbiota diversity	Prospective RCT	120	Significantly improved 90-day survival (75% vs 56.6%, p = 0.044) and reduced incidence of deaths due to infection (3.6% vs 19.3%, p = 0.01) at the 90-day mark compared to daily prednisolone.	27

10% to 17% in patients with severe AH who received a single dose of infliximab with or without prednisone compared to 38% in patients who received three doses of infliximab in combination with prednisone.[24] While this review did note the potential for single-dose infliximab to act as an alternative agent with contraindications to steroids, further studies are needed to confirm these findings.

IL-1 receptor inhibitors

Anakinra is an IL-1 receptor inhibitor with anti-inflammatory properties. While it has been associated with a reduction in alcohol-associated hepatic steatosis, a recent phase IIb double-blind RCT studying the efficacy and safety of anakinra + zinc (A+Z) compared to prednisone was stopped early after a prespecified interim analysis showed prednisone was associated with higher 90-day overall survival (90% *vs.* 70%; hazard ratio for death = 0.34, 95% CI 0.14–0.83, p = 0.018) and transplant-free survival (88% *vs.* 64%; hazard ratio for transplant or death = 0.30, 95% CI 0.13–0.69, p = 0.004) than A+Z.[25]

Anti-oxidants

Metadoxine

Metadoxine (MTD) is an antioxidant that participates in glutathione synthesis and inhibits hepatic steatosis. An open-label study randomized 135 patients with severe AH into either daily prednisone (PDN) therapy, PDN+MTD three times daily therapy, pentoxifylline (PTX) three times daily therapy, or PTX+MTD three times daily for 1 month. MTD was found to significantly improve the survival rate at 3- (PTX+MTD 59.4% *vs* PTX 33.3%, p = 0.04; PDN+MTD 68.6% *vs* PDN 20%, p = 0.0001) and 6-months (PTX+MTD 50% *vs* PTX 18.2%, p = 0.01; PDN+MTD 48.6% *vs* PDN 20%, p = 0.003); MTD patients also maintained greater alcohol abstinence than the other study groups (74.5% *vs* 59.4%, p = 0.02).[26] While RCTs with larger sample sizes are needed, these results signal that metadoxine is a safe therapy with potential benefits in AH patients.

Gut-liver axis

Fecal microbiota transplantation (FMT)

Gut microbiota have long been theorized to play a role in the pathogenesis of AH and represents another promising research area of interest. A recent open-label study randomized 120 patients with severe AH into daily prednisolone therapy for 28 days or daily healthy donor FMT for seven days. FMT was found to significantly improve 90-day survival (75% vs 56.6%, p = 0.044, FMT HR = 0.528, 95% CI 0.279–0.998) and reduced the incidence of deaths due to infection (3.6% vs 19.3%, p = 0.01) at the 90-day mark.[27] FMT continues to be a promising avenue for further clinical trials given its encouraging results in recent studies. However, given past reports of infections transmitted from FMTs triggering FDA alerts, more studies on the risks versus benefits of FMTs in immunocompromised AH populations (i.e. on or recently received steroid therapy) are needed. Additionally, the high cost of FMT is an additional potential barrier for widespread adoption.

Conclusions

AH is a severe complication of significant chronic alcohol use that is associated with high morbidity and mortality. Although our understanding of its pathogenesis through the gut-liver axis and inflammatory pathways has continued to deepen, there remains a scarcity of efficacious therapeutic options for its treatment. Alcohol abstinence and nutritional support remain the mainstays of long-term management. For patients presenting with acute severe AH, glucocorticoids are the pharmacological treatment of choice. However, there is limited evidence to suggest they improve survival beyond the immediate short-term, and their potent side effects with prolonged treatment present a significant challenge for many patients and practitioners. While many novel therapies under investigation have borne mixed or only early results thus far, liver regeneration stimulants like DUR-928 and advances in FMT represent promising avenues of research that bring hope that our collective lack of effective treatments for AH will soon come to an end.

References

Readers may access the full list of references here.

Clinical-Endoscopic-Histologic Discrepancies in Inflammatory Bowel Disease: An Expert Perspective with Special Focus on Crohn's Disease

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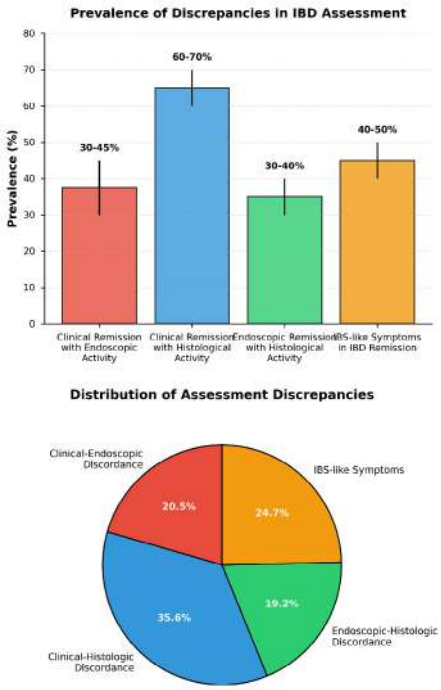

Figure 1

Introduction

The assessment of disease activity in inflammatory bowel disease (IBD), particularly Crohn's disease (CD), represents a complex clinical challenge that extends beyond traditional symptom-based evaluation. A growing body of evidence demonstrates significant and often clinically meaningful discrepancies between patient-reported symptoms, endoscopic findings, and histological inflammation. This phenomenon, often termed "clinical-endoscopic dissociation" or "histologic-endoscopic discrepancy," has profound implications for therapeutic decision-making, disease monitoring, and long-term outcomes.

The modern paradigm of IBD management has evolved from symptom control toward objective measures of mucosal healing, driven by compelling evidence that endoscopic remission predicts superior long-term outcomes including reduced hospitalization, surgery, and disease progression.[1] However, the relationship between clinical symptoms, endoscopic appearance, and microscopic inflammation is far from linear, creating diagnostic and therapeutic dilemmas that clinicians face regularly in practice.

THE SPECTRUM OF DISCREPANCIES

Clinical Remission with Endoscopic Activity

Perhaps the most clinically significant discrepancy occurs when patients report symptomatic improvement or complete clinical remission while harboring ongoing endoscopic inflammation. Studies consistently demonstrate that 30-45% of patients with Crohn's disease in clinical remission have active endoscopic disease, and up to 60-70% demonstrate persistent histological inflammation despite clinical quiescence.

This dissociation carries substantial prognostic implications. Patients with persistent endoscopic activity despite clinical remission have significantly higher rates of clinical relapse within 12-18 months compared to those achieving both clinical and endoscopic remission. A landmark study by Frøslie et al.[1] demonstrated that mucosal healing, defined as the ab-

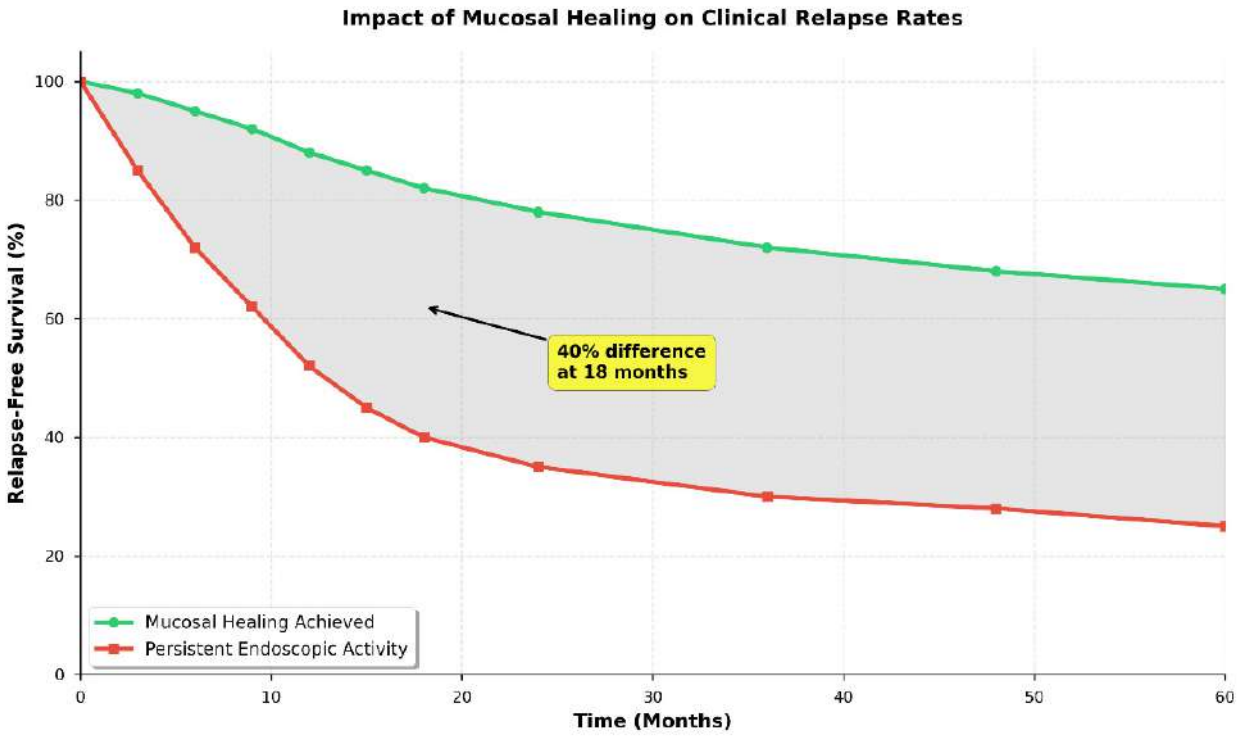

Figure 2

sence of ulceration on endoscopy, was the strongest predictor of sustained clinical remission over five years, surpassing clinical indices in prognostic value.

Several mechanisms underlie this discrepancy. First, symptom generation in IBD is multifactorial and not exclusively related to active inflammation. Factors including visceral hypersensitivity, altered gut motility, bile salt malabsorption, bacterial overgrowth, and psychological factors contribute to symptom experience independent of inflammatory burden.

Second, the threshold for symptom generation varies considerably between individuals, with some patients remaining asymptomatic despite moderate endoscopic inflammation while others experience significant symptoms with minimal visible disease.

Third, anatomical factors play a crucial role. Inflammation in bowel areas with less sensory innervation (such as the terminal ileum) may produce fewer symptoms than disease in more sensitive areas (such as the rectum). Stricturing disease may cause minimal inflammation but significant symptoms through mechanical obstruction, while active inflammation in a capacious segment may produce little symptom burden.

Endoscopic Remission with Persistent Histological Activity

The advent of treat-to-target strategies emphasizing mucosal healing[2, 3] has highlighted another important discrepancy: the presence of histological inflammation despite endoscopic remission. Recent studies employing systematic biopsy protocols have revealed that 30-40% of patients with endoscopic mucosal healing in Crohn's disease demonstrate persistent microscopic inflammation on histology.

This histologic activity in the absence of endoscopic lesions is not merely an academic observation. Emerging evidence suggests that histological remission predicts more durable clinical remission than endoscopic healing alone.[4, 5] Patients achieving both endoscopic and histological remission have lower rates of clinical relapse and disease progression compared to those with endoscopic healing but persistent microscopic inflammation.

The pathophysiological basis for this discrepancy relates to the resolution kinetics of inflammation. Macroscopic healing occurs relatively rapidly with effective therapy, as ulceration epithelializes and gross mucosal architecture improves.[6] However, complete resolution of microscopic inflammation—including normalization of crypt architecture, elimination of basal plasmacytosis, and resolution of lamina propria inflammatory infiltrates—occurs more slowly and may lag endoscopic improvement by months.

Furthermore, endoscopic assessment, even with high-definition technology, has inherent limitations in detecting subtle mucosal abnormalities.

Mild erythema, granularity, or villous blunting may be endoscopically unapparent yet histologically significant. Sampling error also contributes to discrepancy, as random biopsies may miss patchy microscopic inflammation in areas appearing endoscopically normal.

Active Symptoms with Minimal Endoscopic Findings

A particularly challenging clinical scenario occurs when patients report significant symptoms despite minimal or absent endoscopic inflammation. This pattern is increasingly recognized in IBD and raises important differential diagnostic considerations.

Several mechanisms account for this discrepancy. Irritable bowel syndrome (IBS)-like symptoms are common in IBD patients in remission, occurring in up to 40-50% of cases. These symptoms reflect visceral hypersensitivity, altered gut-brain signaling, and microbiome dysbiosis rather than active inflammation. Distinguishing between IBS-type symptoms and true disease activity remains challenging, as clinical indices like the Crohn's Disease Activity Index (CDAI)[13] do not differentiate between inflammatory and functional symptoms.

Small bowel inflammation beyond the reach of colonoscopy represents another important cause. Standard colonoscopy with ileoscopy examines only the terminal ileum, missing proximal small bowel disease in approximately 20-30% of Crohn's disease patients. Video capsule endoscopy and magnetic resonance enterography[20-22] have revealed that many symptomatic patients with normal colonoscopies harbor active jejunal or proximal ileal diseases.

Microscopic inflammation, as discussed above, may produce symptoms despite endoscopically normal mucosa. Additionally, non-inflammatory complications of IBD—including strictures, fistulae, bile salt diarrhea, bacterial overgrowth, and pancreatic insufficiency—can produce symptoms mimicking active disease without endoscopic inflammation.

Extraintestinal manifestations, particularly arthralgia and fatigue, frequently cause symptom burden unrelated to intestinal inflammation. These manifestations may persist or even worsen despite intestinal mucosal healing, contributing to clinical-endoscopic dissociation.

Note on Healthcare Disparities and Specialist Gaps

An important consideration in evaluating clinical-endoscopic discrepancies is the availability of specialized expertise. A lack of IBD specialists, experienced endoscopists, and histopathologists creates significant gaps in the accurate evaluation of disease severity. This challenge is particularly pronounced in middle- and low-income countries (MLICs), where limited access to advanced diagnostic techniques and specialist training may lead to under recognition of subclinical inflammation or misattribution of symptoms.

In many MLICs, the scarcity of dedicated IBD centers means that patients are often managed by generalists who may not be familiar with the subtle endoscopic or histological markers of disease activity. Furthermore, the high cost of advanced imaging (like MRE) and the lack of standardized histological reporting further widen the gap between clinical perception and objective disease state. Addressing these disparities through targeted education, international collaboration, telemedicine, and capacity-building initiatives is essential for improving IBD care and ensuring that "treat-to-target" strategies are feasible globally.

Specific Considerations of Crohn's Disease

Crohn's disease presents unique challenges regarding clinical-endoscopic-histologic correlation due to several distinctive features.

Transmural and Discontinuous Nature

The transmural inflammatory pattern characteristic of Crohn's disease means that significant inflammation may exist in deeper bowel wall layers while the mucosa appears relatively normal endoscopically. Cross-sectional imaging with MRI or CT enterography[20-22] often reveals wall thickening, edema, and inflammatory changes invisible to endoscopy. This transmural disease can produce significant symptoms including pain, obstruction, or systemic inflammation despite reassuring endoscopic findings.

The discontinuous, skip-lesion pattern of Crohn's disease creates sampling challenges. Unlike ulcerative colitis, where disease extent can be reliably determined by endoscopy, Crohn's disease may spare examined segments while actively involving areas beyond endoscopic reach. The rectum is spared in approximately 50% of Crohn's colitis cases, and isolated small bowel disease occurs in 30-40% of patients.

Location-Specific Discrepancies

The anatomical distribution of Crohn's disease significantly influences clinical-endoscopic correlation. Terminal ileal disease, the most common pattern, produces fewer symptoms per unit of endoscopic inflammation compared to colonic disease. Patients may have extensive ileitis with minimal symptoms, while limited colonic involvement produces prominent symptoms.

Upper gastrointestinal Crohn's disease presents particular diagnostic challenges. Esophageal, gastric, and duodenal involvement often produces atypical symptoms including dyspepsia, nausea, and epigastric pain that may be attributed to other causes. Standard colonoscopy misses this dis-

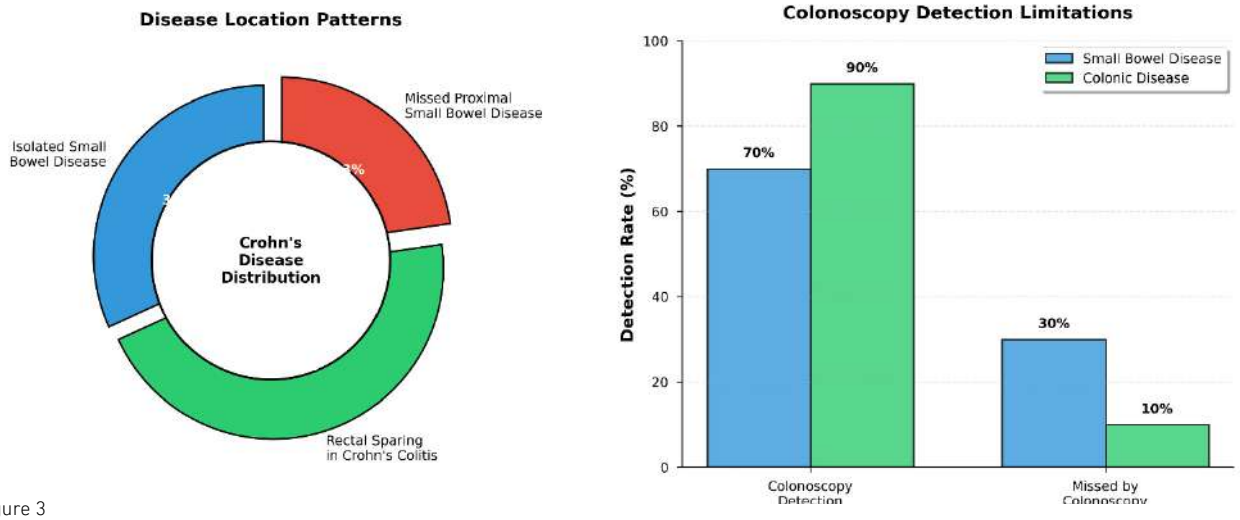

Figure 3

ease entirely, and upper endoscopy is not routinely performed in all Crohn's patients.

Perianal disease represents another dissociation point. Patients may have quiescent intestinal inflammation but active perianal complications, or conversely, healed perianal disease with active luminal inflammation. Perianal findings require dedicated examination and imaging and do not correlate with proximal disease activity.

Penetrating and Stricturing Complications

The progression of Crohn's disease from inflammatory to penetrating or stricturing phenotypes creates important clinical-endoscopic discrepancies. Fistulae and abscesses may produce minimal endoscopic findings at their intestinal origin, yet cause significant symptoms and systemic inflammation. Strictures may be endoscopically impassable, preventing assessment of proximal inflammation, or may appear as subtle narrowing while causing significant obstructive symptoms.

Cross-sectional imaging is essential in these scenarios but adds another layer of complexity to assessment. MRI findings of bowel wall thickening, enhancement, and fat wrapping may indicate active inflammation, chronic fibrosis, or both—distinctions that are clinically critical but often difficult to make radiologically.[20-22]

Impact of Prior Surgery

Postoperative Crohn's disease presents unique assessment challenges. Anastomotic inflammation may represent recurrent disease, surgical trauma, or non-specific reactive changes. The endoscopic Rutgeerts score,[16] used to assess postoperative recurrence, demonstrates variable correlation with symptoms. Many patients with high Rutgeerts scores remain asymptomatic, while others with low scores report significant symptoms.

Surgical alterations in anatomy, including ileocecal valve resection and bypassed segments, complicate both clinical and endoscopic assessment. Bacterial overgrowth is common after ileocecal resection and produces symptoms indistinguishable from active Crohn's disease but without endoscopic inflammation.

DIAGNOSTIC TOOLS AND THEIR LIMITATIONS

Clinical Activity Indices

The Crohn's Disease Activity Index (CDAI),[13] while historically the standard for clinical trials, demonstrates poor correlation with endoscopic findings. The CDAI assigns substantial weight to subjective symptoms and functional parameters unrelated to inflammation, including stool frequency (which may reflect bile salt diarrhea or bacterial overgrowth), abdominal pain (which may be functional), and general well-being (influenced by numerous non-inflammatory factors).

Studies show that fewer than 50% of patients with CDAI scores indicating clinical remission have endoscopic remission, and conversely, some patients with active endoscopic disease have CDAI scores below 150.[13] The Harvey-Bradshaw Index, a simplified clinical score, demonstrates similar limitations in correlating with objective inflammation.

Endoscopic Scoring Systems

Multiple endoscopic scoring systems have been developed for Crohn's disease, including the Crohn's Disease Endoscopic Index of Severity (CDEIS) and the Simple Endoscopic Score for Crohn's Disease (SES-CD).[14] While more objective than clinical indices, these systems have limitations. They assess only colonoscopically accessible bowel, missing small bowel disease in a significant proportion of patients. Inter-observer variability ex-

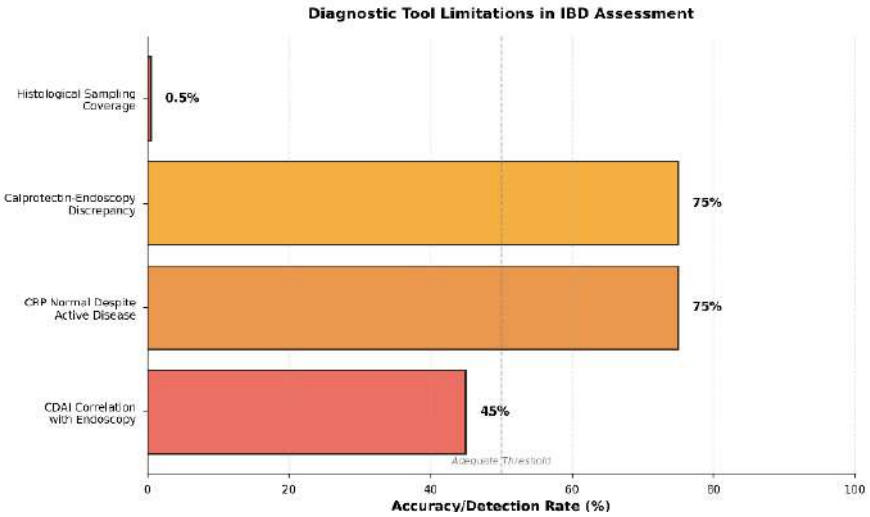

Figure 4

ists even among experienced endoscopists, particularly for subtle findings.

The definition of mucosal healing lacks standardization. Some definitions require complete absence of ulceration, while others accept minor erosions or erythema. This variability impacts research interpretation and clinical decision-making. Additionally, endoscopic scores may not capture functionally significant complications like strictures or fistulae that lack active inflammation.

Histological Assessment

Histological evaluation, while providing detailed assessment of microscopic inflammation, faces its own challenges. Sampling error is substantial, as biopsies represent less than 1% of mucosal surface area. Patchy inflammation may be missed entirely or underestimated. Optimal biopsy protocols remain debated, with some experts advocating for systematic sampling of multiple segments regardless of endoscopic appearance.

Histological scoring systems for Crohn's disease are less well-validated than those for ulcerative colitis. The Geboes score and the Nancy Histological Index have shown promise but require specialized pathology expertise and are not universally employed. Interobserver variability exists, and distinguishing active inflammation from chronic architectural changes or treatment effects can be challenging.

The clinical significance of specific histological features remains incompletely understood. While features like basal plasmacytosis, crypt architectural distortion, and granulomas indicate chronic inflammation, their prognostic value varies.[9] Some histological changes may persist indefinitely despite clinical and endoscopic remission, raising questions about the realistic goals of histological healing.

Biomarkers

Serum and fecal biomarkers provide non-invasive assessment of inflammation but demonstrate imperfect correlation with endoscopic findings. C-reactive protein (CRP) elevation correlates better with extensive disease than limited inflammation and may be normal in up to 25% of patients with active endoscopic disease.[23, 24] Genetic polymorphisms affect CRP production, further limiting its sensitivity.

Fecal calprotectin shows better correlation with endoscopic activity than clinical indices but has limitations.[10, 12] Elevated calprotectin may reflect non-IBD pathology including infections, medications (particularly NSAIDs), and functional disorders. Conversely, isolated small bowel disease may produce normal calprotectin levels. Thresholds for defining remis-

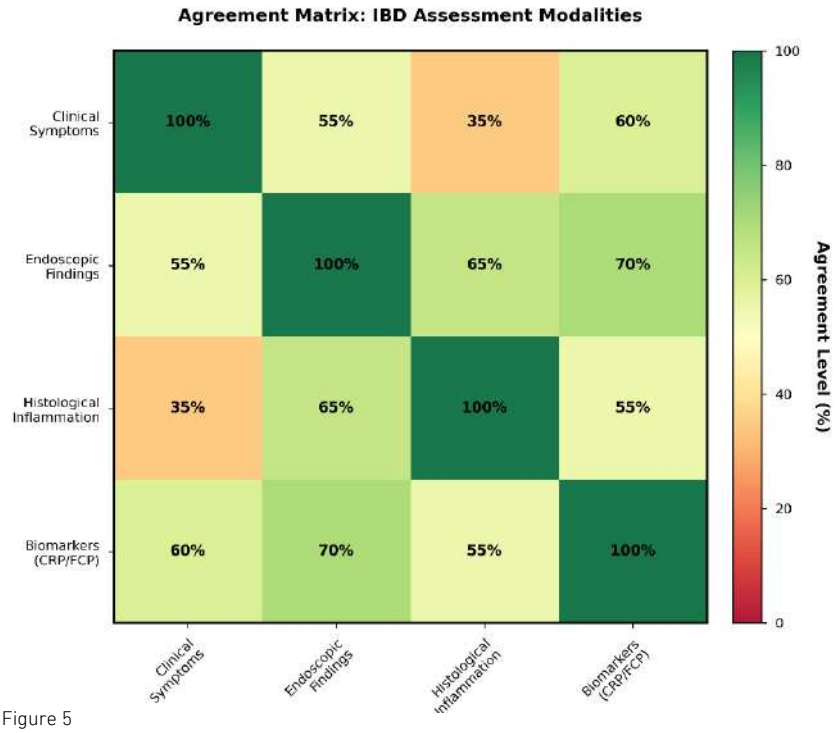

Figure 5

sion vary, and discrepancies between calprotectin levels and endoscopic findings occur in 20-30% of cases.

Newer biomarkers including fecal lactoferrin, serum interleukins, and microRNA profiles show promise but require validation.[11, 12] No biomarker perfectly predicts endoscopic activity, and combinations of biomarkers with clinical assessment provide better correlation than any single measure.

CLINICAL IMPLICATIONS AND MANAGEMENT STRATEGIES

Treat-to-Target Approach

The recognition of clinical-endoscopic discrepancies has driven the treat-to-target paradigm in IBD management. This strategy emphasizes objective treatment targets—primarily endoscopic remission—over symptom control alone. The STRIDE II consensus recommendations[3] advocate for endoscopic healing as a primary treatment target, acknowledging that clinical remission alone is insufficient.

However, implementing treat-to-target requires balancing multiple considerations. Endoscopic assessment is invasive, costly, and carries small but definite risks. The optimal frequency of endoscopic monitoring remains debated, with most guidelines recommending reassessment 6-12 months after treatment initiation or modification, then less frequently if remission is achieved.

For patients in clinical remission with elevated biomarkers, endoscopic assessment is generally warranted to detect subclinical disease. Conversely, patients with persistent symptoms despite normal biomarkers present a dilemma. In these cases, distinguishing inflammatory disease from functional symptoms is crucial to avoid unnecessary treatment escalation.

Role of Cross-Sectional Imaging

MRI enterography has become essential in Crohn's disease management, particularly for evaluating small bowel disease beyond colonoscopic reach. MRI findings of active inflammation—including mural enhancement, wall thickening, edema, and mesenteric inflammation—may explain symptoms in patients with normal colonoscopy. Additionally, MRI detects penetrating complications like abscesses and fistulae that may be endoscopically occult.

However, MRI-endoscopy correlation is imperfect. MRI may show wall thickening and enhancement in areas that appear normal endoscopically, representing either transmural inflammation with mucosal sparing or fibrotic changes without active inflammation. Diffusion-weighted imaging and quantitative MRI parameters show promise in distinguishing inflammation from fibrosis but require standardization.

The integration of MRI findings into treatment decisions requires clinical judgment. Not all MRI abnormalities mandate treatment intensification, particularly if patients are clinically well and biomarkers are normal. Conversely, transmural inflammation despite mucosal healing may justify continued or escalated therapy to prevent complications.

Managing Discrepancies in Clinical Practice

When faced with clinical-endoscopic dissociation, a systematic approach is essential.

For patients with symptoms but no objective inflammation:

- Exclude infection with stool studies including *Clostridioides difficile*, enteric pathogens, and *Giardia*.
- Assess for small bowel disease with capsule endoscopy or MRI enterography.
- Evaluate for IBD complications, including strictures, fistulae, bile salt diarrhea, and bacterial overgrowth.

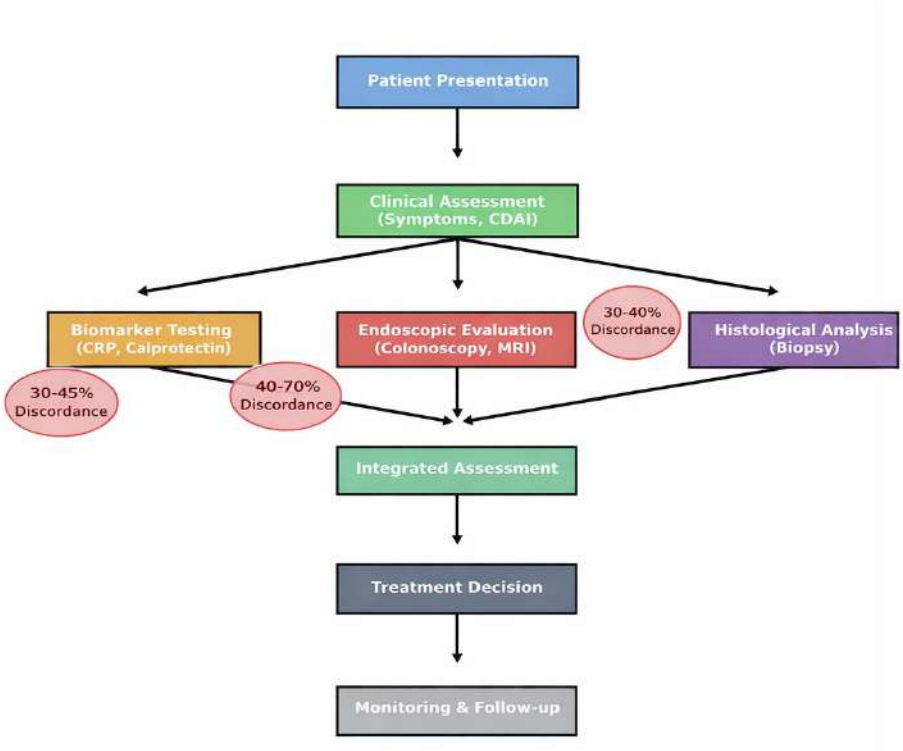

Figure 6

- Consider functional overlay and employ Rome IV criteria to diagnose superimposed IBS.
- Assess medication side effects, particularly from opiates or antidepressants.
- Screen for and address extraintestinal manifestations.
- Avoid unnecessary treatment escalation that exposes patients to therapy risks without addressing the true cause of symptoms.

For patients in clinical remission with objective inflammation:

- Reassess and optimize medical therapy, potentially escalating treatment.
- Consider therapeutic drug monitoring to ensure adequate drug exposure.
- Evaluate for treatment resistant mechanisms.
- Discuss treatment goals and shared decision-making, as some patients may prioritize life over aggressive treatment.
- Monitor closely for disease progression and complications.
- Recognize that endoscopic remission provides better long-term outcomes than clinical remission alone.[1, 4, 5]

For patients with endoscopic remission but histological activity:

- The approach remains controversial given limited prospective data.
- Consider histological findings in the context of clinical trajectory.
- In patients with frequent relapses or high-risk features, histological remission may justify continued aggressive therapy.
- In stable patients with mild histological activity, observation may be reasonable.
- Further research is needed to define optimal management strategies.[9]

Special Populations

Pediatric patients with Crohn's disease demonstrate particularly significant clinical-endoscopic dissociation. Children may minimize or fail to report symptoms, and growth failure or delayed puberty may be the only manifestation of ongoing inflammation. Consequently, pediatric guidelines emphasize objective disease monitoring with regular endoscopy and biomarker assessment.

Elderly patients present opposite challenges. Multiple comorbidities, polypharmacy, and age-related symptoms confound assessment. Functional limitations may prevent reliable symptom reporting. Additionally, the risks of endoscopy and aggressive immunosuppression are higher, requiring careful risk-benefit analysis.

Pregnant patients require special consideration. Clinical symptoms may be attributed to pregnancy rather than disease activity, while concerns about fetal safety limit investigation. Non-invasive monitoring with biomarkers and ultrasound is emphasized, with endoscopy reserved for specific indications.

EMERGING CONCEPTS AND FUTURE DIRECTIONS

Histological Remission as a Treatment Target

Growing evidence supports histological remission as an important treatment endpoint. Multiple studies now demonstrate that histological healing predicts more durable remission than endoscopic healing alone.[4, 5, 9] The concept of "deep remission"— encompassing clinical, endoscopic, and histological remission—is gaining traction as the optimal treatment goal.

However, challenges remain in implementing histological targets. Standardized scoring systems and systematic biopsy protocols are needed. The optimal histological definition of remission requires clarification—should any inflammation be accepted, or should complete normalization be the goal? The feasibility and cost-effectiveness of routine histological monitoring need evaluation.

Prospective studies examining whether treatment adjustment based on histological findings improves outcomes are ongoing. Until such data are available, histological assessment should complement but not replace endoscopic evaluation in treatment decisions.

Molecular and Advanced Imaging Techniques

Novel technologies may improve clinical-endoscopic correlation. Confocal laser endomicroscopy and endocytoscopy allow real-time microscopic imaging during endoscopy, potentially detecting inflammation invisible to conventional endoscopy. However, these techniques require expertise, are time-consuming, and have not yet demonstrated clinical utility beyond research settings.

Molecular markers of inflammation, including mucosal cytokine profiles and gene expression signatures, may provide more precise inflammation assessment than histology alone. Mucosal healing biomarkers measured in biopsy specimens could guide treatment decisions. Machine learning algorithms analyzing multiple data types—clinical, endoscopic, histological, biomarker—may improve disease activity prediction.

Artificial intelligence applications in endoscopy show promise for standardizing disease assessment and reducing interobserver variability. Computer-assisted systems can calculate endoscopic scores in real-time and may detect subtle mucosal changes that human observers miss. However, validation in diverse populations and practice settings is needed before routine implementation.

Personalized Treatment Targets

The recognition that clinical-endoscopic correlation varies between individuals suggests that personalized treatment targets may be optimal. Some patients achieve excellent quality of life with mild residual inflammation, while others require complete histological remission to prevent progression. Patient phenotype, genotype, disease history, and preferences should inform individualized treatment goals.

Risk stratification algorithms incorporating clinical, genetic, serological, and microbiological data may identify patients who benefit from aggressive treat-to-target strategies versus those for whom symptom control is sufficient. Pharmacokinetic and pharmacodynamic monitoring can optimize drug exposure and predict treatment response, allowing personalized therapy.

The emerging concept of precision medicine in IBD emphasizes matching patients to optimal therapies based on molecular signatures. As predictive biomarkers improve, treatment algorithms may evolve beyond trial-and-error approaches toward mechanistically guided therapy selection.

Patient-Reported Outcomes and Quality of Life

While objective inflammation assessment is critical, patient-centered outcomes remain paramount. Patients prioritize symptom control, quality of life, and functional status over endoscopic scores. Discordance between patient priorities and physician-focused outcomes can lead to dissatisfaction and non-adherence.

Validated patient-reported outcome measures that distinguish inflammatory symptoms from functional overlay are needed. Shared decision-making where treatment goals are established collaboratively, considering both objective disease activity and patient values, improves satisfaction and outcomes. Some patients may reasonably choose to accept mild endoscopic activity to avoid treatment-related risks or burdens.

The integration of patient-reported outcomes with objective measures in composite endpoints represents an important evolution. Treatment success should encompass both mucosal healing and meaningful improvement in quality of life, functionality, and patient-defined goals.

Conclusion

The discrepancies between clinical symptoms, endoscopic findings, and histological inflammation in inflammatory bowel disease, particularly Crohn's disease, represent a fundamental challenge in disease assessment and management. These dissociations arise from the complex, multifactorial nature of symptom generation, the limitations of assessment tools, and the unique pathophysiological features of Crohn's disease including its transmural, discontinuous nature and propensity for complications.

Recognition of these discrepancies has transformed IBD management toward objective treat-to-target strategies emphasizing mucosal healing.[2,3] However, implementation requires judicious use of endoscopy, cross-sectional imaging, biomarkers, and histology while maintaining focus on patient-centered outcomes. No single assessment modality perfectly captures disease activity, and integrated, multimodal evaluation provides the most accurate assessment.

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Readers may access the full list of references here.

New Frontiers in Eosinophilic Esophagitis Treatment: The Rise of Advanced Therapies

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Introduction

Eosinophilic esophagitis (EoE) is a chronic inflammatory condition of the esophagus mediated by a type 2 inflammatory response to allergens. EoE causes eosinophilic infiltration of the esophagus leading to fibrostenotic complications and symptoms of esophageal dysfunction.[1] Global incidence and prevalence of EoE continues to rise over time.[2] It is estimated that the projected global incidence and prevalence rates will be 12.67/100,000 and 110.82/100,000 by 2037 with increases throughout regions in which EoE was previously unknown. In particular, Asia has experienced increasing incidence and prevalence of the disease.[3]

Diagnosis is made with endoscopic sampling of the esophagus in those with symptoms of esophageal dysfunction. Current guidelines reiterate the diagnostic criteria of the AGREE consortium of >15 eosinophils per high powered field on biopsy in a patient with symptoms of esophageal dysfunction and/or high clinical suspicion for EoE.[4] Endoscopy can be used to assess the esophageal disease activity of EoE to include rings, linear furrowing, strictures, edema (noted by decreased vascularity), and exudates. These are included on the Endoscopic Reference Score (EREFS). Further findings during endoscopy include fragile esophageal mucosa, commonly referred to as "crepe paper esophagus" and firm mucosa on biopsy (i.e the "tug" sign).[5]

EoE leads to a complex interaction of type 2 inflammation of the esophageal mucosa in response to environmental allergy triggers. This continued inflammation leads to worsening barrier dysfunction of the esophageal epithelium, which, in turn, further propagates more inflammation.[6] In response to these environmental triggers, epithelial cells of the esophagus release thymic stromal lymphopoietin (TSLP), which activates type 2 lymphoid cells in the esophagus. Overall, the type 2 inflammatory response of the esophagus is ultimately driven by type 2 helper T cells. These cells produce pro-inflammatory cytokines such as interleukin (IL) -4, IL-5, and IL-13, which further activate the inflammatory response in the esophageal mucosa. IL-4 and IL-13 are key central mediators of this response. They share overlapping signaling receptors such as IL-4Rα, a receptor that is expressed on various lymphocyte types to include eosinophils. Their action on this receptor increases the release of IL-4, IL-5, and IL-13. Furthermore, IL-4 and IL-13 upregulate the expression and release of key chemokines such as eotaxin and periostin. These chemokines promote chemotaxis of eosinophils to the esophageal mucosa to further propagate inflammation and contribute to eventual fibrosis of the esophagus.[7] The pro-inflammatory cytokines of IL-4, IL-5, and IL-13 are key targets for advanced therapies in the treatment of EoE.

Treatments

Multiple treatments exist for EoE that are not advanced therapies. Many of these, due to their ease of administration, are considered first-line therapies among multiple societal guidelines around the world. These include proton pump inhibitors (PPI), swallowed topical corticosteroids, and dietary elimination therapy.[3] Recent guidelines from the American College of Gastroenterology suggest that these should be considered first-line anti-inflammatory treatments to resolve eosinophilic inflammation of the esophagus. The decision of which anti-inflammatory treatment to initiate upon diagnosis hinges on shared decision making with the patient and their provider. The mainstay of treatment for fibrostenotic disease remains esophageal dilation therapy.[5]

Proton Pump Inhibitors (PPIs)

PPI therapies are believed to have multiple mechanisms to treat EoE, including restoration of the mucosal barrier via reduction of acidic refluxate and inhibition of eotaxin driven recruitment of eosinophils. However, there remains a paucity of studies regarding their efficacy. Two randomized controlled trials have been performed on PPI therapy but only in comparison to swallowed topical corticosteroids.[3] These demonstrated

both histologic and symptomatic efficacy of PPIs for treatment of EoE.[5] Overall, when considering their efficacy among these studies and observational studies, the unweighted histologic response rate is 42%.[8]

Topical Corticosteroids

Historically, swallowed topical corticosteroids were the first medical treatments used for EoE. Earlier guidelines recommended the use of swallowed fluticasone delivered by inhaler. However, there are now commercially available oral budesonide solutions and budesonide orodispersible tablets in the United States and Europe, respectively. Recent phase 3 trials of these formulations demonstrated a 62-95% histologic response rate.[5, 8]

Dietary Therapy

Elimination diets can also be considered as a first-line therapy for treatment of inflammation secondary to EoE in properly counseled patients. Elimination diets require the elimination of common allergen triggers from the diet with assessments of histologic response. The six most common allergens (in order of likelihood to cause inflammatory response in the esophagus) are: milk (dairy), wheat, soy, egg, nuts/peanuts, and fish/shellfish. The empiric six food elimination diet (SFED) excludes each of these foods from the diet for 6-8 weeks. This is followed by a 6-8 week reintroduction period of each of these groups in order of least likely to cause inflammation. Each reintroduction is followed by an endoscopy with tissue sampling to assess for histologic disease activity.[5] Given this onerous task of identifying food triggers, alternative diets to include four-food (FFED) and one food (OFED) (dairy) elimination diets have been proposed. Pooled histologic remission rates for the SFED, FFED, and OFED are 61.3%, 49.4%, and 51.4%.[9] Elemental formula diets have been studied in pediatric and adult populations, which have an over 90% response rate. However, due to poor palatability, non-adherence is common and percutaneous gastrostomy tube placement may be necessary. Furthermore, this dietary strategy has significant developmental complications for pediatric patients as well as psychosocial implications for both adult and pediatric patients.[8]

Advanced Therapies

Based on the efficacy of the aforementioned treatments for EoE, it is clear that there are significant gaps in treatment for symptom improvement and to fully induce and maintain histologic remission. Multiple advanced therapies (i.e. biologics and small molecules) have been studies for the treatment of EoE. For the purposes of this review, only those which have demonstrated both symptomatic and histologic efficacy will be discussed. Biologics such as omalizumab, mepolizumab, reslizumab, benralizumab, and lirentelimab have been studied but failed to meet either symptomatic, histologic, or both efficacy end points.[3]

Dupilumab

Dupilumab is the only biologic therapy that is currently approved for use for EoE in the United States and Europe. It is approved for the treatment of patients aged ≥ 1-year-old weighing ≥ 15 kg.[3] It is a monoclonal antibody agent that blocks the IL-4Rα, thus, blocking the actions of both IL-4 and IL-13 as described above. It was assessed in two studies of patients aged 12 years and up and 1-11 years.[10, 11] The study in adults and adolescents enrolled patients with >15 eosinophils per high power field on endoscopic sampling as well as Dysphagia Symptom Questionnaire (DSQ) scores of ≥ 10. Patients were enrolled into Part A or Part B of the study for a 24-week treatment period. Part A enrolled randomized patients to 300 mg dupilumab weekly or placebo arm. Part B enrolled patients into 300 mg weekly dupilumab, 300 mg every 2 week dupilumab, or placebo arms. Patients from Parts A and B who were in remission at 24 weeks were enrolled into Part C to receive 300 mg dupilumab weekly.[10] At 24 weeks of treatment in Part A, 25/42 (60%) patients receiving weekly dupilumab were in histologic remission, which was defined as <6 eosinophils per high powered field, compared to 2/39 (5%) receiving placebo. Similarly, in Part B, 47/80 (59%) of patients on weekly dupilumab, 49/81 (60%) of patients on every 2 week dupilumab, and 5/79 (6%) of those receiving placebo were in histologic remission. Part C demonstrated sustained histologic remission at week 52 for those who had received weekly dupilumab in Part A, and those who initially received placebo showed increases in histologic remission (18/30, 60%).[10] However, when comparing reductions in DSQ scores, only those who received weekly dupilumab demonstrated a significant reduction.[10] Therefore, the recommended dosage for patients aged 12 years and older weighing at least 40 kg is 300 mg weekly.

Data in the pediatric studies of patients aged 1 to 11 years demonstrated similar results. Patients were randomized to groups with low dose or high dose dupilumab as well as two placebo groups. At the conclusion of 16 weeks of treatment, 68% of patients in the high dose groups and 58% of patients in the low dose group achieved histologic remission defined by <6 eosinophils per high power field, whereas only 3% of patients in the placebo groups did so.[11] Pediatric dosing is weight dependent, with those 15-30 kg receiving 200 mg of dupilumab every other week and those weighing 30-40 kg receiving 300 mg of dupilumab every other week.

Cendakimab

Cendakimab is a biologic medication that has been recently studied for treatment of EoE. It binds directly to IL-13 to prevent its interaction with IL-13 receptors. In a recent phase 3 trial, cendakimab was studied in the treatment of EoE for patients aged 12-75. Coprimary endpoints were assessed that included histologic response defined at <6 eosinophils per high power field and change from baseline dysphagia days. At 24 weeks, the patients receiving weekly treatments with cendakimab showed a significant reduction in baseline dysphagia days compared to placebo (-6.1 [0.3] vs -4.2 [0.4] days). Furthermore, 28.6% of patients receiving cendakimab demonstrated histologic response compared to 2.2% of patients receiving placebo. Both of these outcomes were statistically significant findings.[12] At present, cendakimab is not commercially available for treatment of patients with EoE.

Etrasimod

Etrasimod is an oral, once-daily dosed, selective sphingosine-1 phosphate receptor modulator that has been approved for treatment of ulcerative colitis. A phase 2 study was recently published trialing its use for eosinophilic esophagitis. Patients were randomized to 2 mg daily etrasimod, 1 mg daily etrasimod, and placebo groups. The primary end point was percent change in peak eosinophil counts from baseline. At week 16, the median percentage changes in peak eosinophil count was -58.4% for etrasimod 2 mg, -39.4% for etrasimod 1 mg, and -21.5% for placebo group. Only the median change peak eosinophil count for the etrasimod 2 mg group was statistically significant compared to placebo.[13] Further study is required to determine the effectiveness of etrasimod in the treatment of EoE.

Conclusion

In summary, EoE is a chronic inflammatory condition of the esophagus caused by type 2 inflammation in response to allergens in the esophageal mucosa. Per recent societal guideline updates, the mainstays of initial treatments for inflammatory disease activity remain proton pump inhibitors, swallowed topical corticosteroids, and elimination diets.[3, 5-6, 8] However, these have variable histologic response rates as well as poor adherence in the case of elimination diets. Biologic therapies have been studied for their use in EoE. At present, dupilumab is the only approved biologic therapy available in the United States and Europe.[3] However, both cendakimab and etrasimod have been studied with positive findings in their recently published trials.[12-13] Further study is required to determine their role in the treatment paradigm of EoE.

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Govind Makharia, MD, DM, DNB, FRCP

LOC Chairman
New Delhi, India

On behalf of the Indian Society of Gastroenterology (ISG) and the World Gastroenterology Organisation (WGO), it gives us immense pleasure to welcome you all to the World Congress of Gastroenterology (WCOG 2026) – a landmark event being held for the very first time in India, in the vibrant national capital, New Delhi.

India has emerged as a significant contributor to global gastrointestinal research, with a growing focus on diseases highly relevant to both local and international populations. Premier medical institutions and research organisations in India have played pivotal roles in developing national and international guidelines, advancing epidemiological surveillance, and fostering translational research.

Hosted by the Indian Society of Gastroenterology, in partnership with the World Gastroenterology Organisation, WCOG 2026 promises to be a unique convergence of minds from across the globe – gastroenterologists, hepatologists, pancreatologists, endoscopists, gastrointestinal surgeons, and dieticians, nurses, technologists and other healthcare professionals deeply invested in advancing care in our field.

Our theme, "Transforming Gastrointestinal Health, Preserving Nature," reflects not just a scientific pursuit but a commitment to the larger well-being of our planet. Expect a dynamic blend of cutting-edge research, meaningful discussions, and the kind of cross-disciplinary exchange that will shape the future of medicine.

We are delighted to share this journey with leaders from across the

Contribute to the World Congress of Gastroenterology 2026

WGO and the Indian Society of Gastroenterology (ISG) are now accepting abstract submissions for the upcoming World Congress of Gastroenterology 2026 in New Delhi, India, on September 30, 2026 – October 3, 2026. This premier event seeks cutting-edge research, clinical studies, and innovations in digestive health. Submitting an abstract is an excellent way to connect with the global gastroenterology community by sharing your research on an international scale.

There is no limit to how many General Abstracts you may submit. All abstracts must be submitted by Sunday, 31 May 2026 for consideration. For more information, including submission guidelines, please visit https://wcog2026india.com/abstracts/.

ABSTRACT CATEGORIES

Basic Science
Biliary Tract and Gallbladder Diseases
Endoscopy and Interventional Gastroenterology
Gastrointestinal Oncology
Hepatology
Luminal Gastroenterology/Neurogastroenterology
Inflammatory Bowel Disease
Microbiome and Gut Health
Pancreatology
Pediatric Gastroenterology
Preventive Gastroenterology and Hepatology
Education
Miscellaneous

global gastroenterology community, alongside enthusiastic participation from industry partners, who bring innovations to the forefront of practice.

And while the Congress will be rich in science, we encourage you to soak in the cultural vibrancy of New Delhi – a city that is as historic as it is modern, as spiritual as it is spirited. From its legendary food and heritage sites to its bustling bazaars (markets) and eclectic nightlife, New Delhi is sure to be an experience in itself. And, if you have a little more time, you should also take in some of the iconic nearby attractions such as Agra and the Taj Mahal and the wonders of Rajasthan.

We look forward to your active participation, your invaluable support, and above all, to making WCOG 2026 a memorable milestone in every sense – scientifically, socially, and culturally.

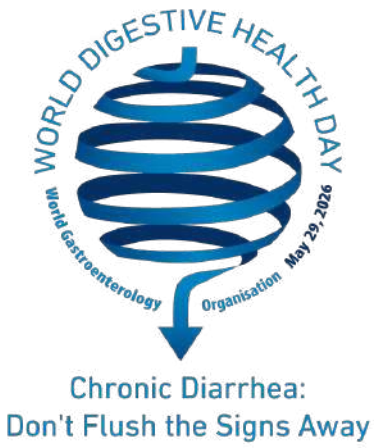
Cheers!

Celebrate World Digestive Health Day on 29 May with WGO

Each year, the World Gastroenterology Organisation (WGO) celebrates World Digestive Health Day (WDHD) by launching a global public health campaign to increase awareness about the prevention, prevalence, diagnosis, management, and treatment of digestive diseases and disorders. This year's campaign, "Chronic Diarrhea: Don't Flush the Signs Away," culminates on Friday, 29 May 2026.

Chronic diarrhea is an often underreported and misunderstood condition, as many individuals experience embarrassment and therefore refrain from seeking treatment unless they develop serious symptoms. Because the condition can signal more serious underlying diseases, such as ulcerative colitis or irritable bowel syndrome, the need for increased awareness and timely consultation is greater than ever.

The theme, "Chronic Diarrhea: Don't Flush the Signs Away," underscores three key messages:



1. Know what your colon is trying to tell you.
2. When in doubt, get underlying diseases ruled out.
3. Chronic diarrhea deserves attention, not embarrassment.

WGO invites you to engage with the campaign by using the hashtags #WDHD2026 and #DontFlushTheSigns on social media. Share your perspectives, experiences, and creative approaches to raising awareness about chronic diarrhea, and contribute to a vibrant and inclusive global conversation.

In addition, WGO encourages participants to use Selfie Cards, a fun and impactful way to spread awareness. Take a photo with a short message about chronic diarrhea and share it with the global community. Submissions from around the world will be featured on WGO's social media channels and in future publications.

The WDHD website remains an invaluable resource throughout the year, offering comprehensive information about the 2026 campaign and previous WDHD initiatives. Whether you're a healthcare professional, educator, or member of the public, we invite you to explore these resources and help make a positive impact on digestive health in your community. Together, let's raise awareness about chronic diarrhea and create a healthier world, free of stigma, for everyone. ■

Meet the 2026-2027 WGO Committee Roster

In September of 2025, WGO held its General Assembly and confirmed the 2026-2027 Governing Council. Our Governing Council is made up of the Executive Committee and the chairs of each of our specialized committees. These individuals serve as leaders of WGO's global community and work tirelessly to achieve its many goals. Chairs are responsible for leading their groups through initiatives and meetings and serve as the committee's advocate throughout the organization. WGO would not be possible without the dedicated service, time, and knowledge our members provide, especially those in leadership roles.

This term, we are excited to announce the creation of the new Education Committee. Developed to further innovate the organization and best represent the needs and interests of our members, the Education Committee is comprised of three task forces: Guidelines, Scientific Program, and Media and Community Engagement. We are excited to see the goals and projects they will achieve alongside WGO's other committees.

Please join us in congratulating the following individuals on being named to a WGO committee for the 2026-2027 term.

Governing Council

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Professor Carolina Olano
Uruguay

President-Elect
Professor Vivek Kaul
United States

Past President and Chair of Nominations Committee
Professor Geoffrey Metz
Australia

Secretary General
Professor Anita Afzali
United States

Treasurer and Chair of Finance Committee
Professor Kaichun Wu
China

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Professor Dan Dumitrascu
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Professor Anahita Sadeghi
Iran

Chair, Education Committee
Professor Kelly Burak
Canada

Chair, Endoscopy Committee
Professor Nazish Butt
Pakistan

Chair, Hepatology Committee
Professor Alice Lee
Australia

Chair, IBD Committee
Professor Susana Lopes
Portugal

Chair, Media and Community Engagement Committee
Professor Tony Tham
Ireland

Chair, Train the Trainers Committee
Professor Wojciech Marlicz
Poland

Chair, Training Centers Committee
Professor Luis Carlos Sabbagh
Colombia

Chair, Young GI Committee
Professor Georgiana-Emmanuela Gîlcă-Blanariu
Romania

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Sebastián Niño Ramirez, Colombia
Amit Mathur, India
Sandeep Nijhawan, India
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Maisam Akroush, Jordan
Kolawole Oluseyi Akande, Nigeria
Lutumba Ramseyce, Democratic Republic of the Congo
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Desmond Leddin, Canada
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Aleksejs Derovs, Latvia
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Hasan Maulahela, Indonesia
Vikash Goolab Lala, South Africa
Maryam Alkhatry, United Arab Emirates
Ruben Sergio Muñoz Camacho, Bolivia
Nikhil Sonthalia, India
Nawal Alkhalidi, Iraq
Quang Trung Tran, Germany
Nayantara Coelho-Prabhu, United States
Julio Fernando Toledo Cuque, Guatemala
Patricia Anne Cabral-Prodigalidad, Philippines
Hugo Guedes, Brazil
Ignacio Moratorio, Uruguay
Dacio Hector Cabrera Hinojosa, Peru
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Kavel Visrodia, United States
Apichat Kaewdech, Thailand

Women in Academia: The Myth of Merit International Women's Day 2026 #GiveToGain

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Throughout history, academia has always been upheld as a merit-based system, one where hard work and perseverance dictate the success achieved. However, while this may work in theory, it is seldom the truth in practice. Unfortunately, women in academia face systemic barriers at every stage, whether that be in terms of harassment, reduced funding, the gap in authorship, or the lack of promotional opportunities received. These disparities are not just isolated failures, but rather, they outline a system that consistently works against marginalized groups and continues to favor the privileged class.

In the UK, it is estimated that 68% of young women have experienced academic harassment while at university or college.[1] Some examples include but are not limited to unwanted comments or advances, exclusions from networks, and even credit theft. The rise of social and political movements focusing on the mistreatment of women such as Time's Up and #MeToo have catapulted these issues into the public sphere to the point where the general public have a greater awareness. These systemic inequalities are often exacerbated in male-dominated fields where many may feel they are offered little protection and must survive in a 'Man's World.'

Power hierarchies often benefit from keeping systems in place where those who are underrepresented are disproportionately affected. In this case it is women, especially those who may be from minority ethnic or religious backgrounds. The consequences of these effects could lead to reduced productivity, a strain on their mental health, and eventually a decision to leave academia for good. These experiences unequally affect women and, in turn, have long lasting negative impacts on their career trajectories.

When it comes to research articles and academic papers, women's scholarly contributions are grossly undervalued. Conventionally, it is the first and last authors that are given the most importance because they signify the primary drivers of the research, with the first author doing a majority of the hands-on work and the last author providing the overall supervision. It was reported that only around 30% of primary authors in globally renowned journals are women. On average, articles written by women are more likely to be cited than those written by men[2] however, women often experience shorter publishing career lengths due to many contributing factors such as lack of research collaborations, lower levels of specialization, and external familial responsibility. This also leads to a reduction of total published pieces across a woman's career, leaving fewer opportunities to gain those coveted first and last author spots. The lack of acknowledgment of female labor leads to less visibility and affects CV strength, which in turn impacts future funding opportunities, thus becoming a self-fulfilling prophecy.

Women occupy just under half (45%) of all academic jobs and publish at rates that are comparable to men, however they take more years to reach professorship even with the same number of published manuscripts. In the sector, only about 20.5% of professors are women with just 29 out of 166 institutions being led by women in 2013/14.[3] The 'Motherhood Penalty,' coined by Claudia Goldman, sheds light on the fact that the inequality women face when it comes to pay and career gaps is magnified after having their first child, due to career interruptions and caregiving expectations. When looking at promotions, those factors along with committee biases and fewer leadership and mentorship opportunities all play a role in delayed promotion, which some argue compounds inequality over time.

When it comes to the medical profession as a whole, over half of medical students are female. However, when the role transitions to residency and leadership positions, the scales shift, favoring the men in the industry and awarding them with more decision-making and budget powers. How is it that a head start can circle back into detriment, and what does it take to turn majority into minority? Gastroenterology is no exception. This especially rings true in endoscopy, which has the lowest rate of first female authors. Groups like the World Gastroenterology Organisation (WGO) are combating this by ensuring that they balance their main agenda with the United Nations sustainability goals in order to bring about long-term change in a way that perseveres. A main focus is ensuring gender equality on a global scale, whether that is through academic articles and research or through conferences and committee events.

The theme for International Women's Day 2026, 'Give to Gain,' is a crucial stepping point and much-needed demonstration on how we can implement structural changes that combat these setbacks. The 'Give to Gain' pose itself involves two cupped hands, symbolizing giving and receiving. Just as energy cannot be created nor destroyed, in a similar way, we cannot expect to receive if there is nothing contributed in the first place. By setting target areas and focusing on economic independence, education, and STEM leadership, this theme empowers women and provides them the resources to move towards their goals.

These issues are not isolated, and by being interconnected they build on one another to perpetuate the cycle of inequality. Disadvantages and drawbacks accumulate and accelerate the negative impact that results in many women being left behind in academia. Addressing (and in the future eliminating) gender inequality requires a structural change in how institutions evaluate, fund, and promote academics.

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NZSG–NZgNC ASM 2025 Showcases Global Gastroenterology Excellence in Aotearoa, New Zealand

The Executive Committee

New Zealand Society of Gastroenterology
Wellington, New Zealand

The 2025 Annual Scientific Meeting (ASM), co-hosted by the New Zealand Society of Gastroenterology (NZSG) and the New Zealand Gastroenterology Nurses' College (NZgNC), was held in Palmerston North over three days in late November. It included world-class scientific exchange, professional collaboration, and international engagement. The event brought together clinicians, nurses, researchers, trainees, students, and industry partners from New Zealand, Australia, the United Kingdom, and beyond.

An impressive lineup of national and international speakers delivered a program that combined high-impact clinical research with practical advancements in patient care. Presentations included sessions across hepatology, IBD, pediatrics, motility, quality improvement, endoscopy training, and cultural equity, underscoring the multidisciplinary strength of New Zealand's gastroenterology workforce. Presenters included:

- Associate Professor Nick Burgess, an interventional endoscopist from Westmead Hospital and the University of Sydney, shared his expertise in colorectal cancer prevention and advanced endoscopic resection. His research spans polyp-cancer prediction models, EMR/ESD techniques, and global quality-improvement initiatives in bowel cancer screening.
- Associate Professor Britt Christensen, head of the IBD Unit at The Royal Melbourne Hospital and a leading figure in Crohn's disease and ulcerative colitis care, brought a strong focus on intestinal ultrasound, complex IBD management, and improving outcomes for women through pregnancy.
- Professor Evelien Dekker, head of the AUMC clinic for hereditary colorectal cancer and medical director of the Bergman IZA Expertise Center for Endoscopy, presenting her latest work shaping the Netherlands' national colonoscopy, bowel screening, and familial-tumour programs.
- Daniel Lightowler, Clinical Nurse Consultant in IBD at Royal Prince Alfred Hospital and President of the Gastroenterological Nurses College of Australia (GENCA), contributed key insights into advanced nursing roles and patient-centered care models.
- UK-based Senior Lecturer at Birmingham University, Sharon Powell, has more than three decades of NHS experience. She is part of the team developing the Future Endoscopy Workforce through the Midland Endoscopy Training Academy and brought a strong professional nursing lens to the event.

- Associate Professor Avik Majumdar, a transplant hepatologist from Austin Health, Melbourne, whose expertise spans cirrhosis, hepatocellular carcinoma, and portal hypertension.
- Professor Alex Thompson, Director of Gastroenterology at St. Vincent's Hospital, Melbourne, and internationally recognized for his work in liver disease and clinical leadership.
- Dr. Vinay Sehgal, Consultant Gastroenterologist at University College London Hospital. His clinical practice focuses on advanced interventional endoscopy and emerging technologies shaping the future of GI procedures.
- Associate Professor Graham Radford-Smith, a gastroenterologist at the Royal Brisbane and Women's Hospital and Honorary Group Leader at QIMR Berghofer, contributed his deep experience across clinical gastroenterology and research translation.

The success of this year's Annual Scientific Meeting was made possible through the leadership of the 2025 convening team led by Dr. James Irwin of Midcentral Hospital, Palmerston North. The team brought together an event full of educational experiences and social events including a charity Fun Run with proceeds donated to Crohn's Colitis New Zealand, and the always popular ASM dinner.

NZSG thanks all corporate sponsors for their ongoing support of the ASM, which strengthens innovation, education, and professional growth across the gastroenterology community

The Society is hoping to see you at our 2026 ASM being held in Christchurch, November 18–20, where organizers promise another ambitious program and expanded international involvement.

ACADI 2025: A Congress That Made History

Juan David Linares Ramírez, MD

Past Secretary (2023-2025), Colombian Association of Gastroenterology
Gastroenterologist, Clinicas Colsanitas
Member, WGO Endoscopy Committee
Bogotá, Colombia

Diego Mauricio Aponte Martín, MD

Past President (2023-2025), Colombian Association of Gastroenterology
Gastroenterologist, Clinicas Colsanitas
Member, WGO Training Centers Committee
Bogotá, Colombia

Robin Germán Prieto Ortiz, MD

Past Treasurer (2023-2025), Colombian Association of Gastroenterology
Gastroenterologist, Centro de Enfermedades Hepáticas y Digestivas (CEHYD)
Member, WGO Train the Trainers Committee
Bogotá, Colombia

Eduardo Cuello Lacouture, MD

Past President, Colombian Association of Digestive Endoscopy
Past Board of Directors Member (2023-2025), Colombian Association of Gastroenterology
Chief Medical Officer, UGASEND
Barranquilla, Colombia

ACADI 2025 will remain in our collective memory as one of those exceptional gatherings where everything came together: the perfect city, a dedicated team, and, above all, the ideal scientific community. Barranquilla welcomed us with its warm energy, its unmistakable breeze, and that Caribbean spirit that, almost without intending to, permeated every lecture, every workshop, and every opportunity for colleagues to connect.

Contemporary gastroenterology is the result of the coordinated work of a robust network of scientific associations that, from different regions of the world, promote academic advancement, research, continuing medical education, and professional development. Internationally, organizations such as the World Gastroenterology Organisation (WGO), the Pan American Gastroenterology Organization (OPGE), the Inter-American Society of Digestive Endoscopy (SIED), and the Pan American Crohn's and Colitis Organization (PANCCO), establish global standards. Nationally, the Colombian Association of Gastroenterology (ACG), the Colombian Association of Digestive Endoscopy (ACED), the Colombian Association of Coloproctology (ASOCOLOPROCTO), and the Colombian Association of Hepatology (ACH) coordinate clinical practice, continuing education, and academic cooperation in Colombia.

Thanks to this inter-institutional collaboration and the participation of more than 1,400 attendees—including gastroenterologists, endoscopists, hepatologists, coloproctologists, residents, specialized nurses, industry representatives, and allies of the profession—ACADI 2025 not only demonstrated the profound academic interest in the country and the region for scientific updates, but also reaffirmed the congress as an essential meeting point for the Latin American digestive community.

In this context, the WGO-ACG Symposium established itself as one of the most relevant academic spaces at ACADI 2025, integrating international perspectives on highly prevalent and complex issues in daily gastroenterological practice. The participation of global leaders from WGO significantly strengthened the scientific and educational component of the event, giving it a prominent international profile.

The program included the valuable participation of Dr. Carolina Olano, President of WGO, who addressed two topics of great clinical relevance. In her first presentation, she offered an update on irritable bowel syndrome and its overlap with other intestinal diseases, emphasizing diagnostic challenges, the identification of concomitant pathologies, and the need for individualized therapeutic approaches. Dr. Olano then discussed new concepts in celiac disease, highlighting the evolution of diagnostic criteria, non-classical presentations, and the importance of timely diagnosis for preventing complications, thus

offering a modern and comprehensive view of this condition.

For his part, Dr. José María Sanguinetti, a member of WGO's Train the Trainers Committee, provided a comprehensive perspective in two areas of increasing complexity. In his lecture on the management of digestive symptoms in palliative care, he emphasized the gastroenterologist's role in symptom relief, improving quality of life, and interdisciplinary collaboration in patients with advanced disease. Additionally, he presented an update on intestinal failure, addressing pathophysiological aspects, diagnostic criteria, and current therapeutic strategies, with an emphasis on specialized nutritional support and long-term follow-up.

The symposium also featured the participation of Dr. Luis Carlos Sabbagh, Chair of the WGO Training Centers Committee, who presented an update on the new criteria for endosonographic biliary drainage. His presentation highlighted the evolution of advanced endoscopy as a key tool in the management of complex biliary pathologies, as well as the importance of structured and standardized training that guarantees safe and effective procedures, in accordance with WGO's global educational objectives.

The presence of international leaders from WGO reaffirmed ACADI's commitment to excellence in continuing medical education and positioned the congress as a strategic platform for the transfer of global knowledge adapted to the Latin American context.

Among the main academic highlights of the congress were:

- Keynote lectures with top-level international guests.

- Specialized symposia with updates on digestive physiology, advanced endoscopy, hepatology, inflammatory bowel disease, microbiota, nutrition, and endoscopic interventions as an expression of the advancement of minimally invasive surgery.
- A robust research component, with the presentation of 154 posters, 32 oral presentations, and the awarding of academic prizes, including the "José Jácome Valderrama" Prize for Best Research Paper, befitting an international academic event.
- Publication of books and clinical practice guidelines, which strengthen the scientific, historical, and editorial identity of the Association:
  - **Critical Appraisal Manual:** based on gastroenterology research designs, a practical guide for interpreting scientific evidence.
  - **ACG Presidents:** from founders to visionaries, journalistic chronicles a tribute to the 50 presidents who have shaped the history of the Colombian Association of Gastroenterology over 78 years, accompanied by audiovisual material that highlights the human dimension of each leader.
  - **Treatise on Pancreatology – Second Edition**: a monumental work of approximately 900 pages, the result of intense, modern, and up-to-date collaborative work.
  - In the area of clinical practice guidelines, and in partnership with academia and with the support of one of the country's leading universities, three methodologically rigorous guidelines were developed:

  - Clinical practice guideline for the diagnosis and treatment of Helicobacter pylori infection in adults: 2025 Update.
  - Clinical practice guideline for the diagnosis and treatment of gastroesophageal reflux disease (GERD) in adults: 2025 Update.
  - Colombian clinical practice guideline for colorectal cancer screening in adults: 2025 Update.

These guidelines are the result of disciplined interinstitutional work and represent an invaluable contribution to clinical practice and digestive health in the country.

The Colombian Association of Gastroenterology expresses its sincere gratitude to the World Gastroenterology Organisation for its valuable participation in the ACADI 2025 Congress, as well as for its ongoing commitment to continuing medical education, academic excellence, and the strengthening of gastroenterology globally. Its presence was fundamental in enriching scientific exchange and consolidating the international character of this event. ■

APDW 2025: Continuing a Legacy Of Excellence

Stephen Tsao, MBChB (Leicester, UK), MRCP (UK), FAMS (Singapore), FRCP (Edinburgh)

APDW 2025 President
Singapore

APDW 2025 reaffirmed its position as the Asia-Pacific region's leading platform for gastroenterology, convening a vibrant community of clinicians, researchers, and industry partners in Singapore. Over five packed days—two days of precongress activities followed by a three-day main meeting—the congress delivered breadth, depth, and tangible engagement across science, education, and innovation. Over 3,000 delegates from 60 countries participated, reflecting both strong regional representation and growing global reach.

Registration

Registration spanned multiple categories designed to accommodate varied learning paths and professional needs. Dedicated programming also drew 424 registrants for Nurses' Day. Altogether, these cohorts formed the congress total of 3,169. Importantly, the meeting recorded 2,281 international delegates.

Geographic Footprint

APDW 2025's audience was anchored by the host nation, with Singapore (849) leading attendance. The next largest delegations were Japan (312), China (289), South Korea (193), Philippines (160), Malaysia (134), Bangladesh (133), Hong Kong (129), Australia (120), and Pakistan (112).

Beyond these topten countries, delegate country distribution extended widely across Asia-Pacific and into Europe, North America, and the Middle East, for a total of 60 countries represented. This spread underscores APDW's dual identity as both the regional hub for GI and a genuinely international forum.

Scientific Program

The congress program combined scale with curation: 11 workshops, 5 plenary sessions, 90 concurrent sessions, and an industry program comprising 10 industry symposia plus 1 pre-congress industry workshop. The format enabled participants to navigate from foundational updates to advanced, procedure-oriented content, while plenaries convened the community around high-impact clinical and scientific themes.

The 2025 program was unified under the theme "Innovate, Integrate, Invigorate: A New Era in Gastroenterology," and addressed a comprehensive range of topics. Major themes included:

- advances in digestive endoscopy
- hepatology
- gastrointestinal oncology
- inflammatory bowel disease (IBD)
- functional GI disorders
- gut microbiome science
- metabolic liver disease (including NAFLD/MAFLD)
- integration of artificial intelligence and precision medicine into clinical practice.

Sessions also explored the latest in minimally invasive surgery, new drug therapies, microbiome-based interventions, and care pathway design. The congress placed special emphasis on prevention and early detection, integrated care models for complex diseases, and the importance of diversity, collaboration, and workforce development in gastroenterology.

Abstracts and Presentations

The 2025 edition of APDW maintained strong scholarly momentum. The program recorded 1,888 abstract submissions. In total, 1,256 individual abstract speakers contributed to the scientific discourse, acknowledging that many presented more than once. Abstract submissions reflected wide geographic diversity, with 44 countries represented in the pool. The top five submitting countries were China (641), Japan (204), South Korea (153), India (151), and the Philippines (129)—a distribution consistent with APDW's regional leadership and the strength of its East and Southeast

Asian research communities.

Invited Faculty and Chairs

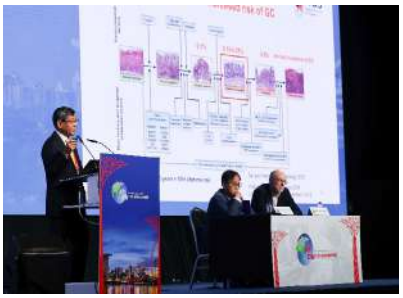
Faculty engagement was extensive and international. The program listed 390 invited speakers and 227 chair/moderator/judge roles spanning 28 countries. The depth and diversity of the faculty supported a balanced program—from cuttingedge interventional endoscopy to hepatology's most urgent challenges—while ensuring that sessions combined methodological rigor with practical clinical relevance.

Delegate Interests and Topic Trends

Self-declared areas of interest illustrate where clinical demand and innovation are converging:

- **Gastroenterology:** GERD & esophageal disease (**396**), GI oncology (**367**), pancreatitis & biliary tract diseases (**344**), IBD (**337**), upper GI bleeding (**225**), functional dyspepsia & gastritis (**172**), H. pylori (**163**), and gut–brainaxis disorders (**139**).
- **Endoscopy:** ERCP & biliary drainage (**506**) and ESD/EMR (**392**) led the list, followed by colorectal (**390**) and upper GI endoscopy (**312**). EUS (**262**), biliary endoscopy (**142**), small bowel (**46**), and tunnel techniques (**21**) rounded out procedural interests.
- **Hepatology:** NAFLD/MAFLD (**505**) showed the single highest topic interest count across the liver domain, followed by hepatitis B/C (**388**), HCC (**292**), liver failure (**216**), and portal hypertension (**153**), with additional responses for transplantation complications and "Others."

Collectively, these distributions spotlight ongoing demand for advanced interventional endoscopy (particularly ERCP and ESD) and the metabolic liver disease spectrum, alongside sustained attention to chronic viral hepatitis, GI malignancy, and bleeding management.



Onsite Technology and Engagement

The APDW app supported discovery, planning, and networking. It recorded 1,760 downloads and 117,314 page views, with the Program page alone accounting for 17,740 views (15%). Exhibitor interactions were robust, with 2,043 leads captured through the platform. The Opening Ceremony & Plenary Session 1 emerged as the most popular academic session with 2,294 cumulative views/registrations, and Stephen Tsao's profile was the most viewed speaker page (179 views), suggesting effective session design and speaker curation.

Industry Partnerships

Industry engagement was a cornerstone of APDW 2025, with the congress offering a robust platform for collaboration between biomedical companies, device manufacturers, pharmaceutical firms, and healthcare innovators. With Fujifilm and Olympus onboard as Platinum sponsors, a total of 15 companies sponsored APDW 2025, and 46 exhibitors participated. Sponsors and exhibitors benefited from tailored opportunities to showcase products, host educational symposia, and connect directly with delegates through the exhibition.

Conclusion

APDW 2025 delivered on scale, scientific rigor, and engagement. With 3,169 delegates from 60 countries, a 1,888 submission abstract program yielding 960 accepted presentations, and a multicountry faculty spanning 28 nations, the meeting achieved both depth and diversity. Topic interest clustered around interventional endoscopy and metabolic liver disease while maintaining comprehensive coverage of core GI and hepatology domains. Marketing and digital metrics—high impressions, strong email engagement, and substantial app usage—demonstrate healthy audience demand and effective outreach. Together, these outcomes underscore APDW's continuing role as the region's premier forum for translating evidence, advancing practice, and fostering collaboration across academia, clinical care, and industry.

SBAD 2025 Brings Together Thousands of Doctors and Consolidates Decisive Advances in Brazilian Gastroenterology

Áureo de Almeida Delgado, MD

President, Brazilian Federation of Gastroenterology
São Paulo, Brazil

At a time when gastrointestinal diseases intensify in Brazil due to the festive period, the Brazilian Digestive System Week (SBAD 2025) brought together thousands of gastroenterologists, endoscopists, and surgeons from across the country from November 13 to 15 at the Anhembi District (São Paulo) to discuss scientific updates that directly impact national clinical practice. The event focused on topics such as reflux, acid-related diseases, fatty liver, inflammatory bowel disease, pancreatic diseases, liver pathologies, stomach diseases, and the launch of the V Brazilian Consensus on *Helicobacter pylori*, in addition to sessions dedicated to celiac disease with international specialists. This year's edition also set a record for participation, bringing together 5,500 registered participants over three days of activities.

According to the president of the Brazilian Federation of Gastroenterology (FBG), Dr. Áureo Delgado, understanding the dietary, climatic, and epidemiological particularities of each region of Brazil is fundamental for providing adequate guidance to patients. "The gastrointestinal tract responds immediately to dietary excesses and alcohol consumption, especially in the summer. Medical practice needs to be aligned with evidence and the cultural differences of the country," he stated, reinforcing the commitment of medical societies to continuing education. The president also highlighted the importance of immune-mediated diseases, especially IBD and eosinophilic esophagitis, which received excellent updates during the event.

Data from the Ministry of Health indicate that diseases of the digestive system are among the main causes of emergency room visits between November and February, with an increase of up to 25% for conditions such as food poisoning, intense abdominal pain, and acute gastritis. In this context, SBAD reinforces its relevance by disseminating updated knowledge about GERD, Nonalcoholic fatty liver disease, IBD, celiac disease, and new prevention strategies, as well as strengthening the integration between FBG, SOBED, and CBCD, a central partnership to reduce regional health inequalities and improve patient care.

Closing the event, Dr. Áureo celebrated the success of the 24th edition of SBAD, highlighting the full rooms, the praise received, and the impact of the content presented. He thanked everyone for their participation and announced that the next edition will take place in Fortaleza in November 2026, reinforcing the ongoing commitment of medical societies to scientific updating and evidence-based clinical practice. "SBAD reinforces that knowledge is the most powerful tool to expand care and offer more equitable assistance throughout the country," concluded the president. ■

KDDW 2025 Solidifies Its Position as a Premier International Platform in Gastroenterology

Joo-Sung Kim, MD, MS, PhD

President, KDDW 2025 Organizing Committee
President, The Korean Society of Gastroenterology
Seoul, Korea

KDDW 2025 was held from November 13 to 15, 2025, at Grand Walkerhill Seoul, Korea, featuring 68 symposium sessions with participation from approximately 204 domestic and 43 international speakers. The congress provided extensive coverage of key topics in digestive diseases and offered highly acclaimed educational opportunities, such as the PG Course and Hands-on programs, designed for young clinicians and researchers.

The scientific program spanned the full spectrum of gastrointestinal medicine—from basic science to clinical applications—including upper gastrointestinal disorders, liver diseases, pancreaticobiliary diseases, intestinal disorders, functional gastrointestinal diseases, and gastrointestinal cancers. Society-led symposia showcased the latest insights and clinical experiences in hepatology, gastroenterology, pancreaticobiliary medicine, functional disorders, and diagnostic imaging. Multidisciplinary and combined sessions emphasized collaborative treatment strategies and integrated approaches across internal medicine, surgery, radiology, pathology, and related specialties.

This year, particular attention was given to the clinical application of cutting-edge technologies, such as artificial intelligence (AI), precision medicine, and digital healthcare,

along with active discussions on translational and convergence research connecting basic and clinical fields.

A total of 637 abstracts were submitted, with 115 selected for oral presentations and 462 for poster presentations. Throughout the congress, various academic awards—including Best Abstract, Outstanding Presentation, and Excellence Awards—were presented, and Contribution Awards recognized corresponding authors who made significant scholarly impact.

KDDW 2025 welcomed 1,972 participants from 47 countries, creating a meaningful forum for global collaboration in gastrointestinal medicine. Participants actively exchanged new research findings and clinical experience, fostering academic dialogue as well as opportunities for institutional partnership, joint research development, and the integration of educational programs.

With engagement from both emerging and advanced countries, the congress addressed global strategies to reduce disparities in the diagnosis and treatment of digestive diseases. In-depth discussions were also held on the adoption of advanced technologies, development of innovative therapies, and establishment of intersociety partnerships. KDDW 2025 solidified its role as a major platform shaping the future of gastrointestinal medicine and strengthened the foundation for expanded international collaboration and global medical networks. ■

Bridging the Gap: A Biomedical Scientist's Reflection on Genomics, Mentorship, and the Future of Biomedical Research in the Management of Liver, Pancreas and Biliary Cancers in Africa

Samuel Jere, BASc

Biomedical Scientist and Research Fellow, University of North Carolina Global Projects Zambia (UNC-GPZ)
Lusaka, Zambia

The Africa HepatoPancreatoBiliary Cancer Consortium 2025, which was held in Johannesburg, South Africa from August 12-16, 2025, served as a critical reflection of the challenges and opportunities in building a biomedical research career on the African continent. Bringing together over 200 participants from around the world, the conference highlighted the remarkable work being done in hepatobiliary cancers and infections across Africa. Additionally, the conference highlighted the significant challenges of pursuing a career in basic scientific research in Africa, while also outlining some of the initiatives being taken to address these issues.

The event began with transformative pre-conference workshops. At the Boston Scientific Institute for Advanced Research, I witnessed the "surgical theater" of advanced endoscopy. While consultant gastroenterologists like Drs. Akwi Asombang, Mashiko Setshedi, Galya Chinnery, Vikash Lala, Neo Seabi, and Prof. Sandie Thomson demonstrated life-saving techniques, my perspective as a scientist was drawn to the invisible contributions of engineers and scientists. It reaffirmed my path: I want to be a scientist who pushes healthcare forward through innovation and discovery.

As a biomedical scientist with interests spanning from infectious diseases to genomic epidemiology, attending a conference dominated by clinical practitioners can often feel like navigating a foreign landscape. However, day two of the Africa HepatoPancreatoBiliary Cancer Consortium (AHPBCC) pre-conference served as a powerful reminder that the bridge between the bench and the bedside is not only necessary, but is being actively built by dedicated communities of interdisciplinary researchers.

The day began with a strategic deep dive into the architecture of scientific funding, led by Professor Muhammad El-Kassas, a gastroenterologist from Egypt. In an era where research is increasingly competitive, Prof. El-Kassas underscored a shifting reality: industrial organizations now provide the lion's share of global research funding. This necessitates a "tailored approach" to grant writing, where the scientist must align their proposal with a company's objectives without losing sight of the core scientific problem. He introduced a rigorous framework for the literature review, the "five Cs," challenging us to move beyond simple summaries to cite, compare, contrast, critique, and connect the existing body of work to our own. This "homework," as he called it, is the foundation upon which compelling, fundable research is built

This focus on structural rigor

transitioned seamlessly into the basic and translational research workshop, a session I had anticipated as a rare opportunity to engage with the genomic landscape of the continent. The diversity of expertise in the room was striking, covering the full spectrum of the central dogma from transcriptomics to metabolomics. A particularly engaging roundtable with Professor Paul Palwende Romuald Boua highlighted the molecular etiology of cancer, specifically how genomic sequencing can revolutionize the early detection and prognosis of hepatocellular carcinoma (HCC).

The conversation took a poignant turn when we discussed viral hepatitis, a significant public health challenge in Zambia. I raised the question that remains a critical gap in our local literature: why do some patients with hepatitis B progress rapidly to HCC while others remain asymptomatic for a lifetime? The ensuing discussion among experts emphasized that answering this requires more than just clinical observation; it demands robust laboratory capacity for genomic sequencing coupled with advanced bioinformatics. Understanding which HBV genotypes are the most aggressive drivers of HCC in African populations is a research avenue that could fundamentally alter our treatment protocols.

The interdisciplinary journey continued as I moved from genomics to a focused session on proteomics with Dr. Michael Anton Bauer from the University of Arkansas. Our discussion on T-cell exhaustion in cancer served as a perfect case study for how basic science directly informs patient care. It has also highlighted a personal and professional turning point: the realization that informatics and machine learning are no longer optional skills for the modern scientist, but are the primary tools required to translate complex biological data into clinical solutions.

Beyond the data and the methodology, the data day was defined by the spirit of mentorship. Professor Regina Appiah-Opong, a toxicologist from the Noguchi Memorial Institute in Ghana, shared her journey from pharmacy to the forefront of African science. Her advice to publish early and often resonated deeply, framing publication not just as a career requirement, but as a way to ensure that African researchers are active participants in the global scientific conversation.

Ultimately, day two of the pre-conference provided more than just technical knowledge; it provided a sense of place. In regions like Zambia, where structured career pathways for biomedical researchers are still blossoming, it is easy to feel confined to routine laboratory work. However, the insights shared by these experts reaffirmed my conviction that the future of African healthcare depends on those driven by curiosity. By leveraging genomics and bioinformatics to answer pressing health questions, we are not just supporting clinical practice; we are leading it. I left the session with a renewed determination: I do not just belong in the lab; I belong in the research that will shape the future of African medicine.

While trends in pancreatic, liver, and biliary cancers continue to rise, an open dialogue must be kept amongst clinicians and researchers across the African continent in order to foster better collaborative efforts towards the fight against these diseases and many more. The Africa HepatoPancreatoBiliary Cancer Consortium is an amazing example of an organization. bringing together over 200 African researchers and clinicians.

The 5th annual scientific meeting will be hosted in Abuja, Nigeria, August 12–15, 2026.

The Latest News in WGO Global Guidelines and Cascades

WGO's Committees and Review Teams are starting 2026 by continuing to work on updating existing Guidelines.

An update to the **Hepatocellular Carcinoma (HCC)** Guideline is ongoing under the leadership of Professor Mohamed El-Kassas (Egypt) and Doctor Calvin Pan (USA), with support from WGO's Hepatology Committee. Liver cancer is the fourth most common cause of death globally, accounting for over 800,000 deaths annually. HCC represents approximately 90% of primary liver cancers. The current version of the WGO Guideline dates to 2009.

Work also continues on the updated **Hepatitis B** Guideline. The hepatitis B virus (HBV) causes acute and chronic liver disease and is endemic in many areas of the world. The virus is transmitted through contact with blood or other body fluids from an infected person and is endemic throughout the world. This update is being led by Hepatology Committee Chair Professor Alice Lee (Australia) and Doctor Calvin Pan (USA).

A Resource Sensitive Solution

An update to the **Inflammatory Bowel Disease (IBD)** Guideline continues to be led by Professor Michael Schultz (New Zealand) with the assistance of WGO's IBD Committee, chaired by Professor Susana Lopes (Portugal). This Guideline will also include cascades, addressing diagnosis and treatment of IBD.

Looking ahead to 2027, a brand-new **Chronic Diarrhea** Guideline, chaired by Professor Govind Makharia (India), is in the works.

Please continue to watch upcoming issues of *e-WGN* as well as our website for news on the dissemination of these very important guidelines.

Calendar of Events

Please check the WGO Meetings and Events Calendar for the latest updates at https://www.worldgastroenterology.org/meetings/meetings-and-events-calendar

WGO RELATED EVENTS

World Digestive Health Day 2026
When: May 29, 2026
Location: Worldwide Events
Organizer: World Gastroenterology Organisation
Website: https://wdhd.worldgastroenterology.org/

World Congress of Gastroenterology 2026
When: September 30, 2026 – October 3, 2026
Location: India International Convention & Expo Centre
Address: New Delhi, India
Organizers: World Gastroenterology Organisation and Indian Society of Gastroenterology
Website: https://www.worldgastroenterology.org/meetings/world-congress-of-gastroenterology

WGO Member Societies Submit Your Event
Are you a WGO Member Society wanting to share your event with WGO readers? Visit https://www.worldgastroenterology.org/forms/submit-event.php to submit your event for publication in WGO's website conference calendar as well as the quarterly *e-WGN* calendar of events!

CALENDAR OF EVENTS

Dutch Digestive Disease Days 2026
When: March 18, 2026 – March 19, 2026
Location: Veldhoven
Country: Netherlands
Organizer: Nederlandse Vereniging Voor Gastro-enterologie
Website: https://www.nvge.nl/meetings-en-congressen/digestive-disease-days

International Symposium on Helicobacter and Upper Gastrointestinal Diseases (HUG 2026)
When: March 19, 2026 – March 21, 2026
Location: Lotte Hotel
Address: Seoul, Korea
Organizer: Korean College of Helicobacter and Upper Gastrointestinal Research
Website: www.helicobacterkorea.org

JFHOD 2026
When: March 19, 2026 – March 22, 2026
Location: Paris
Country: France
Organizer: Société Nationale Française de Gastro-Entérologie
Website: http://www.snfge.org/

56th Annual Meeting of GEST
When: March 21, 2026 – March 22, 2026
Location: Taipei
Country: Taiwan
Organizer: The Gastroenterological Society of Taiwan
Website: http://www.gest.org.tw/

29th Annual Meeting
When: March 25, 2026 – March 27, 2026
Location: Madrid
Country: Spain
Organizer: Asociacion Espanola de Gastroenterologia
Website: https://www.aegastro.es/

Gazi Gastroenterology Days
When: April 2, 2026 – April 4, 2026
Location: Ankara
Country: Turkey
Organizer: Gazi University Department of Gastroenterology
Website: https://gazigastrogunleri.org/tr/

AWIG 2026
When: April 15, 2026 – April 19, 2026
Location: Ocho Rios
Country: Jamaica
Organizer: Association of West Indian Gastroenterologists
Website: https://www.awigcaribbean.org/

32nd National Congress
When: April 16, 2026 – April 18, 2026
Location: Rome
Country: Italy
Organizer: Società Italiana di Gastroenterologia ed Endoscopia Digestiva
Website: https://www.sigeitalia.it

APASL 2026
When: April 22, 2026 – April 25, 2026
Location: Lütfi Kırdar International Convention and Exhibition Centre
Address: Istanbul, Turkey
Organizer: Asian Pacific Association for the Study of the Liver
Website: https://www.apasl2026istanbul.org/

DDW 2026
When: May 2, 2026 – May 5, 2026
Location: Chicago, Illinois
Country: USA
Organizers: AGA, AASLD, ASGE
Website: https://ddw.org/

EASL 2026
When: May 27, 2026 – May 30, 2026
Location: Fira Barcelona
Address: Barcelona, Spain
Organizer: EASL
Website: https://easl.eu/event/easl-congress-w0w6/

85th Congress de la SEPD
When: June 11, 2026 – June 13, 2026
Location: Seville
Country: Spain
Organizer: Sociedad Espanola de Patologia Digestiva
Website: https://www.sepd.es/inicio

BSG Live'26
When: June 22, 2026 – June 25, 2026
Location: Liverpool
Country: United Kingdom
Organizer: British Society of Gastroenterology
Website: https://live.bsg.org.uk/

Annual Meeting of the Asociación Hondureña de Gastroenterología
When: July 30, 2026 – August 1, 2026
Location: Centro de Convenciones Hotel Copantl Sula
Address: San Pedro Sula, Honduras
Organizer: Asociación Hondureña de Gastroenterología

AGW 2026
When: August 28, 2026 – August 31, 2026
Location: Perth, WA
Country: Australia
Organizer: Gastroenterological Society of Australia
Website: https://www.gesa.org.au/

IFSO 2026
When: September 1, 2026 – September 4, 2026
Location: Toronto, Ontario
Country: Canada
Organizer: IFSO
Website: https://www.ifso.com/

22nd World Congress for Esophageal Diseases
When: September 16, 2026 – September 18, 2026
Location: Kyoto
Country: Japan
Organizer: ISDE
Website: https://isde-congress.net/future_congresses/

EUS-ENDO 2026
When: September 17, 2026 – September 19, 2026
Location: Strasbourg
Country: France
Organizer: Course Director Dr. Marc Giovannini
Website: www.eus-endo.org

Indonesian Digestive Disease Week (IDDW) 2026
When: September 30, 2026 – October 4, 2026
Location: Jakarta
Country: Indonesia
Organizer: Indonesian Society of Gastroenterology
Website: https://pbpgigastro.com/

UEG Week 2026
When: October 17, 2026 – October 20, 2026
Location: Barcelona
Country: Spain
Organizer: UEG
Website: https://ueg.eu/week

JDDW 2026
When: November 5, 2026 – November 7, 2026
Location: Kobe
Country: Japan
Organizer: Organization of JDDW
Website: https://www.jddw.jp

Federation of Neurogastroenterology and Motility Meeting
When: November 5, 2026 – November 7, 2026
Location: Grand Hyatt Convention Center
Address: Bogota, Colombia
Organizers: FNM and the Sociedad Latinoamericana de Neurogastroenterología
Website: https://fnm2026meeting.com/

The Liver Meeting 2026
When: November 5, 2026 - November 9, 2026
Location: Denver, Colorado
Country: United States
Organizer: AASLD
Website: www.aasld.org

APDW 2026
When: November 25, 2026 – November 29, 2026
Location: Manila
Country: Philippines
Organizer: APDW
Website: https://www.apdwcongress.org/

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Navigate through this hub of knowledge: www.biocodexmicrobiotainstitute.com/pro