OneGI

SECOND ANNUAL GI & LIVER *Summit*

What's New in GI Pharmacotherapy?

Philip Schoenfeld, MD, MSEd, MSc (Epi)
Editor-in-Chief, Evidence-Based GI: An ACG Publication
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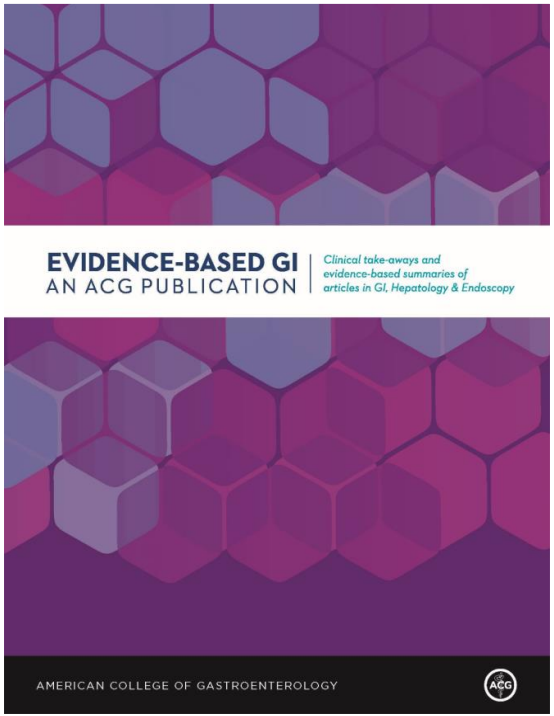
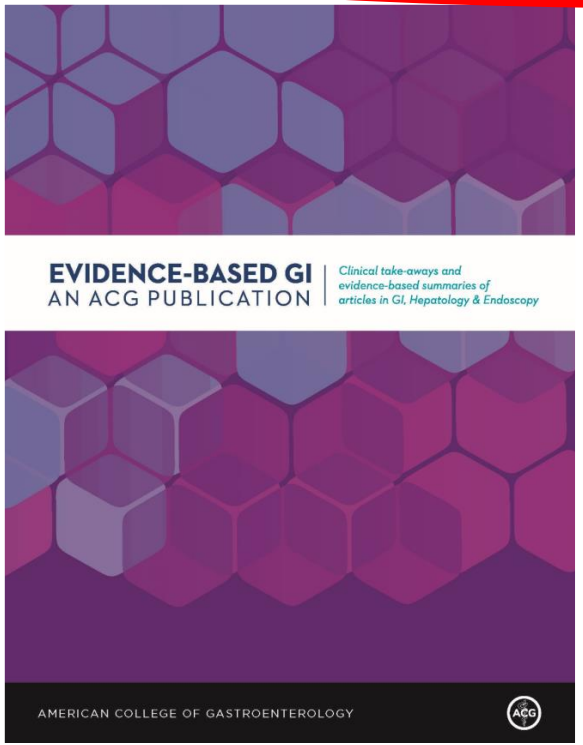
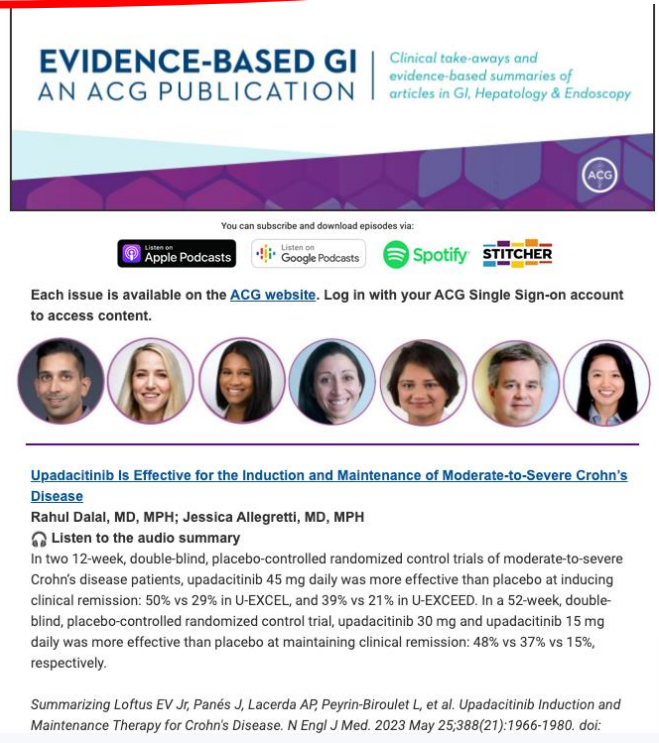
EVIDENCE-BASED GI
AN ACG PUBLICATION
Clinical take-aways and
evidence-based summaries of
articles in GI, Hepatology & Endoscopy
AMERICAN COLLEGE OF GASTROENTEROLOGY
ACG

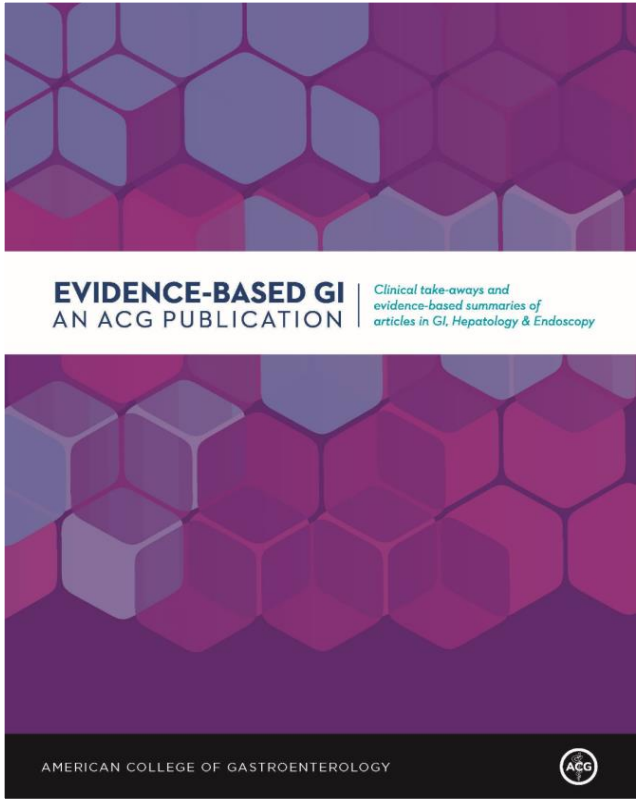


- Monthly online ACG publication. Blast e-mail sent mid-month. Issues archived at ACG website.
- Summarizes important GI clinical research recently published in non-GI journals, including NEJM, JAMA, Lancet, etc.
- Each summary provides structured abstract and expert commentary
- Designed to be read on your phone
- Weekly podcasts and tweetorials

American College of. New issue of Evidenced-Based GI - Each issue is available on the ACG website. Log in with your A... Jul 12







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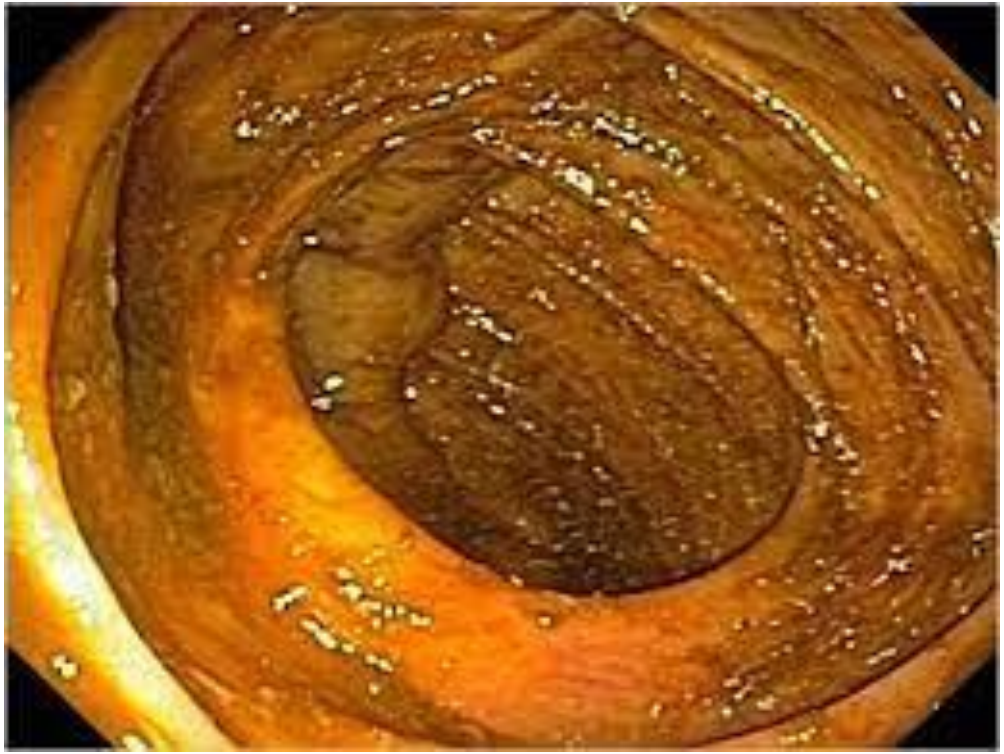
Poor Bowel Preps: A Daily Frustration!



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Clinical take-aways and evidence-based summaries of articles in GI, Hepatology & Endoscopy

It's a Bad "Prep" Even Though the Patient Took It Correctly: Consider 15 mg Bisacodyl plus 4-Liter PEG Split Prep Before Next Colonoscopy

Philip Schoenfeld, MD, MSEd, MSc (Epi)

Chief (Emeritus)-Gastroenterology Section, John D. Dingell VA Medical Center, Detroit, MI

This article reviews Sey MSL, Von Renteln D, Sultanian R, et al. A Multicenter Randomized Controlled Trial Comparing Bowel Cleansing Regimens for Colonoscopy After Failed Bowel Preparation. Clin Gastroenterol Hepatol 2022; In Press.

Philip Schoenfeld, MD, MSEd, MSc (Epi)
Editor-in-Chief

Tweetorial provided by:

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Our first EBGI Ambassador
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Why Do Patients Have Bad Preps Even When They Are Compliant With Instructions and Complete the Prep?

- **Risk Factors for colonic dysmotility and inadequate bowel preparation despite compliance**
- Obesity
- Current opioid use
- Diabetes mellitus
- History of using constipation treatments
- Current use of anticholinergics (including TCA)
- *Prior history of inadequate prep!*

Why Do Patients Have Bad Preps Even When They Are Compliant With Instructions and Complete the Prep?

- **<u>Risk Factors for colonic dysmotility and inadequate bowel preparation despite compliance</u>**
  - Obesity
  - Current opioid use
  - Diabetes mellitus
  - History of using constipation treatments
  - Current use of anticholinergics (including TCA)
  - *<u>Prior history of inadequate prep!</u>*

Note: In non-compliant patient, additional patient education is probably more beneficial than prescribing supra-therapeutic bowel prep regimen.

- No prior RCT assessing patients who successfully completed 4L PEG split-prep but still had inadequate cleansing.
- Multi-center, single-blind RCT
- Intervention: 4L PEG split prep + 15mg bisacodyl (taken at 2pm on day before scope) vs 6L PEG split prep + 15mg bisacodyl
- Outcome: Adequate bowel prep based on BBPS ≥6 with ≥2 in each segment
- Patient Demographics: 37% obese, 41% with IBS-C or CIC, 10% on opioids. Prior bowel prep: 35% used 4L PEG; 38% used 2L PEG; 12% used sodium picosulfate

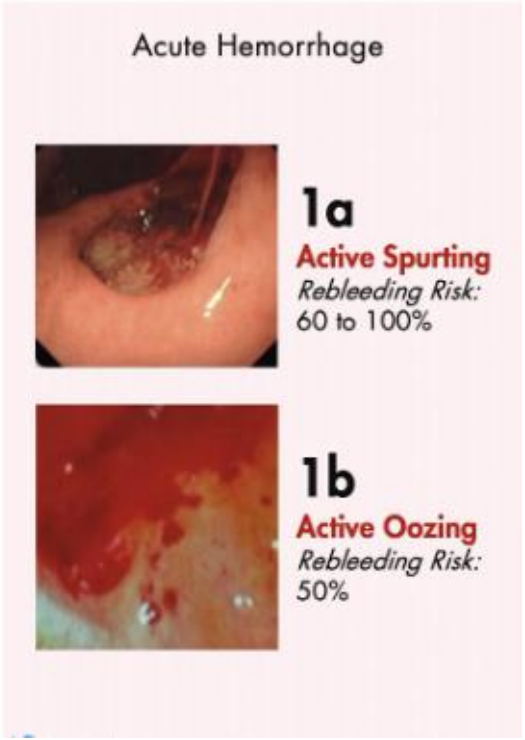
It's a Bad "Prep" Even Though the Patient Took It Correctly: Consider 15 mg Bisacodyl plus 4-Liter PEG Split Prep Before Next Colonoscopy

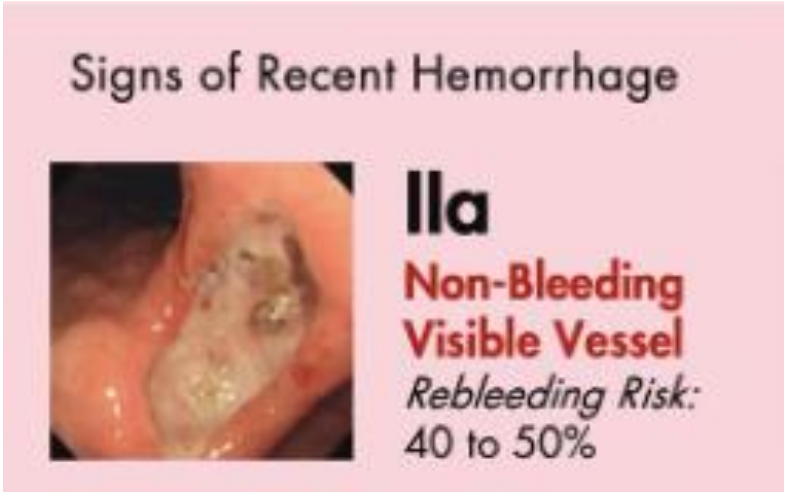
Outcome		Split-dose 4L + bisacodyl (n=97)	Split-dose 6L + bisacodyl (n=99)	*P*-value
Adequate cleansing	Defined as BBPS ≥6	83 (91.2%)	78 (87.6%)	0.44
	Defined as adequate to identify polyps >5mm	82 (91.1%)	76 (85.4%)	0.24
Secondary endpoints	Cecal intubation rate, n (%)	87 (98.7%)	82 (92.1%)	0.19
	Adenoma detection rate, n (%)	34 (37.4%)	28 (31.5%)	0.41
Adherence	Diet + consumed 100% of prep	67 (81.7%)	53 (68.0%)	0.05
	Diet + consumed 80% of prep	71 (86.6%)	57 (73.1%)	0.03

My Practice:

- For patients with history of poor bowel preparation or 2 risk factors for poor prep >>>>
- Prescribe 4 liters PEG split-prep + 15 mg bisacodyl at 2pm on day before procedure.

Forrest 1a, 1b, and IIa Bleeding Peptic Ulcers: Best Practices to Control Bleeding and Reduce Re-Bleeding





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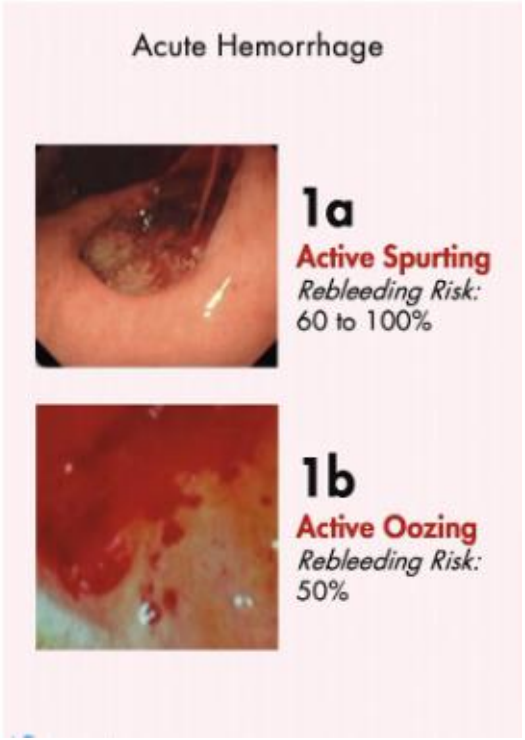

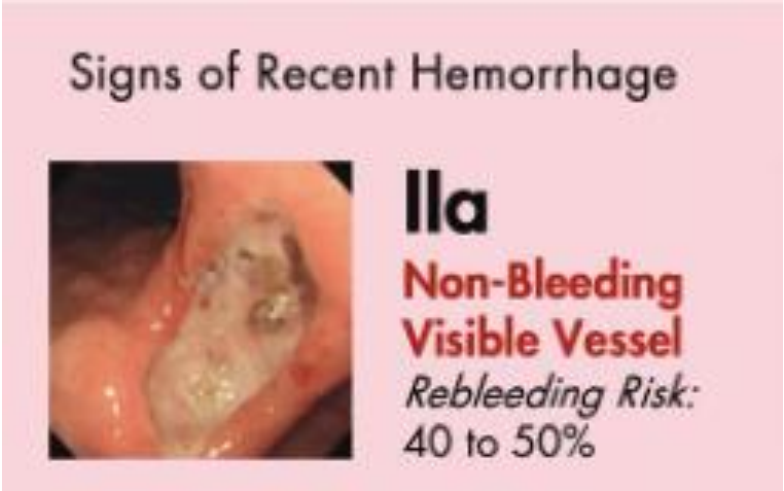

These are re-bleeding risks without endoscopic intervention + PPIs. However, even with conventional therapy, failure to control bleeding or re-bleeding is 10-20%!

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Clinical take-aways and evidence-based summaries of articles in GI, Hepatology & Endoscopy

Over-the-Scope Clips Decrease Non-Variceal Upper GI Bleeding vs Standard Endoscopic Treatment… In the Right Patient

Jennifer M. Kolb MD, MS

Assistant Professor of Medicine, Division of Gastroenterology, Hepatology and Parenteral Nutrition, VA Greater Los Angeles Healthcare System, David Geffen School of Medicine at UCLA, Los Angeles, CA

This summary reviews Lau JYW, Li R, Tan C et al. Comparison of Over-the-Scope Clips to Standard Endoscopic Treatment as the Initial Treatment in Patients With Bleeding From a Nonvariceal Upper Gastrointestinal Cause: A Randomized Controlled Trial. *Ann Intern Med* 2023 Apr;176(4):455-462. doi: 10.7326/M22-1783

Correspondence to Jennifer M. Kolb, MD, MS. Associate Editor. Email: EBGI@gi.org

Drs Kolb, Chauhan and Ezeani have no disclosures

Tweetorial Provided by:

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PGY-3, @TJUHospital

EBGI Ambassadors

Over-The-Scope-Clip Highlights

- Nitinol clips mounted on a clear plastic cap
- Attached to the endoscope externally
- Target tissue suctioned into cap
- Deployed clip results in 8 opposing prongs to approximate anchoring into mucosal tissue

Adapted from-Over the scope clip system… Kobara et al. *JGH*. 2018.

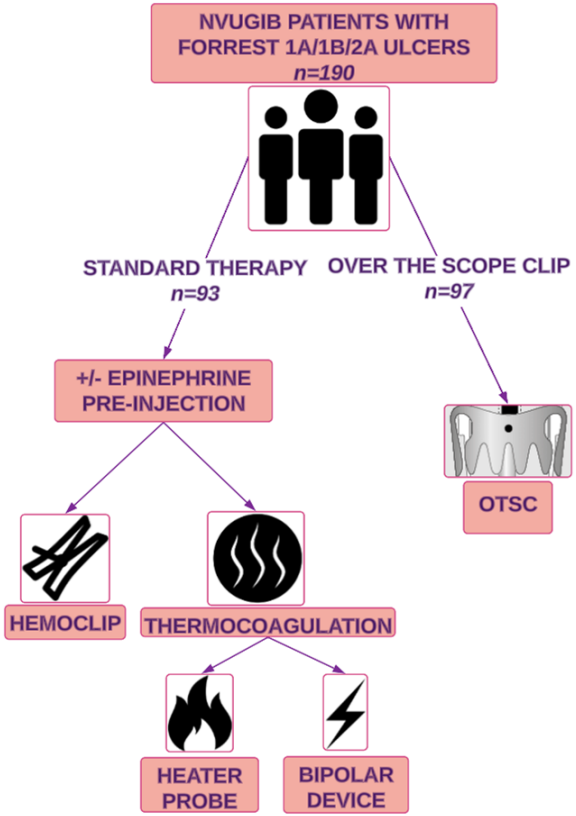
“Over-the-Scope clips decrease non-variceal upper GI bleed vs Standard Endoscopic Treatment… In the right Patient”
Summary of Lau JY, Tan C, Sun X, et al. Comparison of Over-the-Scope Clips to standard Endoscopic Treatment as the initial Treatment in patients with Bleeding from a Nonvariceal Upper Gastrointestinal Cause. Ann Intern. Med. 2023; 176(4):455-462

IMPORTANCE

10-20% Risk of Re-Bleed in High-Risk Lesions with Conventional Treatment

10-20% risk of re-bleed in high-risk lesions with conventional treatment

May affirm OTSC as new first line therapy for NVUGIB (vs. currently only after treatment failure).



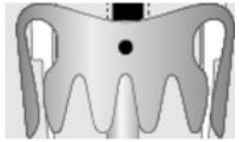
Primary Endpoint

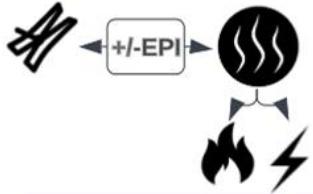
"Over-the-Scope clips decrease non-variceal upper GI bleed vs Standard Endoscopic Treatment… In the right Patient"
Summary of Lau JYW, Tan C, Sun X, et al. Comparison of Over-the-Scope Clips to standard Endoscopic Treatment as the initial Treatment in patients with Bleeding from a Nonvariceal Upper Gastrointestinal Cause. Ann Intern. Med. 2023; 176(4):455-462

30-day probability of further bleeding (Composite score)

- Failure to control Bleeding (Primary hemostasis)
- Recurrent bleeding (within 30 days)

STUDY RESULTS

STANDARD THERAPY		OTSC
		
14.6%	FURTHER BLEEDING 95% CI 3.3-20.0, *P*=0.006	3.2%
6.2%	PRIMARY HEMOSTASIS FAILURE 95% CI: 0.7-11.8	1.1%
8.8%	30-DAY RECURRENT BLEED 95% CI: -0.3 to 14.4	2.2%



VS.

"Over-the-Scope clips decrease non-variceal upper GI bleed vs Standard Endoscopic Treatment… In the right Patient"
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My Practice:

- Worked with advanced endoscopists and endoscopy technicians to learn how to mount OTSC clip and practice placement.

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Treating *Helicobacter pylori* Infection With Vonoprazan, A Potassium-Competitive Acid Blocker: A New Paradigm

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Chief Emeritus-Gastroenterology Section, John D. Dingell VA Medical Center, Detroit, Michigan

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Tweetorial provided by:

Romy Chamoun, MD
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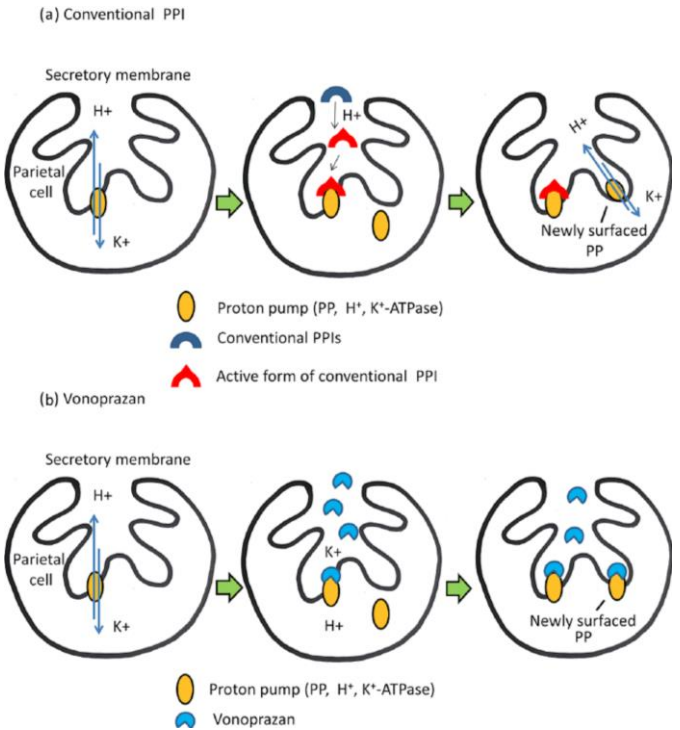
EBGI Ambassador
PGY-3, Lankenau Medical Center



Conventional PPIs are

- Unstable in canaliculi
- Rapidly degraded
- Not able to inhibit new proton pumps (PPs) that surface after administration of the drug.

→ require a few days to reach their maximum effect

Vonoprazan, a potassium-competitive acid blocker acts differently:

✓does not require acid activation

✓rapidly absorbed in the small intestine

✓binding to H+/K+-ATPase in a K+-competitive manner

✓more stable than conventional PPIs in the canaliculi

→ fast and stable inhibition of gastric acid secretion

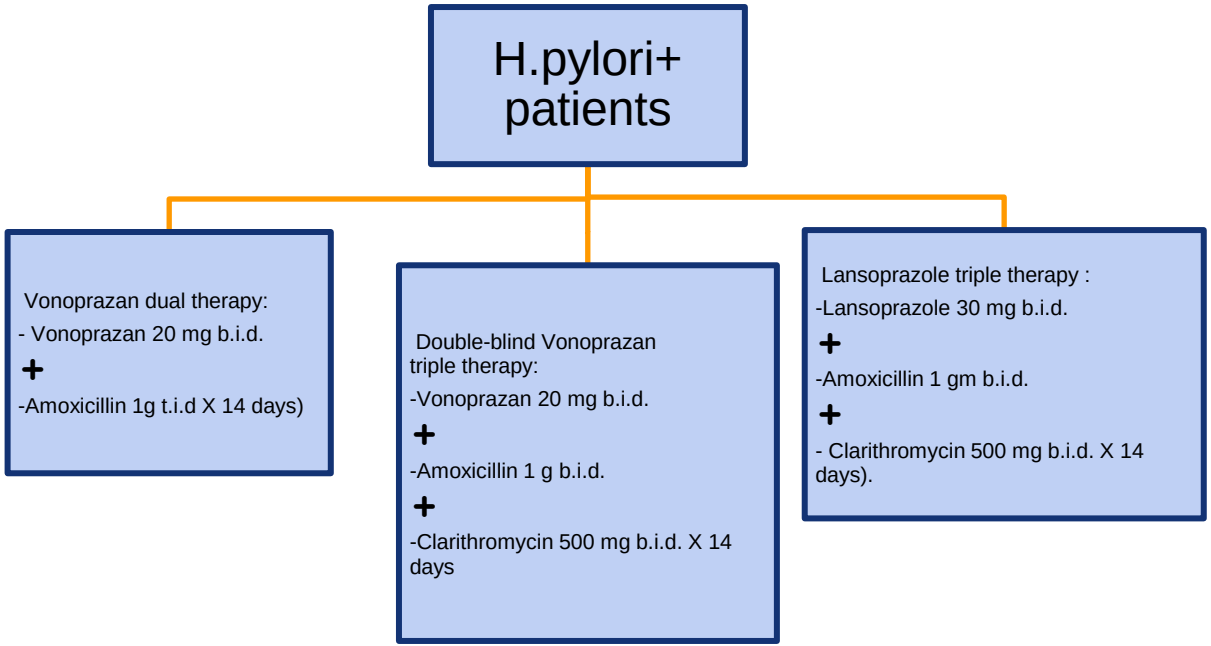
Adapted from: Akazawa et al. Vonoprazan-based therapy for Helicobacter pylori eradication: experience and clinical evidence. *Therapeutic Advances in gastroenterology*. 2017. 9 (6) 845-852.

Inclusion Criteria

A - > 18 years old

B – Tested for H. pylori due to dyspepsia or PUD

C - They were tx-naïve + had *H.pylori* confirmed with a positive ^{13}C-urea breath test



Adapted from: Chey WD, Megraud F, Laine L, et al. Vonoprazan Triple and Dual Therapy for *Helicobacter* pylori Infection in the US and Europe: A Randomized Controlled Trial. *Gastroenterology.* 2022 Jun 6;S0016-5085(22)00609-6.

US and European phase 3 RCT comparing vonoprazan- and lansoprazole-based regimens

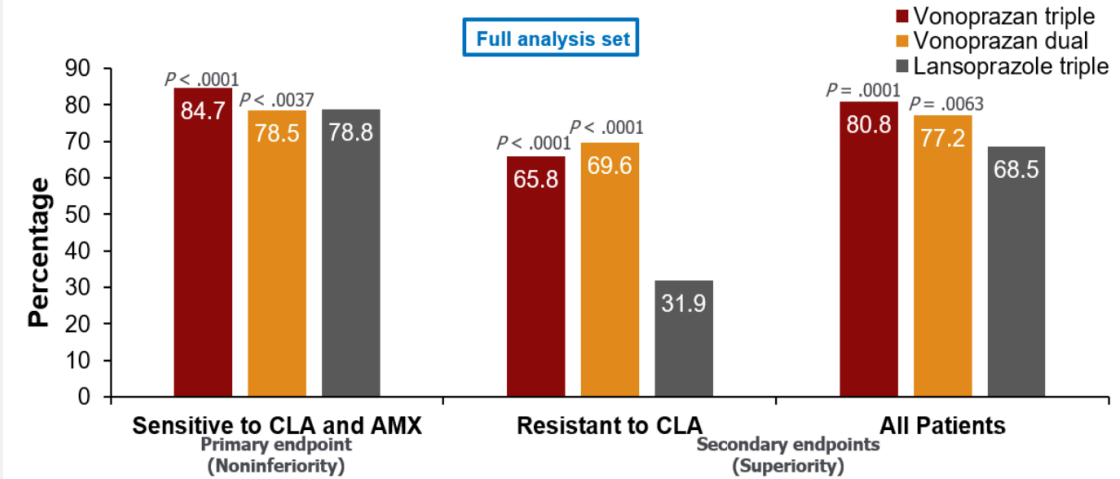


Figure 1: *Helicobacter pylori* eradication rates.
AMX, amoxicillin ; CLA, clarithromycin; RCT, randomized controlled trial.

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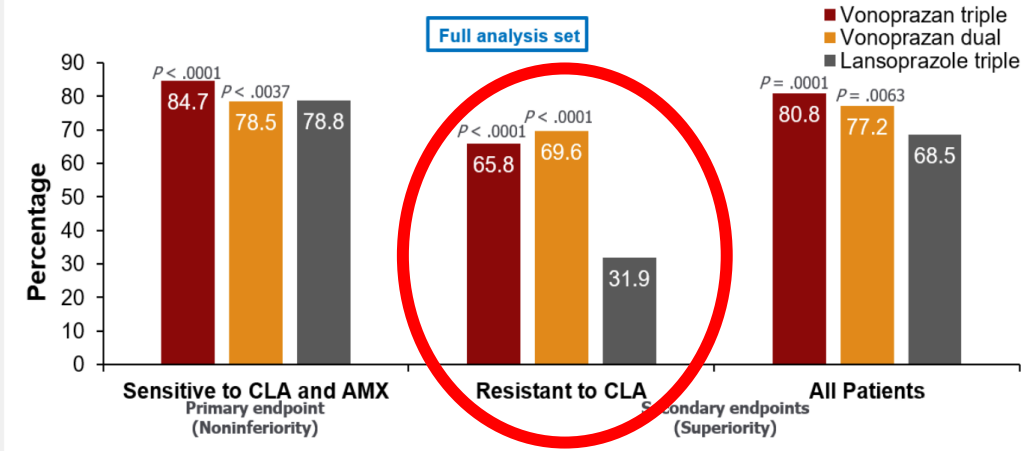


Figure 1: *Helicobacter pylori* eradication rates.
AMX, amoxicillin ; CLA, clarithromycin; RCT, randomized controlled trial.

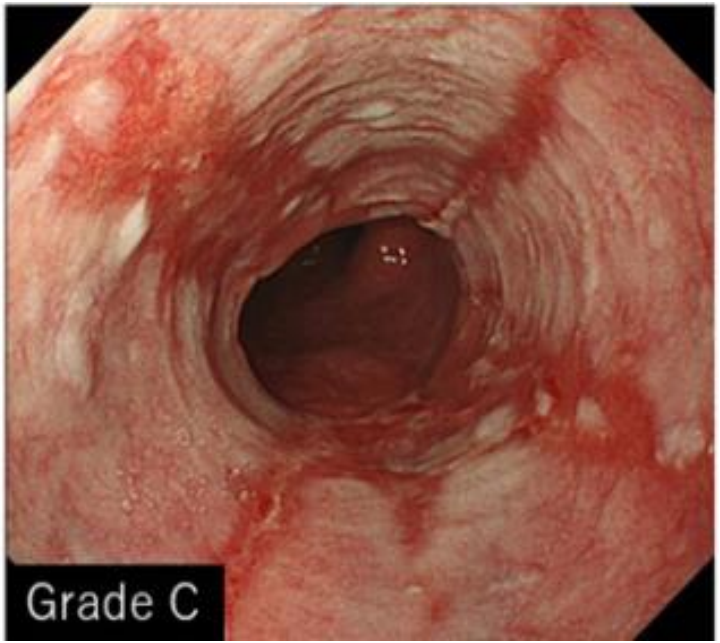
If clarithromycin resistance is > 15-20% in your region or if your patient previously tx with "-mycins" antibiotic, use vonoprazan-based regimen

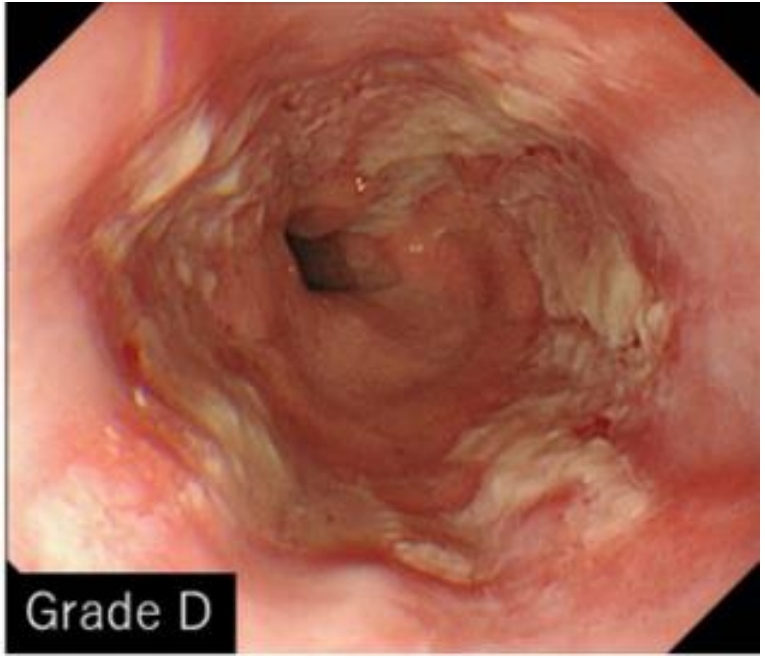
Adapted from: Chey WD, Megraud F, Laine L, et al. Vonoprazan Triple and Dual Therapy for *Helicobacter* pylori Infection in the US and Europe: A Randomized Controlled Trial. *Gastroenterology.* 2022 Jun 6;S0016-5085(22)00609-6.

My Practice:

- Worked I don’t use clarithromycin-based h.pylori treatment regimens. Currently, I rely on bismuth-based quadruple regimens.
- When vonoprazan-based regimens become available in next 6 months, will use vonoprazan 20mg bid + 1000mg amoxicillin tid X 14 days as my primary regimen.

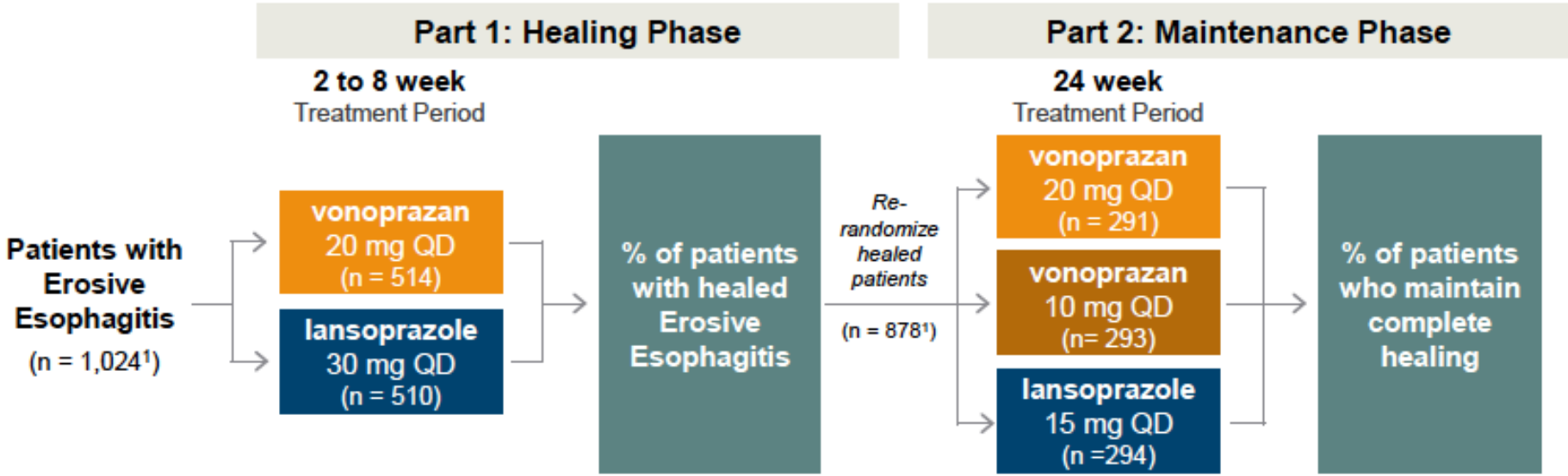
LA Class C & D Erosive Esophagitis: Best Practices for Healing & Maintenance of Healing



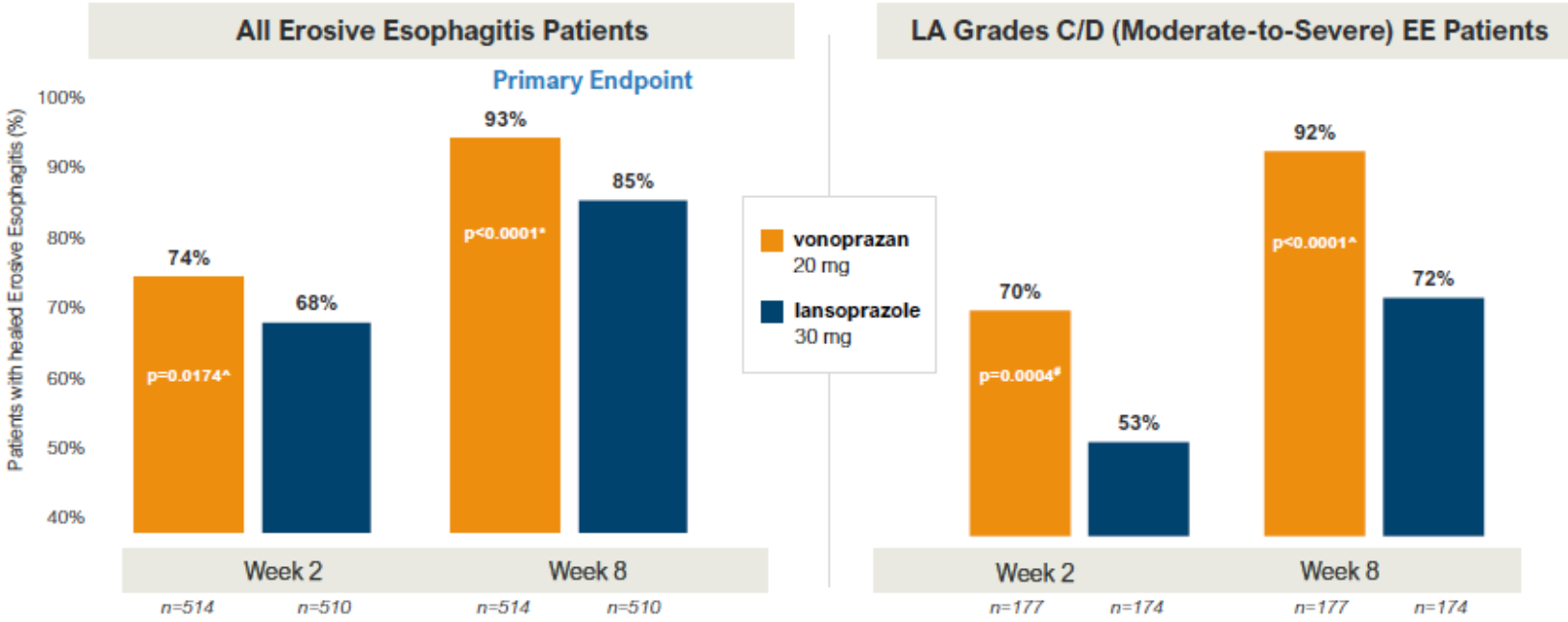


PHALCON-EE phase 3 study design

US/Europe study in Erosive Esophagitis



Healing endpoints



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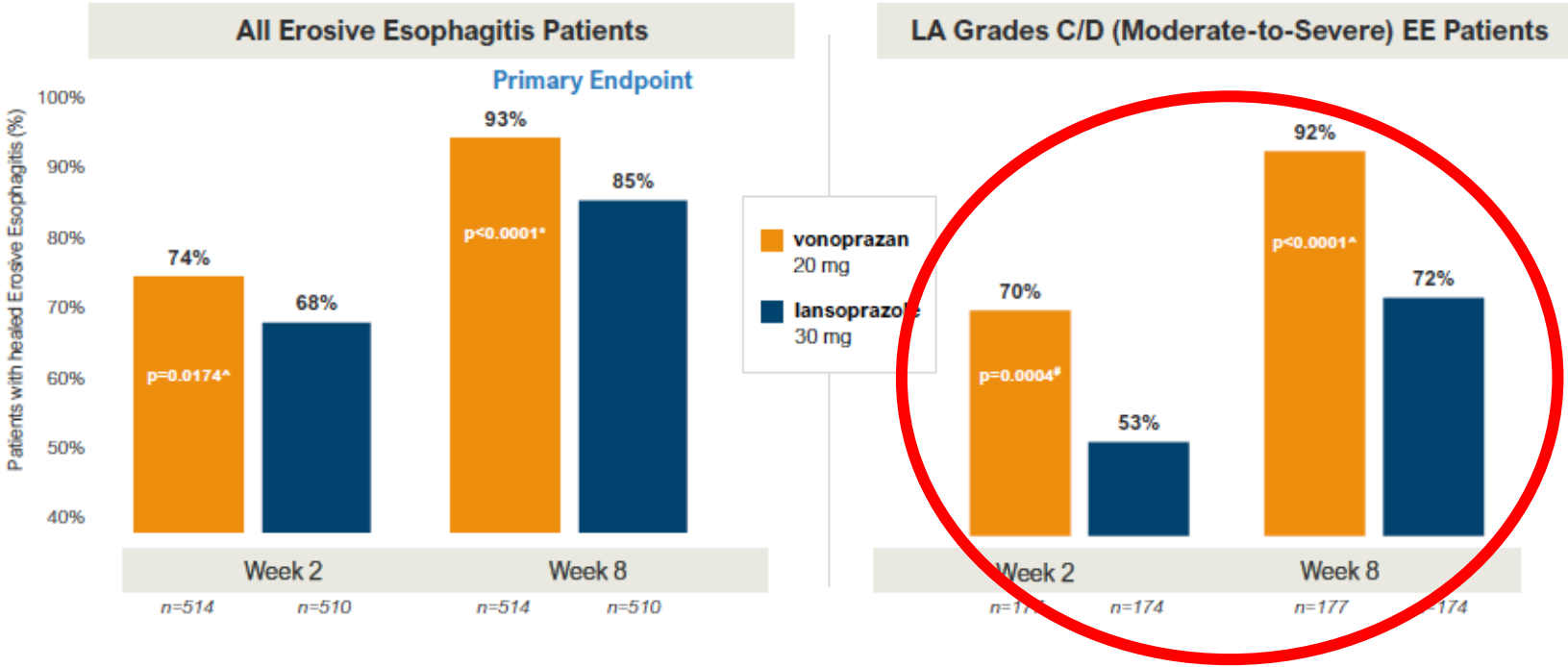
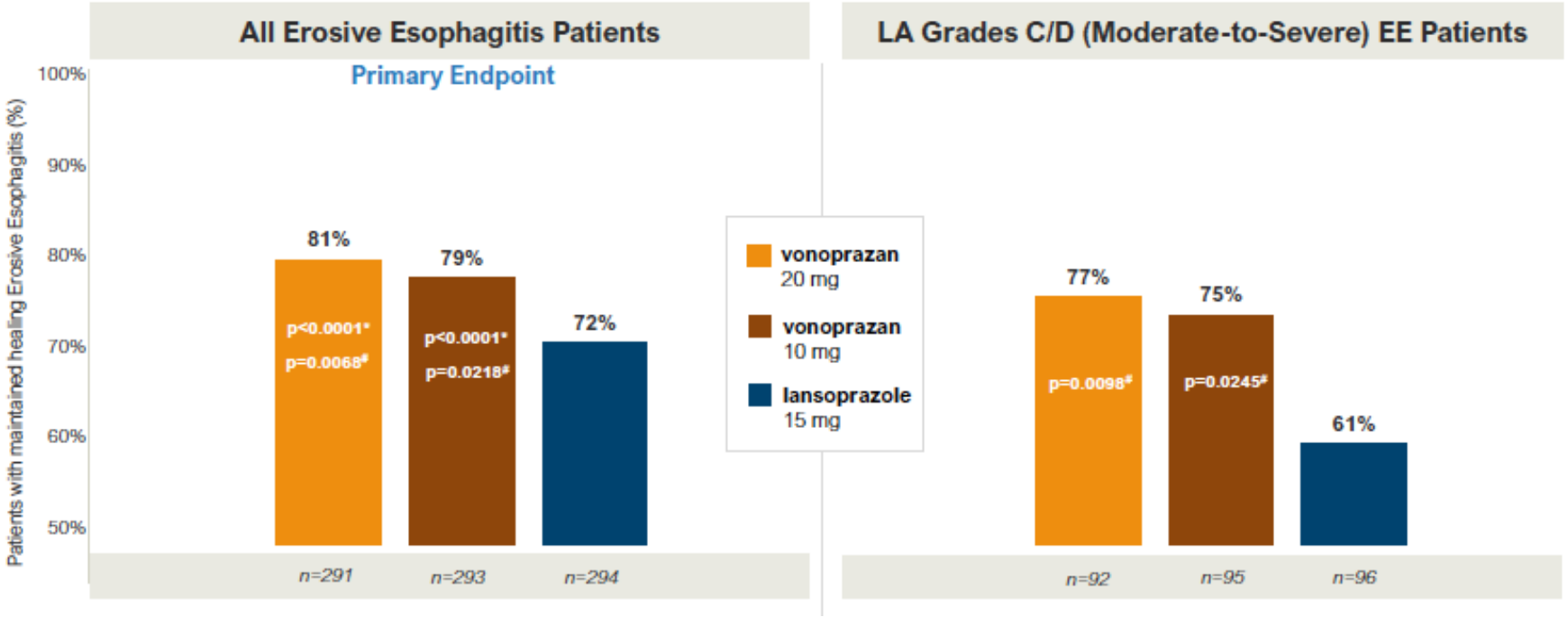


Maintenance of healing endpoints



Maintenance of healing endpoints