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Swiss Association for the Study of the Liver
Swiss Society of Endoscopy Nurses and Associates

Abstracts of the annual meeting 2026

Interlaken (Switzerland), September 17–18, 2026

SWISS SOCIETY OF GASTROENTEROLOGY (SGG-SSG)
SWISS ASSOCIATION FOR THE STUDY OF THE LIVER (SASL)
SWISS SOCIETY OF ENDOSCOPY NURSES AND ASSOCIATES (SVEP-ASPE)

ABSTRACTS OF THE ANNUAL MEETING 2026

INTERLAKEN, SEPTEMBER 17–18, 2026

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IBD ORAL PRESENTATIONS

IBD1

The tryptophan metabolite 8-methoxykynurenate activates GPR35 to drive eosinophilic esophagitis through IL-18 and barrier dysfunction

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Background: Eosinophilic esophagitis (EoE) is a chronic inflammatory disorder characterized by dysregulated cytokine responses and impaired epithelial barrier function. Although G protein-coupled receptor 35 (GPR35) regulates inflammatory and epithelial pathways, its role in EoE remains unknown.

Methods: We investigated how GPR35 drives macrophage-epithelial signaling in EoE using human metabolomics, genetic mouse models, and ligand discovery approaches.

Results: GPR35 expression was markedly upregulated in active EoE patients and was predominantly detected in macrophages in EoE models. Strikingly, deletion of *Gpr35* in macrophages attenuated EoE pathology, which correlated with reduced Il-18 levels. Metabolomics and molecular docking identified 8-methoxykynurenate (8-MK) as an endogenous GPR35 ligand enriched in active EoE biopsies. Functional validation demonstrated that 8-MK stimulation in macrophages increased Il-18 production, while *Il18* deletion protected mice from experimental EoE. Mechanistically, Gpr35 promoted Il-18 expression through dysregulated intracellular calcium flux and subsequent inflammasome activation. Critically, IL-18 impaired epithelial barrier function by reducing transepithelial electrical resistance and increasing macromolecule flux in air-liquid interface cultures.

Conclusions: We identify an 8-MK-GPR35 axis linking tryptophan metabolism to IL-18-mediated barrier dysfunction in EoE, highlighting GPR35 as a therapeutic target.

IBD2

The novel anti-integrin αvβ6 autoantibodies show high diagnostic accuracy and outperform anti-neutrophil cytoplasmic antibodies and anti-Saccharomyces cerevisiae antibodies in distinguishing ulcerative colitis from Crohn's disease: a prospective cross-sectional study

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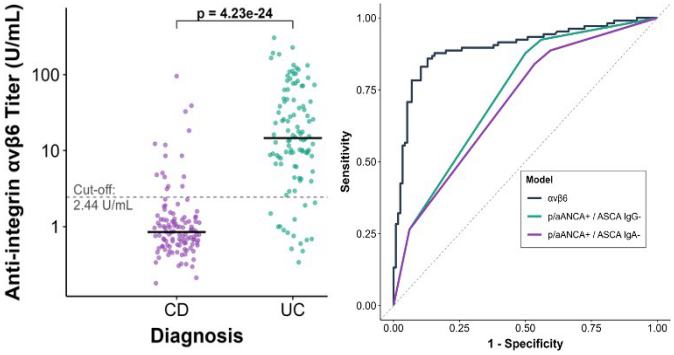
Background: Better biomarkers are needed to reliably distinguish ulcerative colitis (UC) from Crohn's disease (CD). We assessed the diagnostic accuracy of anti-integrin αvβ6 autoantibodies for differentiating UC from CD and compared their performance with the conventional serological markers anti-neutrophil cytoplasmic antibodies (p/aANCA) and anti-Saccharomyces cerevisiae antibodies (ASCA).

Methods: In this prospective cross-sectional observational study, serum anti-integrin αvβ6 autoantibodies, ANCA, and ASCA were analysed in patients with UC and CD. Clinical data, including phenotype and disease activity, were collected. The primary outcome was the diagnostic accuracy of anti-integrin αvβ6 autoantibodies for distinguishing UC from CD. Secondary outcomes included comparison with conventional serological markers and analysis across disease phenotypes.

Figure 1

A: Anti-integrin αvβ6 Ab titers in CD and CD. The optimal cut-off of 2.44 U/mL, which resulted in a sensitivity of 85.8% and a specificity of 87.1%, was determined by the Youden index.

B: Comparative diagnostic accuracy of anti-integrin αvβ6 and p/aANCA+ / ASCA IgG- or IgA-.



Results: A total of 224 patients (118 patients with CD and 106 with UC) were included. Most patients received treatment with biologics or small molecules (CD vs. UC: 92% vs. 75%), with 72% vs. 50% in remission, respectively. At a diagnostic cut-off of 2.44 U/mL, anti-integrin αvβ6 autoantibodies demonstrated an accuracy of 86.5%, with a sensitivity of 85.8% and specificity of 87.1% for discriminating CD from UC. In multivariate logistic regression analysis, anti-integrin αvβ6 autoantibodies was an excellent independent predictor of UC (OR 36.18, 95% CI 17.0-83.0, $p = 4.86 \times 10^{-19}$). The anti-integrin αvβ6 autoantibody-based model showed improved performance compared with conventional serology using ANCA and ASCA status (AIC 184.8 vs. 252.4, $p = 5.58 \times 10^{-16}$). The anti-integrin αvβ6 autoantibody positivity rates differed significantly across Montreal classifications, with a gradient towards colonic CD and UC; L1 (ileal CD): 7.9%, L3 (ileocolonic CD): 8.1%, L2 (colonic CD): 43.8%, UC: 85.8% (Fisher's exact test, $p = 2.04 \times 10^{-31}$). A trend towards higher anti-integrin αvβ6 autoantibody positivity with increasing disease activity was observed.

Conclusions: Anti-integrin αvβ6 autoantibodies demonstrate high diagnostic accuracy and outperform conventional serological markers in distinguishing UC from CD, suggesting to implement this test in daily clinical practice for cases with an undetermined IBD phenotype. Importantly, this study provides the first direct comparison of anti-integrin αvβ6 autoantibodies with p/aANCA and ASCA using the same serum samples.

IBD3

Risk of Venous Thromboembolism During Pregnancy and Postpartum in Women With Inflammatory Bowel Disease: A Swiss Population-Based Cohort and Case-Control Study

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Background: IBD often affects reproductive-age women. Even though both pregnancy and IBD are understood as VTE risk factors, data on their combined peripartum VTE risk are limited.

Methods: Using nationwide Swiss data from all inpatient deliveries between 2012 and 2022, we conducted a population-based cohort study (postpartum follow-up [≤3 months and long-term]) and case-control study (pregnancy [10 months preceding delivery] and delivery hospitalization) to assess peripartum VTE risk in women with IBD. Stabilized IPTW logistic and Cox regression estimated odds ratios and hazard ratios respectively.

Results: Among 658,776 women, 1,831 had IBD (CD, n = 1,021; UC, n = 810). In the case-control analysis, IBD was associated with increased VTE risk during pregnancy (OR, 4.61; 95% CI, 1.70–12.48) and at delivery hospitalization (OR, 3.51; 95% CI, 1.94–6.33). No excess risk was observed in the postpartum period (≤3 months; HR, 0.99; 95% CI, 0.14–7.02). During a median follow-up of 3.4 years, VTE occurred in 10 women with IBD (IR, 11.1 per 100,000 PY) and 744 women without IBD (IR, 2.1 per 100,000 PY), yielding a HR of 5.24 (95% CI, 2.65–10.36).

Conclusions: IBD was associated with a substantially increased VTE risk during pregnancy, delivery hospitalization, and long-term follow-up, but not in the postpartum period. These findings support consideration of individualized thromboembolic risk assessment throughout pregnancy and the peripartum period in women with IBD.

IBD4

Dupilumab is effective and safe in refractory patients with eosinophilic esophagitis: real-world evidence from Switzerland and Austria

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Background and aims: We aimed to assess the effectiveness and safety of dupilumab in adult EoE patients prospectively included into the Swiss and Austrian EoE cohort.

Patients and methods: Clinical (VAS dysphagia 0-10), endoscopic (EREFS), and histologic activity (peak eosinophils/hpf) at baseline (T1) was compared to the corresponding activities assessed at the first endoscopic control under dupilumab.

Results: We included 74 adults with EoE (62.2% males). Treatments at baseline: swallowed topical corticosteroids (STC, 97.3%); PPI (75.7%); food elimination diets (55.4% of patients). Reasons to initiate dupilumab: histologically refractory EoE under conventional treatment (77%), weight gain under STC (8.1%), repetitive candidiasis under STC (14.9%). Disease activity at baseline: dysphagia-VAS 5 (IQR 4-7), EREFS 4 (IQR 3-5, range 0-7), peak eos count 73/hpf (IQR 32-107, range 0-238). All patients were treated with dupilumab 300mg sc weekly. The first endoscopic and histologic control took place at week 29 under dupilumab (IQR 24-40). Significant improvements as compared to baseline were observed under dupilumab regarding symptoms (dysphagia-VAS 1.5, IQR 0-2, range 0-5), endoscopic activity (median EREFS 1, IQR 1-2, range 0-3), and peak eos counts (median 3, IQR 0-8, range 0-21) ($p<0.001$ for all three domains). 69/74 (93.2%) were in histologic remission (defined as

<15 eos/hpf) under dupilumab. Side effects: injection site reaction (3/74, 4.1%), headache (3/74, 4.1%), acne (1/74, 1.3%). Dupilumab was continued in 70/74 (94.6%) of patients.

Conclusions: In this population of refractory EoE patients, dupilumab was effective in significantly improving symptoms, histology and endoscopic activity and showed a favorable safety profile.

IBD5

Baseline microbial ecology predicts responsiveness to D-lactate-free probiotic therapy in coitis

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Background. Gut microbial ecology influences intestinal inflammation and may determine responsiveness to probiotic therapies. However, the therapeutic effects of D-lactate-free probiotics during colitis remain poorly understood.

Methods. Acute DSS-induced colitis was established in mice with distinct baseline microbiota configurations. Mice received D-lactate-free probiotic supplementation before and during DSS exposure. Disease severity was assessed using disease activity index, histopathology, colon length, cytokine profiling, and serum D-lactate levels. Gut microbiota dynamics were analyzed using 16S rRNA sequencing, ecological network analysis, and machine-learning approaches.

Results. D-lactate-free probiotics reduced colitis severity in a microbiota-dependent manner. Responsive mice showed reduced inflammation, improved histopathology, and lower serum D-lactate concentrations. Baseline microbial communities enriched in short-chain-fatty-acid-associated taxa were linked to responsiveness, whereas inflammatory-associated taxa predominated in non-responsive mice. Ecological network analysis revealed distinct microbial interaction structures between groups. Random forest modeling identified baseline microbiota composition as a strong predictor of therapeutic response.

Conclusions. Baseline microbial ecology strongly influences responsiveness to D-lactate-free probiotic therapy during intestinal inflammation, highlighting the importance of microbiota-informed precision probiotic approaches.

IBD6

Upadacitinib Achieves High Rates Of Symptomatic Remission In Patients With Ulcerative Colitis After One Year Of Treatment, Regardless Of Levels Of Potential Prognostic Markers At Week 8 – Interim Data From The IBD-DACH Study EUROPE

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Background: This analysis presents interim data at weeks (wk) 8 and 52 following Upadacitinib (UPA) induction in a large real-world cohort of patients with ulcerative colitis (UC).

Methods: EUROPE is an ongoing, prospective, non-interventional, multinational study in patients with active UC undergoing therapy initiation with UPA. Here, we show symptomatic and intestinal ultrasound (IUS) examination results one year after UPA induction in 123 patients.

Results: Over 53% of the UPA population achieved complete stool frequency normalization at wk 8 and over 68% at wk 52, compared to 4.1% at baseline. At each of these timepoints, more than 85% of patients had no rectal bleeding. 61.7% of patients with documented IUS measurements showed normalization of bowel wall thickness (BWT) at wk 8. Nonetheless, the proportion of patients in symptomatic remission at wk 52 was similarly high, regardless of whether BWT normalization had occurred by wk 8 or not. Among the 303 patients included in the safety analysis (≥ 1 dose of UPA), 148 adverse events (AE) were reported in 72 patients, in addition to 22 serious AE in 16 patients.

Conclusions: High rates of symptomatic remission were observed at wk 52 in patients who remained on UPA therapy.

HEPATOLOGY ORAL PRESENTATIONS I

Hepa1

HBsAg Cannot Reliably Report cccDNA Activity: Implications for Functional Cure Endpoints in Chronic Hepatitis B Trials

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Background: Functional cure of chronic hepatitis B (CHB) is defined by sustained HBsAg loss with undetectable HBV DNA after treatment discontinuation and represents the central endpoint of current HBV clinical trials. The concept of functional cure assumes that HBsAg loss reflects elimination or durable silencing of cccDNA. However, HBsAg can also originate from transcriptionally active HBV DNA integrated into the host genome (iDNA), potentially uncoupling serum HBsAg from intrahepatic cccDNA activity. Whether iDNA-derived HBsAg can be distinguished from cccDNA-derived HBsAg has remained unclear.

Methods: We combined quantitative serum HBsAg measurements, intrahepatic HBsAg immunostaining, and droplet digital PCR-based profiling of HBV DNA and RNA in liver biopsies from patients with CHB to identify cases in which HBsAg expression was predominantly driven by either cccDNA or iDNA. We then compared HBsAg abundance, secretion characteristics, intrahepatic staining patterns, and envelope protein isoform composition between groups.

Results: Molecular profiling identified distinct cohorts with predominantly cccDNA-driven (n = 10) or iDNA-driven (n = 17) HBsAg expression. In iDNA-driven cases, cccDNA and replicative intermediates were nearly absent despite widespread intrahepatic HBsAg expression, indicating that >99% of HBV transcription originated from integrated HBV DNA. Nevertheless, HBsAg produced from iDNA was indistinguishable from cccDNA-derived HBsAg across all evaluated features. All three envelope proteins (L, M, and S) were detected in liver tissue and serum in both groups, with comparable L/S ratios by western blot and immunofluorescence.

Intrahepatic HBsAg burden strongly correlated with serum HBsAg levels irrespective of HBsAg origin, indicating similar secretion behavior. Furthermore, all established intrahepatic HBsAg staining patterns occurred in both groups, with no pattern uniquely associated with cccDNA- or iDNA-driven expression.

Conclusion: HBsAg derived from integrated HBV DNA is molecularly and histologically indistinguishable from cccDNA-derived HBsAg. Consequently, serum HBsAg cannot reliably report cccDNA burden or transcriptional activity in many patients with CHB. These findings challenge the current definition of functional cure.

Hepa2

SMG6-dependent RNA Decay Maintains dsRNA Homeostasis and Restrains Immunogenicity in Hepatocellular Carcinoma

Enes S. Arpa [1], Virginie Ricci [1], Ilja E. Shapiro [2], Marija Jokic [3], Yahya Mohammadzadeh [2], Dirk Mossmann [4], Michael N. Hall [4], Jan Rehwinkel [5], Giovanni Ciriello [2], Tatiana V. Petrova [2], Sanjiv A. Luther [3], Michal Bassani-Sternberg [2], David Gatfield [1]

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Background: Nonsense-mediated mRNA decay (NMD) eliminates aberrant transcripts to maintain transcriptome integrity, yet its broader physiological roles remain incompletely defined.

Methods: Here, using a liver-specific, inducible mouse model, we selectively inactivate the endonuclease SMG6 – the terminal effector of NMD – in a genetic model of hepatocellular carcinoma.

Results: SMG6 loss completely prevents tumour development and triggers robust innate and adaptive immune responses.

Mechanistically, SMG6 inactivation causes the cytoplasmic accumulation of endogenous double-stranded RNAs (dsRNAs), leading to type I interferon induction via the dsRNA sensor MDA5 and revealing an unexpected physiological role for NMD in maintaining dsRNA homeostasis. In parallel, stabilisation and translation of normally degraded transcripts generate non-canonical MHC-I-presented peptides that elicit potent $CD8^+$ T-cell responses. These findings identify SMG6-dependent NMD as a central gatekeeper that restrains dsRNA-driven antiviral signalling and suppresses immunogenic transcript expression.

Conclusions: Our work establishes selective SMG6 inhibition as a promising strategy to enhance tumour immunogenicity and suggests that targeting terminal NMD activity could represent a conceptually distinct avenue for cancer immunotherapy.

Hepa3

Dynamic effects of microbial and host factors modulating innate immune responses in patients with acute decompensation of liver cirrhosis

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Background: Monocyte and macrophage dysfunction is a hallmark of immune cirrhosis and a major driver of infection susceptibility and disease progression. However, the dynamic interplay between microbial signals and host-derived factors shaping innate immune responses during acute decompensation remains incompletely understood.

Methods: We investigate monocyte and macrophage differentiation and functional dynamics across cirrhosis progression using multiparametric flow cytometry and imaging mass cytometry.

Results: Preliminary data demonstrate stage-dependent reprogramming of circulating monocytes, characterized by dysregulated expression of multiple phenotypic markers. These alterations are associated with a progressive decline in antibacterial immune competence in advanced disease. Integrative analyses of longitudinal patient samples and experimental models further reveal dynamic macrophage fate transitions and progressive remodeling of the hepatic immune microenvironment across cirrhosis evolution.

Conclusion: This study defines the temporal emergence of immune paresis in cirrhosis and identifies candidate immunotherapeutic targets, providing a framework for future host-directed immunomodulatory strategies.

Hepa4

Associations between Cardiac Function and Post-Albumin Hypervolemia in Decompensated Cirrhosis

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Background: Hypervolemia was found in up to 50% of patients with decompensated cirrhosis after guideline-based albumin therapy using point-of-care ultrasound (POCUS) of the inferior vena cava (IVC). The predictive role of baseline cardiac function for post-albumin volume overload needs to be explored.

Methods: We assessed associations between transthoracic echocardiography parameters (TTE), IVC-derived hypervolemia (maximum IVC diameter > 2.1cm, IVC collapsibility < 50%), as well as liver-related outcomes in a prospective cohort study. Variables with $p<0.1$ in univariable analyses were analyzed in multivariable regression models adjusting for age, sex and model for end-stage liver disease (MELD).

Results: Among 54 patients with decompensated cirrhosis (22.4% female, median age 62 years, median MELD 15, diastolic dysfunction ≥1 [DD]: 36.1%, cardiac cardiomyopathy [CCM]: 15.8%), post-albumin hypervolemia occurred in 51.3%. In multivariable analyses, higher right ventricle right atrium gradients (RVRA) were independently associated with hypervolemia (odds ratio [OR]1.8 per 5 mmHg increase, 95% confidence interval [CI] 1.1–3.1; $p = 0.02$). DD was associated with spontaneous bacterial peritonitis at 3 months (OR 20.8, 95%CI 1.8–245.3; $p = 0.02$), and CCM with hepatic encephalopathy at 3 months (OR 6.1, 95%CI 1.3–28.7; $p = 0.02$).

Conclusions: Higher RVRA was associated with post-albumin hypervolemia, suggesting increased susceptibility to fluid challenge in conditions associated with subclinically elevated pulmonary arterial pressure in decompensated cirrhosis. Observed associations between TTE abnormalities and liver-related outcomes require confirmation.

Hepa5

Direct Portal Pressure Assessment by Endoscopic Ultrasound: First Swiss Single-Centre Experience With EUS-Guided Portosystemic Pressure Gradient Measurement Using the EchoTip Insight System

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Background: Assessment of portal hypertension (PH) remains central for risk stratification and therapeutic decision-making in chronic liver disease and porto-sinusoidal vascular disorder (PSVD). The current gold standard, hepatic venous pressure gradient (HVPG), indirectly estimates portal pressure and may underestimate or fail to detect pre-sinusoidal forms of PH. In 2025, the EchoTip Insight system (Cook Medical) was newly introduced in Switzerland, enabling direct endoscopic ultrasound-guided portosystemic pressure gradient measurement (EUS-PPG) via invasive pressure assessment of the portal and hepatic veins during EUS. Beyond direct portal pressure measurement, EUS-PPG offers the possibility of combined endohepatology procedures including EUS-guided liver biopsy and variceal assessment within a single session. We report the first Swiss single-centre experience with EUS-PPG.

Methods: We retrospectively analysed the first eight consecutive patients undergoing EUS-PPG measurement at our tertiary hepatology centre between August 2025 and May 2026. Clinical characteristics, technical feasibility, sedation modality, laboratory parameters, procedural findings, complications, and clinical impact on management were evaluated.

Results: Eight patients underwent EUS-PPG measurement (7 males, 1 female; age range 31–72 years). Indications included evaluation of PH in the setting of primary or secondary prophylaxis of variceal bleeding. Underlying diseases consisted of liver cirrhosis in three patients and PSVD in five patients. Five patients presented with thrombocytopenia (range 44–132 G/L); one patient with platelets of 44 G/L received peri-procedural platelet transfusion. INR values ranged from 1.0 to 1.6. Two procedures were performed under general anaesthesia with endotracheal intubation, whereas six patients received deep sedation using propofol and fentanyl. Mild ascites was present in

two patients. In two cases, EUS-guided liver biopsy was simultaneously performed during the same procedure. In one patient, acute hemodynamic response to propranolol therapy was assessed using EUS-PPG.

Measured PPG values ranged from 2 to 21 mmHg. Clinically significant PH was identified in four patients (16, 17, 20, and 21 mmHg), whereas PH could be excluded in four patients. No adverse events occurred. Importantly, EUS-PPG findings were clinically relevant in all patients and directly influenced subsequent management, including identification of discordance with previously normal HVPG measurements, initiation of non-selective beta-blocker prophylaxis, and decision-making regarding transjugular intrahepatic portosystemic shunt (TIPS) placement.

Conclusions: This first Swiss single-centre experience demonstrates that EUS-PPG using the EchoTip Insight system is feasible, safe, and clinically impactful in patients with suspected portal hypertension, including PSVD. Direct portal pressure assessment may provide important advantages over HVPG, particularly in pre-sinusoidal PH, and allows integration into a broader "endohepatology" approach combining hemodynamic assessment and tissue acquisition within a single minimally invasive procedure.

Hepa6

Living-Donor Liver Transplantation for Pembrolizumab-Induced Vanishing Bile Duct Syndrome in a Patient with Triple-Negative Breast Cancer: A Swiss Proof-of-Concept Case

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Background: Immune checkpoint inhibitor-induced liver injury (ChILI) is an uncommon but potentially life-threatening complication of cancer immunotherapy. Vanishing bile duct syndrome (VBDS) represents one of its most severe manifestations and is frequently refractory to corticosteroids and conventional medical therapy. Liver transplantation may be the only life-saving treatment; however, recent or active malignancy is generally considered a contraindication because of concerns regarding tumor recurrence under immunosuppression. We report a unique Swiss case of successful living-donor liver transplantation (LDLT) for pembrolizumab-induced VBDS in a patient with triple-negative breast cancer.

Methods: A 39-year-old woman with newly diagnosed triple-negative invasive breast cancer received neoadjuvant carboplatin/paclitaxel and a single dose of pembrolizumab. Shortly thereafter, she developed severe cholestatic liver injury. Comprehensive diagnostic work-up excluded alternative etiologies, and causality assessment strongly supported grade 3 ChILI (CIOMS/RUCAM score >8). Clinical, biochemical, histological, oncological, and transplant outcomes were assessed longitudinally.

Results: The patient rapidly developed progressive cholestatic liver failure with bilirubin peaking at 400 µmol/L, alkaline phosphatase and gamma-glutamyl transferase exceeding 1,000 U/L, transaminases above 300 U/L, and significant coagulopathy. Liver biopsy demonstrated severe ductopenia with vanishing bile ducts consistent with evolving VBDS. Despite intensive treatment including high-dose corticosteroids, prolonged immunosuppression, N-acetylcysteine, ursodeoxycholic acid, and cholestyramine, liver injury progressed relentlessly. During this period, the patient underwent definitive breast cancer surgery followed by adjuvant radiotherapy. Restaging demonstrated an excellent oncological response without evidence of residual or recurrent disease. Given irreversible VBDS, progressive liver failure, young age, favourable oncological prognosis, and the availability of a suitable living donor, a multidisciplinary decision was made to proceed with transplantation. Five months after onset of ChILI, the patient underwent successful LDLT using a graft donated by her sister. Post-transplant immunosuppression consisted of corticosteroids, tacrolimus, and temporary mycophenolate mofetil. One episode of acute T-cell-mediated rejection responded completely to steroid pulse therapy. At 18 months follow-up, the patient remains free of breast cancer recurrence with excellent graft function and no evidence of chronic rejection. Biliary complications were successfully managed with endoscopic and percutaneous interventions.

Conclusions: Pembrolizumab-induced VBDS is a rare but devastating complication that may progress despite aggressive medical therapy. This case demonstrates that liver transplantation can be a feasible life-saving option in highly selected patients, even in the setting of a recent malignancy. As immune checkpoint inhibitors are increasingly used, early referral to transplant centers and multidisciplinary evaluation are essential, as transplantation may represent the only curative treatment for irreversible VBDS.

ENDOSCOPY ORAL PRESENTATIONS

Endo1

EDIGO: A bedside score for stratifying early adverse-event risk after initial endoscopic biliary drainage for malignant biliary obstruction

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Background: Early adverse events (AEs) after endoscopic biliary drainage (EBD) for malignant biliary obstruction (MBO) are frequent, yet early post-procedural triage still relies on clinician judgment. We aimed to quantify ≤7-day AEs after initial drainage and derive a practical risk score.

Methods: Retrospective single-centre cohort of consecutive patients undergoing initial EBD for MBO by ERCP or EUS-guided drainage (2016–2023). The primary endpoint was any clinical AE

≤7 days (AGREE classification); major AEs were AGREE ≥ IIIA. Prespecified pre-/periprocedural variables were entered into a multivariable logistic model, internally validated, and translated into a bedside score (EDIGO).

Results: Among 461 patients, 15.4% had any ≤7-day AE and 9.8% a major AE. The score included five predictors: ASA III, preprocedural cholangitis, altered anatomy, higher baseline total bilirubin, and Bismuth-Corlette type IV obstruction. The model showed an AUC of 0.800, preserved in the simplified score (0.779). At the prespecified low-risk threshold (EDIGO 0–1), 34.7% of patients were classified as low risk, with 94.4% sensitivity, 97.5% negative predictive value. Observed ≤7-day AE rates increased stepwise across risk groups: 2.5% for score 0–1, 16.8% for score 2–4, and 53.3% for score ≥5. Clinician-selected outpatient management involved a similar proportion (34.1%) but with a higher observed ≤7-day AE rate (10.8%).

Conclusions: EDIGO is a pragmatic bedside score that stratifies early AE risk after initial EBD for MBO and may help standardize early triage alongside clinical judgment. External validation is required before implementation.

Endo2

TECHNICAL AND CLINICAL OUTCOMES OF ENDOSCOPIC GASTROENTEROSTOMY IN PATIENTS WITH BENIGN GASTRIC OUTLET OBSTRUCTION: A RETROSPECTIVE MULTICENTER STUDY IN THE DACH REGION

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Introduction: Endoscopic ultrasound-guided gastroenterostomy (EUS-GE) with lumen-posing metal stents (LAMS) is well-studied for treating malignant gastric outlet obstruction (GOO). However, there is limited data on using this method for benign GOO.

Methods: This retrospective multicenter study was conducted in the DACH region (Germany, Austria, and Switzerland). All patients who underwent EUS-GE for treating benign GOO were identified and included retrospectively. The study evaluated technical and clinical success rates, incidence of adverse events (AEs) and follow-up data.

Results: 85 patients underwent an attempt of EUS-GE for treatment of benign GOO at 15 study centers. The median age was 64 years (IQR: 57 – 75) and 32 patients were female (37.6%). Most common etiologies of benign GOO were acute and chronic pancreatitis in 23 (27.1%) and 20 (23.5%) cases, respectively. Technical success was achieved in 81 of 85 (95.3%) patients. The used LAMS had a diameter of either 15 mm (n = 8, 9.4%) or 20 mm (n = 77, 90.6%). Clinical success after EUS-GE, defined as an increase in the GOOSS of a least 1 point was observed in 74 of 80 (94.1%) of patients with such information available. Median GOOSS prior to EUS-GE was 1 (IQR: 1-2) and increased to 3 (IQR: 2-3) after EUS-GE. There were 8 procedure-related AEs resulting in an overall AE rate of 9.4%, of which 6 were classified as intraprocedural and 2 as postprocedural AEs. Severity was classified as mild in 4, as moderate in 3, and as severe in one case. For 46 patients (54.1% of the total cohort) a follow-up of 3 or more months after LAMS placement was available. Two of them (4.3%) required re-intervention for LAMS stenosis (n = 1 argon plasma coagulation; n = 1 LAMS-in-LAMS placement). Four patients (8,7%) required additional treatment (n = 3 patients underwent pancreatic resection with gastrojejunostomy for either chronic pancreatitis or suspected malignancy but Surgery was not related to LAMS dysfunction; n = 1 patient underwent placement of a PEG tube with jejunal extension).

Conclusion: EUS-GE is a safe and effective option for the treatment of benign GOO and can be used for bridging as well as permanent therapy.

Endo3

Endoscopic ultrasound-guided drainage of liver abscesses (EUS-LAD): Multicenter retrospective analysis of the DACH-EUS study group

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Background: Endoscopic ultrasound (EUS)-guided drainage of liver abscesses (EUS-LAD) is gaining increasing importance as an alternative to percutaneous drainage, particularly for left-sided or anatomically challenging abscesses. The aim of this retrospective multicenter analysis was to evaluate EUS-guided drainage of liver abscesses with regard to technical feasibility, clinical success and safety.

Methods: Retrospective multicenter analysis of EUS-LAD cases from seven centers in the DACH region since 2020. Primary endpoints were technical and clinical success rates as well as the occurrence of adverse events (AEs). Secondary endpoints included the access route, types of stents used, as well as required stent exchanges and duration of drainage.

Results: A total of 19 patients were included. The median age was 64 years (range 45–85 years), and 13 patients (68%) were male. Technical success was achieved in 18 of 19 patients (94.7%). Clinical success was observed in all technically successful cases (18/18, 100%) and was associated with a marked decrease in inflammatory markers as well as substantial reduction in abscess size on follow-up imaging. Median CRP levels decreased from 47 mg/L at baseline to 10 mg/L at day 10, while median leukocyte count decreased from 10.1 $\times 10^9$/L to 6.8 $\times 10^9$/L. Median abscess size decreased from 6.0 cm at baseline to 0.0 cm at follow-up imaging. One mild adverse event (5.6%) occurred in the form of post-interventional bacteremia, which was managed conservatively with antibiotic therapy. All drainages were performed via a transgastric access route. In 3/18 patients, percutaneous drainage had been performed prior to EUS-guided drainage. Lumen-apposing metal stents (LAMS) were used in 8/18 patients, plastic stents in 7/18 patients, and a combination of both in 3/18 patients. The median drainage duration was 46 days (IQR 34–68; range 20–137), and the median procedure duration was 21 minutes (IQR 15–32). Endoscopic stent exchange was required in 5/18 patients (28%). In patients with metastatic malignancy, stent removal was not performed in 5/18 cases due to the palliative disease situation.

Conclusion: EUS-LAD for left-sided liver abscesses demonstrated a high technical and clinical success rate and proved to be very safe. Thus, EUS-LAD may represent an effective and safe therapeutic option for left-sided liver abscesses and a good alternative to percutaneous drainage.

Endo4

Endoscopic Ultrasound-Guided Radiofrequency Ablation for Pancreatic Neuroendocrine Tumors: A Single-Center Experience

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Background: Endoscopic ultrasound-guided radiofrequency ablation (EUS-RFA) for pancreatic neuroendocrine tumors (pNET) is developing as an alternative to surgery for small tumors. We evaluated its efficacy and safety in a single-center cohort.

Methods: This is a retrospective study of patients treated with EUS-RFA from December 2015 to December 2025 at a single tertiary center. Histological confirmation with grading was performed before treatment. Technical success was defined as the possibility of performing radiofrequency treatment. Clinical success was defined as the disappearance of lesions and/or contrast enhancement on follow-up imaging or symptoms resolve in case of functional pNET. We used the AGREE classification for adverse events

Results: Forty-five patients were included (female 27/45 [60%]; mean age 60.8 years). Tumors were non-functional in 39/45 (86.7%) and functional (insulinoma) in 6/45 (13.3%), with a cystic component in 7/45 (15.6%); mean size was 12.2 mm (range 5–27 mm) and 39/45 (86.7%) were solitary. A mean of 1.2 sessions per patient (range 1–3) was performed. The technical success rate was 45/45 (100%), and the clinical success rate was 80% (36/45) at the first session, and 97.8% (44/45). 13.2% (6/45) patients had a grade III complication. They required endoscopic management for ductal stenosis by endocanal biliary drainage or drainage of pancreatic collection. Eventually, one patient required surgery for recurrent collections. No procedure-related deaths were reported. No recurrences were recorded, with a mean follow-up of 22.1 months (median 13 months, range 0-84).

Conclusion: EUS-RFA is an effective, safe alternative to surgery for selected pNET, with excellent technical and clinical efficacy, combined with a superior safety profile to surgery.

Endo5

EUS-guided hepaticogastrostomy with temporary versus definitive stenting in malignant biliary obstruction

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Background: Endoscopic ultrasound-guided hepaticogastrostomy (EUS-HGS) using partially covered metal stents (PCMS) is performed to manage malignant biliary obstruction (MBO). Recent advantages in oncology have significantly improved patient survival. This study aims to investigate whether EUS-HGS using a non-definitive stenting technique with fully covered metal (FCMS) and double pigtail stents may offer advantages in terms of efficacy, safety, and long-term patency compared to the conventional technique.

Methods: We retrospectively analyzed data from patients with MBO treated by EUS-HGS with FCMS (Niti-S™ biliairy flare

type, Taewoong) between 29.01.2019 and 29.04.2025 at a tertiary referral center. FCMS were exchanged for double pigtail plastic stents two weeks after the index procedure. Clinical outcomes were compared to patients treated by EUS-HGS with conventional PCMS (Giobor™, Taewoong).

Results: Sixty-two patients were included (FCMS/DPS n = 19; PCMS n = 43). Technical success was 100% in both groups; clinical success was similar (89% vs 88%; p = 1.00). Early adverse events were comparable (10% vs 12%; p = 1.00). Fewer FCMS/DPS patients experienced at least one early or late complication (26% vs 53%; p = 0.058), and complications per patient tended to be lower (0 [0-1] vs 0 [0-11]; p = 0.053). Permanent stenting was independently associated with more complications (IRR 3.62, 95% CI 1.28-11.95; p = 0.021). Reintervention-free and overall survival did not differ.

Conclusions: EUS-HGS with temporary FCMS followed by DPS achieved similar efficacy to definitive PCMS drainage, with a consistent safety signal favoring the two-step strategy.

Endo6

Substantial Heterogeneity in Endoscopy Training Across United European Gastroenterology Member Societies: A Cross-Sectional Analysis of National Curricula

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Introduction: Training in gastrointestinal endoscopy across Europe remains heterogeneous, with substantial variation in curricula, procedural exposure, competency assessment, and access to structured supervision. Recent European analyses have highlighted the need for greater harmonisation of postgraduate gastroenterology training and more robust competency-based educational standards. While several ESGE curricula define standards for specific procedures, it remains unclear how comprehensively these recommendations are reflected in national endoscopy curricula across Europe

Aims and Methods: We performed a cross-sectional review of national endoscopy curricula from 39 United European Gastroenterology Member Societies. Curricula were systematically assessed for inclusion of endoscopic procedures, minimum procedural numbers, and defined competence levels. Procedures were categorised into basic and advanced endoscopic interventions. Where competence descriptors were provided, these were harmonised into a five-level framework ranging from 1 (not specified) to 5 (independent performance), incorporating terms such as supervised participation, supervised performance, and independent practice. Descriptive statistics were used to summarise inclusion rates, numeric thresholds, and variability across member societies.

Results: Basic endoscopic procedures were included more frequently than advanced procedures (mean inclusion rate 61.3% vs. 27.5%). Gastroscopy and colonoscopy were included in all curricula (39/39, 100%), followed by haemostasis (37/39, 94.9%) and polypectomy ≤10 mm (32/39, 82.1%). Several clinically relevant basic skills were less consistently represented, including sigmoidoscopy (18/39, 46.2%), foreign body retrieval (16/39, 41.0%), and lesion tattooing (3/39, 7.7%). Among advanced procedures, ERCP was most frequently included (28/39, 71.8%), followed by PEG and capsule endoscopy (each 23/39, 59.0%), variceal band ligation (22/39, 56.4%), and endosonography (21/39, 53.8%). Highly specialised procedures such as ESD and POEM were rarely included (each 5/39, 12.8%). Where numeric thresholds were available, marked heterogeneity was observed. Mean minimum requirements were 264.6 diagnostic gastroscopies (range 100–750) and 218.5 diagnostic colonoscopies (range 20–500). For ERCP, explicit minimum procedural numbers were available in only 16/39 countries, with a mean minimum of 77.8 procedures (range 5–300). Missing numeric thresholds were common even for frequently included procedures.

Conclusion: National endoscopy curricula across Europe show substantial heterogeneity in procedural content, minimum case-volume requirements, and competence expectations. Although core diagnostic procedures are universally included, they are frequently not linked to clearly defined minimum thresholds or competence levels. Together with the marked variability in practical skills and advanced interventions, and the limited alignment with existing ESGE curricula, this highlights important gaps in current training frameworks. These findings support the development of harmonised European competency-based curricula with transparent benchmarks, validated assessment tools, simulation-based training, and structured pathways for advanced endoscopy.

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GASTROENTEROLOGY ORAL PRESENTATIONS

Gastro1

Reactivation of a Mid-embryonic Program Drives Progenitor Identity in Colorectal Cancer

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Background. Reactivation of developmental programs is a hallmark of cancer, yet the specific embryonic states co-opted by tumors and their functional roles remain poorly defined. We aimed to systematically identify and functionally validate embryonic gene regulatory programs reactivated in colorectal cancer (CRC).

Methods. We established an "oncoembryology" framework integrating transcriptomic and chromatin profiling across embryonic development, adult tissues, and colorectal cancer. Single-cell and spatial analyses were coupled with genetic perturbation and pharmacological targeting in orthotopic in vivo models. Metastatic CRC was modeled using colonoscopy-guided transplantation of organoids.

Results. We identified a mid-embryonic epithelial progenitor program, governed by SoxC transcription factors, that is transiently active during hindgut development and reactivated in CRC. SoxC maintained progenitor identity during embryogenesis and, when aberrantly re-expressed in tumors, sustained cancer cell survival via the secreted factor midkine (Mdk). Genetic ablation of SoxC or Mdk induced tumor cell death and significantly reduced tumor growth and metastasis in vivo. Pharmacological inhibition of Mdk in established tumors recapitulated these effects, identifying a tractable therapeutic vulnerability. A SoxC-driven transcriptional signature defined a tumor cell population absent in standard in vitro systems and stratified patient outcomes.

Conclusion. These findings identify a reinstated embryonic SoxC–Mdk regulatory axis as a driver of CRC progression and a clinically actionable target. Systematic mapping of oncoembryonic programs provides a framework for uncovering mechanistic vulnerabilities in cancer.

Gastro2

Microbial and immunologic characteristics of the recipient are associated with beneficial responses to fecal microbiota transfer in patients with cancer immunotherapy-refractory solid tumors

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Background: Fecal microbiota transfer (FMT) has recently proven to be effective in the treatment of oncologic patients refractory to cancer immunotherapy (CI). However, mechanisms of action and factors predicting response to FMT are unknown.

Methods: We performed a prospective interventional clinical trial to investigate the impact of a single FMT (3 donors with complete or partial response to CI) applied via colonoscopy on 14 patients with solid tumors [including 9 patients with uveal melanoma (UM)], that were previously refractory to CI (NCT05273255).

Results: We found that a high and stable fecal and intestinal tissue microbiome α-diversity, the presence of lysozyme$^+$ monocytes within the intestinal tissue, elevated CD8$^+$ T-cells and high T-cell receptor diversity in the recipients' circulation at baseline are associated with FMT benefit in combination with CI. With respect to long-term outcome at 3 years, 5 FMT recipients were still alive (3 patients with UM). 1 patient with cutaneous melanoma achieved complete remission and systemic therapy was discontinued 80 weeks after FMT. The FMT procedure was safe and well tolerated by all patients enrolled in the trial.

Conclusion: Our data demonstrates that FMT is a safe treatment in patients with solid tumors refractory to CI, including those beyond cutaneous melanoma, particularly the hard-to-treat UM. Importantly, our data show that such survival benefits from FMT likely depend on the microbial and immunological characteristics of FMT recipients rather than of fecal donors.

Gastro3

Early recovery of driving-related cognitive performance following propofol-only sedation for outpatient endoscopy.

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Background: Propofol is widely used for ambulatory gastrointestinal endoscopy because of its rapid onset and short duration of action. Current European guidelines recommend refraining from driving for 24 hours after procedural sedation, although the duration of cognitive impairment after propofol-only sedation remains uncertain.

Methods: In this prospective cohort study, 75 ASA I–II patients (mean age 54 years; 41% female) undergoing elective outpatient endoscopic procedure (33 gastroscopies and 42 colonoscopies) under propofol-only sedation were enrolled. Driving-related cognitive performance was assessed using the Test of Attentional Performance (TAP-M) at baseline, 1 hour and 4 hours after sedation.

Results: Reaction times increased mildly at 1 hour after sedation across several cognitive domains with recovery toward baseline by 4 hours. No clinically significant impairment, defined by abnormal percentile scores, was observed. Error rates remained stable over time. Propofol plasma concentrations declined rapidly and paralleled cognitive recovery.

Conclusions: Propofol-only sedation induced mild and transient cognitive alteration at 1 hour, followed by recovery toward baseline within 4 hours in most driving-related cognitive domains. These findings may support future reassessment of post-sedation driving recommendations in low-risk ambulatory patients.

Gastro4

Intestinal barrier (IB) dysfunction assessed by confocal laser endomicroscopy (CLE) correlates with cirrhosis severity and clinical outcome.

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Background: Intestinal barrier (IB) dysfunction drives complications in advanced chronic liver disease (ACLD). Confocal laser endomicroscopy (CLE) enables high-resolution visualization of transepithelial fluorescein leakage during endoscopy.

Methods: CLE was performed in two clinically well-phenotyped (e.g. liver-related events LRE) cohorts (Bern and Vienna; n = 5 healthy; n = 64 ACLD). Image analysis included novel "3-compartment" and "3-line-method".

Results: Fluorescein permeation into the gut lumen was absent in healthy controls but highly prevalent in ACLD, and linked to decompensation state. 3-line and 3-compartment methods robustly distinguished healthy controls from de-/ and compensated cirrhosis (with lowest inter-observer variability). Quantitative IB measures increased across disease stages, and correlated with HVPG (r = 0.57,p<0.001) and liver function parameters (e.g. albumin: r = − 0.55,p<0.001). CLE-based metrics were linked to a higher LRE incidence during follow-up.

Conclusion: CLE identifies intestinal hyper-permeability in ACLD, that correlates with disease stage, portal hypertension and poor prognosis indicating its potential diagnostic use in liver cirrhosis.

Gastro5

Functional Lumen Imaging Probe (FLIP) Esophageal Motility Patterns Outperform Distensibility Metrics in Differentiating Functional Heartburn From Reflux Disease

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Background: The Functional Lumen Imaging Probe (FLIP) enables real-time assessment of esophagogastric junction (EGJ) distensibility and secondary esophageal motility patterns during endoscopy. The diagnostic utility of FLIP metrics in differentiating functional heartburn from reflux disease remains unclear. We aimed to evaluate whether FLIP classification, motility patterns, EGJ distensibility and diameter differentiate functional heartburn from reflux disease.

Methods: Retrospective analysis of patients with dyspeptic symptoms undergoing FLIP and wireless pH-metry (BRAVO) at the department of Gastroenterology and Hepatology Health Ostschweiz (HOCH) between 2024 and 2026. The primary outcome parameter was a diagnosis of reflux disease. FLIP classifications were dichotomized into normal versus abnormal. Motility patterns were grouped as absent/diminished, normal, and spastic. Baseline characteristics, FLIP findings, and motility patterns were compared between groups using chi-square and t-testing. Multivariable logistic regression was performed to identify independent predictors of functional disease.

Results: A total of 102 patients were included. 59 patients had functional heartburn and 43 reflux disease. Patients with reflux were older and more frequently had hiatal hernia (65.1% vs 22.0%, p<0.001). Normal motility patterns were more common in functional hearburn (66.1% vs 32.6%, p = 0.001), whereas absent/diminished motility was more common in reflux disease (53.5% vs 18.6%, p = 0.001). Median EGJ distensibility (5.0 (IQR, 3.5-7.0) vs 5.0 (IQR, 3.3-7.0), p = 0.897)) and diameter (18.0 (IQR, 15.0-19.0) vs 17 (IQR, 14.5-19.0), p = 0.383) was comparable in patients with functional heartburn and reflux. In multivariable logistic regression analysis a normal motility pattern independently predicted functional hearburn (OR 17.1, 95% CI 1.66–34.86, p = 0.017). Distensibility, diameter, and normal FLIP classification were not independently associated with functional heartburn.

Conclusion: Functional heartburn demonstrates distinct FLIP motility phenotypes characterized by preserved contractile activity. Functional lumen imaging probe motility patterns may outperform the assessment of EGJ integrity measured by EGJ distensibility and diameter in differentiating functional heartburn from reflux disease.

Gastro6

Microbiome Modulation as a Strategy to Enhance Immunotherapy in Metastatic CRC

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Therapeutic success in the treatment of colorectal cancer (CRC) remains elusive. Specifically, the generation and development of metastases result in a particularly poor prognosis in patients, mainly due to the limitation of late-stage therapy options. Recent advances highlight the potential of fecal microbiota transplantation (FMT) to enhance immunotherapy responses across multiple cancer types. However, most CRC subtypes are poorly immunogenic and exhibit limited responsiveness to immune checkpoint inhibitors (ICIs). Given the direct interface between CRC and the gastrointestinal microbiome, we invested whether FMT can modulate immunotherapy efficacy in this setting. Using an orthotopic mouse tumor organoid (MTO) model, we evaluated the impact of FMT on tumor progression and response to ICIs. Preliminary results indicate that FMT induces a consistent anti-tumor effect, with a characteristic increase in CD8+ T-cell infiltration. Contrary to expectations, stool derived from both ICI responders and nonresponders produced comparable therapeutic benefits, suggesting a mechanism of action independent of donor ICI-responder status. Microbiome profiling revealed enrichment of specific *Bacteroides* species in responding groups, identifying these taxa as potential biomarkers or contributors to anti-tumorigenic activity. Collectively, these findings support a new perspective for FMT in enhancing anti-tumor responses in non-immunogenic CRC and highlight microbiome-driven metabolic pathways as promising targets to overcome resistance to immunotherapy.

HEPATOLOGY ORAL PRESENTATIONS II

Hepa7

Discovery of Novel MRGPRX4 Agonists and Antagonists with Implications for Hepatobiliary Pruritus

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Background: MRGPRX4 is a bile acid- and heme metabolite-sensing receptor expressed in peptidergic sensory neurons of dorsal root and trigeminal ganglia. It has emerged as a mediator of hepatobiliary pruritus, a debilitating symptom with limited therapeutic options, yet its pharmacology remains poorly characterized and selective antagonists are lacking.

Methods: Natural product and pharmacological compound libraries were screened for MRGPRX4 ligands using β-arrestin recruitment assays (PathHunter, DiscoverX) at 10 µM. Concentration–response studies determined EC50 or IC50 values.

Results: Novel agonists included dioscin (EC50: 3.83 µM), echinocystic acid (4.17 µM), sophoraflavanone G (5.93 µM) and18-β-glycyrrhetinic acid (11.2 µM). FXR agonists cilofexor (52.1 µM), tropifexor (19.4 µM) and obeticholic acid (23.1 µM) also activated MRGPRX4. Antagonists included psoralidin (0.608 µM), disulfiram (1.50 µM), flavonol (2.82 µM) and berbamine (IC50: 5.16 µM). Clinically used PPAR agonists also inhibited MRGPRX4, including bezafibrate (79.6 µM), elafibranor (23.2 µM), fenofibrate (2.77 µM) and seladelpar (2.25 µM).

Conclusions: Structurally diverse MRGPRX4 agonists and antagonists were identified. FXR agonist-mediated activation may contribute to hepatobiliary itch, whereas inhibition by PPAR agonists may underlie antipruritic effects and therapeutic repurposing opportunities. These findings support further investigation into MRGPRX4 signalling and targeted antipruritic therapy development in hepatobiliary pruritus.

Hepa8

Pharmacological effects of edoxaban and apixaban in patients with liver cirrhosis

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Background Patients with liver cirrhosis (LC) frequently require anticoagulation, yet data on direct oral anticoagulants (DOACs) in LC remain limited. This study evaluated the pharmacological profiles of edoxaban and apixaban in patients with LC.

Methods In this monocentric clinical trial (NCT05869591), 42 non-anticoagulated patients with Child-Pugh A (n = 38) or B (n = 4) LC were randomized to receive edoxaban 60 mg qd (n = 21) or apixaban 5 mg bid (n = 21) for 7 days. Pharmacokinetic and pharmacodynamic parameters were assessed on days 1, 3, 8, and 9, including DOAC peak/trough levels, *ex vivo* thrombin generation (TG), and *in vivo* coagulation markers (F1+2, TAT, D-dimers).

Results The cohort included 12 women (29%) and 30 men (71%), with preserved renal function and a median MELD score of 8 (range, 6-18). Thrombocytopenia was present in 50% of patients (median platelet count, 147 G/L, range 58-358). Edoxaban showed higher peak and lower trough concentrations than apixaban (204/17 ng/mL *vs*. 158/92 ng/mL, respectively). No patient exceeded trough concentrations reported in non-cirrhotic populations. Both DOACs significantly reduced *ex vivo* TG and *in vivo* coagulation markers compared with baseline ($p<0.01$). At day 8, F1+2 and D-dimers decreased by 24% and 23%, respectively; the reduction in DD was -32% with edoxaban ($p = 0.08$) and -22% with apixaban ($p < 0.05$). Patients with thrombocytopenia had a significantly lower D-dimer reduction than those with platelet counts ≥150 G/L (-6% *vs*. -37%; $p<0.05$).

Conclusion Both edoxaban and apixaban achieved effective anticoagulation in patients with LC without excessive drug accumulation. Edoxaban was characterized by higher peak and

lower trough concentrations, while apixaban exhibited greater variability in trough levels. These pharmacokinetic differences may have clinical implications, with higher edoxaban peaks potentially increasing bleeding risk and variable apixaban troughs suggesting possible accumulation during prolonged therapy. Platelet count emerged as the main determinant of *in vivo* anticoagulant response. This reduced DOAC response observed in thrombocytopenic patients further supports that advanced LC is associated with a more pronounced prothrombotic state.

Hepa9

Atezolizumab/Bevacizumab for Recurrent Hepatocellular Carcinoma After Liver Transplantation: First Swiss Experience

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Background: Immune checkpoint inhibitors (ICI) are an established treatment for advanced hepatocellular carcinoma (HCC), but their use after orthotopic liver transplantation (OLT) remains controversial and contraindicated because of the risk of acute graft rejection. Evidence guiding patient selection and risk mitigation is scarce. We report the first Swiss multicentre experience using atezolizumab/bevacizumab for recurrent HCC after OLT following implementation of a predefined rejection-prevention strategy.

Methods: Two patients with advanced recurrent HCC after OLT were treated at tertiary hepatology centres (SG, ZH) in Switzerland after exhaustion of standard therapeutic options, including conversion of calcineurin inhibitor-based immunosuppression to everolimus and treatment with tyrosine kinase inhibitors. Before ICI initiation, both patients underwent liver biopsy to exclude active rejection and assess PD-1 expression within the liver graft. Rejection prophylaxis consisted of everolimus-based immunosuppression, oral budesonide (9 mg qd), and intensive clinical, biochemical, and sonographic monitoring. Atezolizumab (1200 mg) plus bevacizumab (15 mg/kg) was administered every three weeks.

Results: The first patient, a 66-year-old woman, developed aggressive metastatic HCC recurrence in the spine more than six years after OLT despite radiotherapy, conversion to everolimus, and subsequent lenvatinib therapy. At ICI initiation, alpha-fetoprotein (AFP) exceeded 300,000 µg/L and liver biopsy demonstrated no PD-1 expression within the graft. After five cycles of atezolizumab/bevacizumab, AFP showed a marked decline (< 300 µg/L), imaging demonstrated tumour regression, liver function tests remained normal, and no evidence of graft rejection occurred. The second patient, a woman with HCC recurrence ten years after OLT, had progressive disease despite sequential treatment with lenvatinib, cabozantinib, sorafenib, and regorafenib. Liver biopsy before treatment showed no PD-L1 expression. Following a single administration of atezolizumab/bevacizumab, she developed severe biopsy-confirmed T-cell-mediated graft rejection with immune-mediated cholangitis features despite intensified immunosuppression. Tumour response could not be assessed because of rapid clinical deterioration. The patient died within six weeks of treatment initiation from complications related to cholangitis and graft failure.

Conclusion: This first Swiss experience illustrates the dual nature of ICI after liver transplantation: profound antitumour activity may be achievable in selected patients, but life-threatening graft rejection remains a major risk despite extensive preventive measures. ICI should only be considered after exhaustion of established oncological options, in close collaboration with transplant centres, and ideally within standardized treatment protocols and prospective registries. Biomarker-guided patient selection, including assessment of graft immune activation, warrants further investigation.

Hepa10

Selective Targeting Of The Blood-Biliary Barrier Ameliorates Fibrotic and Cholestatic Liver Damage by Enhancing Bicarbonate Secretion and Bile Dynamics.

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Background: Tight junctions, which maintain the blood-biliary-barrier in the liver, have important biological functions that impact cholestatic diseases. In this study, we explored the potential of claudin-3 as new therapeutic target.

Methods: Global- and liver specific claudin-3 knockout mice were subjected to extra- and intrahepatic cholestasis via surgical ligation of the common bile duct (BDL) or chemically, with alpha-naphthyl isothiocyanate (ANIT). Hepatic necrosis and serum liver injury markers were determined. Claudin-3 was knocked down using liver specific GalNAc-siRNAs. PSC and PBC patient liver tissues were stained for claudin-3.

Results: Claudin-3 deletion increased chloride ion output, bile-flow rate and reduced bile acid levels. Following BDL or ANIT, bile acid levels were significantly lower, and tissue injury was remarkably ameliorated in knockout mice. Liver specific claudin-3 knockdown of a using GalNAc-siRNAs ameliorated liver cholestasis and tissue injury. Claudin-3 is expressed in liver tissue of PSC and PBC patients.

Conclusions: Knockout or GalNAc-siRNA mediated inhibition of a claudin-3 protected the liver from cholestatic injury, suggesting translational potential of this treatment approach.

Hepa11

Early disease activity assessment in patients with alveolar echinococcosis: a Swiss single-centre retrospective study.

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Background: Em18 serology and FDG-PET/CT are established markers of disease activity in alveolar echinococcosis. This study evaluated disease activity assessment with both at diagnosis.

Methods: Monocentric, retrospective cohort study of AE patients with probable or definitive AE diagnosis (WHO), negative Em18 ELISA result and available PET imaging at diagnosis.

Baseline data included patient demographics, PNM classification and AE stage, serology, lesion burden, EMUC-CT morphology, metabolic activity on PET, parasite viability on histopathology, treatment strategy and clinical course.

Results: 38 AE patients have been included. Thirteen had no increased metabolic activity of AE lesions on PET. These patients were typically diagnosed at a localized stage, with a P1 classification, smaller AE lesions, and frequently metastasis-like morphology, and showed lower median total IgE. In two cases, PET activity correlated with parasite viability on histopathology. Among the PET-negative patients, ten were followed with a watch-and-wait strategy over a median of 51 months, with two progressive lesions on follow-up requiring treatment initiation and one pre-emptive treatment.

Conclusion: Additional PET imaging in newly diagnosed, Em18-negative AE patients provides important information on disease activity. In Em18 and PET negative patients, a watch-and-wait strategy may be safely pursued.

Hepa12

Predictive Factors For Explantation Or Mortality After Tunneled Peritoneal Catheters In Patients With Cirrhosis And Refractory Ascites : A Swiss Multicentre Retrospective Study

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Background: Tunneled peritoneal catheters (PeCa) implantation represents a therapeutic option in patients with cirrhosis and refractory ascites who are not candidates for TIPS. Early outcomes and complications remain poorly described. In patients undergoing PeCa implantation for refractory ascites, we aimed to study predictive factors for early catheter explantation or mortality, including in patients listed for liver transplantation (LT).

Methods: We retrospectively analysed 74 cirrhotic patients followed in Geneva or Lausanne University Hospital with contraindication to TIPS who underwent a PeCa implantation between 2014 and 2023. The primary outcome was catheter explantation or mortality within 90 days (90-d) after implantation. Predictive factors were evaluated using logistic regression analyses. Continuous values were described as median (IQR) and categorical as n (%).

Results: 74 patients (15% female) were included with a median age of 68 years (60-76); BMI of 23.2 (21-27) kg/m^2, MELD-score of 14 (11-18), and Child-Pugh score of 9 (8-10). Previous spontaneous bacterial peritonitis (SBP) was present in 31% (23/74) of patients prior to PeCa implantation. Within 90-d, the primary endpoint occurred in 52% (39/74) of the patients, including 28% (11/39) PeCa explantation and 72% (28/39) liver transplantation (LT) or death. Causes for explantation were SBP (73%), bleeding (9%), PeCa dysfunction (9%) or cellulitis (9%). In multivariable analysis, ECOG ≥2 (OR 1.9, p<0.01), female sex (OR 2.7, p = 0.02) and history of HCC (OR 1.4, p = 0.02) were independently associated with 90-day outcome. SBP prior to implantation was not associated with the outcome (OR 0.6, p = 0.32). After PeCa implantation, SBP was documented in 15% (11/74) within 90-d, occurring at a median of 20 days (11-56) after implantation. Despite SBP, PeCa could be maintained in 54% (6/11) at 90-d follow-up. We finally assessed the subgroup of patients with PeCa listed for LT (23%, 17/74). In this subgroup, 54% (10/17) underwent LT without complications including 40% (4/10) with PeCa in place at the time of LT. No complications of PeCa prohibiting LT were identified.

Conclusion: PeCa placement is a feasible option for the management of refractory ascites in patients with cirrhosis who are not eligible for TIPS. In multivariable analysis higher ECOG performance status, female sex and a history of HCC were associated with PeCa explantation or death during the study period. Previous SBP was not associated with 90-d primary outcome. In patients listed for LT, PeCa is a feasible option.

POSTER: GASTROENTEROLOGY

G1

Peripheral Blood–Associated Microbial Signatures as Predictors of Therapy Response in Inflammatory Bowel Disease

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A substantial proportion of inflammatory bowel disease (IBD) patients do not respond to treatment or lose response over time. Thus, there is a critical unmet medical need for identifying new predictive biomarkers to guide personalized treatment decisions. We have recently investigated whether bacterial signatures can be detected in peripheral blood mononuclear cells (PBMCs) of IBD patients and now aim to assess their functional relevance during chronic inflammation.

The primary objective of our study is to determine whether individual microbiome patterns in PBMCs or whole blood from Ulcerative Colitis (UC) and Crohn's Disease (CD) patients can predict the response to anti-TNF or anti- α4β7-integrin antibodies.

To answer those questions the proposed study is designed as a retrospective cohort analysis using 100 samples for each disease stratified into responders and non-responders. Blood samples have been collected at two defined time points: baseline prior to therapy initiation and follow-up between 8 and 52 weeks after treatment start. The overall workflow consists of metagenomic profiling of PBMCs and whole blood, integrative bioinformatic analysis and correlation of microbiome data with immune cell phenotypes.

By capturing microbial signals at the interface of barrier dysfunction and systemic immunity, this project represents a conceptual shift in IBD research. These minimally invasive biomarkers offer high translational potential to enable personalized treatment selection and accelerate time to clinical remission.

G2

Update 2026 on the Swiss Eosinophilic Esophagitis Cohort

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Background and aims: The Swiss EoE Cohort Study (SEECS, starting in 2016) collects longitudinal data on adult patients with eosinophilic esophagitis (EoE) to better characterize natural history, long-term treatment outcomes and clinical uptake/impact of emerging treatment options, safety aspects, EoE-specific quality of life, and socio-economic impact.

Patients and methods: Patients are included using validated online instruments (via redcap) for capture of symptoms, EoE-specific quality of life, endoscopic and histologic activity. A follow-up visit is performed once a year. A biobank (located at CHUV) stores biopsies and blood samples. In addition to patients with EoE, samples of patients with gastro-esophageal reflux disease (GERD) and esophagus-healthy controls are collected. SEECS is supported by the Swiss National Science Foundation and the Swiss EoE foundation. Approval from the major Swiss IRB's has been granted.

Results: As of May 2026, 872 patients with EoE, 29 with GERD, and 33 esophagus-healthy controls have been included. Recruitment performance is on track with anticipated 70 EoE patients per year. Biosamples have been provided to collaborators for evaluation of novel diagnostic and therapeutic approaches. As of May 2026, 22 papers were published with SEECS data and several projects are ongoing.

Conclusions: Over the last years, SEECS evolved into one of the largest prospective long-term cohort studies in the world for adult EoE patients. Besides fostering research collaborations in the field of translational and clinical science, it is an excellent tool to monitor efficacy and safety aspects of novel therapeutics after market approval.

G3

Eosinophilic Cholangitis mimicking Cholangiocarcinoma

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Background: Eosinophilic cholangitis (EC) is a rare benign inflammatory disorder characterized by eosinophilic inflammation of the biliary tract, leading to strictures, fibrosis, and biliary obstruction. We report a case of EC mimicking distal cholangiocarcinoma (CC).

Case Description: An 86-year-old woman was admitted with progressive deterioration of her general condition and diarrhea lasting ten days. Laboratory testing demonstrated cholestatic liver enzyme elevation, while abdominal ultrasound showed dilated bile ducts without evidence of cholecystolithiasis. A CT scan revealed a mass at the level of the papilla with extension into the duodenal wall. Endoscopic evaluation, however, showed an unremarkable papillary region. Endoscopic ultrasound identified an intraluminal, exophytic, hypoechoic lesion in the distal common bile duct. Fine-needle aspiration biopsy and ERCP with brush cytology were performed. Histopathological analysis demonstrated inflammatory eosinophilic infiltrates, including duodenal eosinophilia, without evidence of malignancy. Following initiation of systemic corticosteroid therapy, the patient's diarrhea resolved, cholestatic parameters normalized, and follow-up imaging demonstrated complete resolution of the distal bile duct mass and obstruction.

Conclusion: EC is a rare cause of biliary strictures and obstruction. The condition is likely underdiagnosed, accounting for up to 30% of indeterminate biliary strictures after comprehensive evaluation. Imaging findings frequently mimic CC or PSC. 15–24% of patients undergoing surgical resection for suspected biliary malignancy are ultimately found to have benign disease. Systemic corticosteroids are highly effective, with high-dose oral prednisone followed by gradual tapering representing the standard treatment approach, although some patients may require maintenance therapy. Prognosis is excellent with appropriate treatment, making accurate diagnosis essential to avoid unnecessary surgery.

G4

Helicobacter pylori Antibiotic Resistance Patterns in Zürich

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Background: *Helicobacter pylori* is a common gastric pathogen, causing peptic ulcer disease and representing an important driver for gastric carcinogenesis. Widespread use of classic triple eradication regimens has led to rising resistance against clarithromycin and other antibiotics, with clarithromycin resistance reaching around 20% in Europe. This has prompted a shift toward bismuth-based quadruple therapies, although local resistance patterns remain poorly characterized.

Methods: We are conducting a prospective, observational, single-center cross-sectional study assessing *H. pylori* antibiotic resistance patterns in adults undergoing gastroscopy. Eligible patients are ≥18 years old, have a medically indicated gastroscopy and are therapy naïve. Exclusion criteria are emergency gastroscopy, contraindications to forceps biopsy or H. pylori eradication therapy, or reside outside the Canton of Zurich. Gastric biopsies are obtained for phenotypic resistance testing if urease testing is positive.

Results: In this ongoing study, 33 patients were enrolled between June 2025 and April 2026. In total, 20/33 (60.6%) of the participants were female, the mean age was 45 years and only 5/33 (15.2%) were born in Switzerland. In total, 22 different countries of birth were registered. Clarithromycin resistance was detected in 3/33 (9.1%). Resistance rates for remaining antibiotics were: Metronidazole 17/33 (51.5%), Rifampicin 5/33 (15.2%), Levofloxacin 1/33 (3.0%), Amoxicillin 0/33 (0%), and Tetracycline 0/33 (0%).

Conclusions: Our preliminary data suggest that bismuth-based quadruple therapy can be avoided in most cases if antibiotic resistance testing is performed.

G5

Single-Session EUS-Guided Gastroenterostomy (EUS-GE) and Hepaticogastrostomy (EUS-HGS) for Malignant Double Obstruction

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Background: Malignant biliary obstruction combined with gastric outlet obstruction is challenging, particularly when duodenal stenosis prevents ERCP. EUS-GE and EUS-HGS offer an internal double-bypass alternative, but single-session experience remains limited. [1-3]

Case Report: We report our first institutional single-session EUS-GE/HGS in an 81-year-old woman with unresectable pancreatic adenocarcinoma, progressive duodenal stenosis and biliary obstruction with inaccessible papilla. Written informed consent was obtained.

Results: After jejunal distension via a nasobiliary catheter with saline/indigo carmine/contrast, EUS-GE was performed with a 15 x 10 mm Hot-Axios LAMS. A dilated left intrahepatic duct was then punctured, opacified and drained by EUS-HGS using a 10 x 80 mm partially covered Giobor stent, with additional 7 Fr/12 cm plastic stent and gastric clip fixation. Both stents were correctly positioned endoscopically and fluoroscopically, without immediate complication. Oral intake was restarted the same day and advanced after ultrasound control. Bilirubin rapidly normalized, performance and weight improved, and follow-up CT confirmed the biliogastric stent in place and a patent gastroenterostomy despite cancer progression.

Conclusions: Single-session EUS-GE/HGS provided rapid dual palliation in this selected patient with malignant double obstruction. The case supports structured development of therapeutic EUS double-bypass expertise in tertiary multidisciplinary programs.

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G6

Case Report: When Breast Cancer Reaches the Gut

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Background: Breast cancer is one of the most common malignancies among women worldwide. Although long-term remission is frequently achieved, late metastatic recurrence remains a relevant clinical challenge. Metastases typically involve bones, liver and lungs, whereas gastrointestinal involvement is rare and often underrecognized.

Case presentation: We report two cases of women with a history of invasive lobular breast carcinoma diagnosed more than five years earlier and without previously known metastatic disease. Both patients presented with newly developed gastrointestinal symptoms and underwent extensive diagnostic evaluation. In both cases, metastatic breast carcinoma involving the gastrointestinal tract was ultimately identified as the underlying cause of the symptoms. Histopathological and immunohistochemical analyses established the diagnosis of metastatic invasive lobular breast carcinoma.

Conclusions: Late gastrointestinal metastases of breast cancer are uncommon but should be considered in patients with a history of breast cancer presenting with new gastrointestinal symptoms, particularly in cases of invasive lobular carcinoma. These cases highlight the importance of maintaining a broad differential diagnosis, as metastatic breast cancer may mimic primary gastrointestinal malignancies even many years after the initial diagnosis.

G7

Massive gastrointestinal bleeding caused by Meckel's diverticulum in a young adult: a diagnostic challenge

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Background: Meckel's diverticulum is the most common congenital anomaly of the gastrointestinal tract but represents a rare cause of overt gastro-intestinal bleeding in adults. Diagnosis may be challenging, particu-larly in cases with ongoing bleeding and inconclusive initial investi-gations.

Case Presentation: A previously healthy 21-year-old woman presented with severe ab-dominal cramps predominantly in the left lower quadrant, and fresh blood per rectum. An extensive diagnostic work-up was performed, including upper endoscopy (EGD), colonoscopy, CT-Angiography and videocapsule endoscopy. Initial EGD and colonoscopy could not identify a bleeding source. CT-Angiography performed during ongoing bleeding showed no ac-tive extravasation. Videocapsule endoscopy subsequently demon-strated blood within the terminal ileum, prompting repeat ileocolon-oscopy. Inspection of the terminal ileum up to approximately 60–70 cm revealed a non-bleeding diverticulum. Following interdisciplinary discussion with the surgical team, segmental small bowel resection was performed. Histopathological examination confirmed the diagnosis of a Meckel's diverticulum. After surgical resection, the patient recovered completely without recurrent gastrointestinal bleeding.

Conclusions: Meckel's diverticulum should remain an important differential diag-nosis in young patients presenting with hemodynamically significant gastrointestinal bleeding. Extensive evaluation of the terminal ileum during endoscopy and the use of complementary diagnostic modali-ties may facilitate identification of this anatomical abnormality and guide definitive surgical treatment.

G8

Sustained Improvement In Patient-Reported Outcomes With Long-Term Risankizumab Treatment In Patients With Moderately To Severely Active Ulcerative Colitis: Interim 2-Year Results From The Phase 3 COMMAND Open-Label Extension Study

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Background: This post hoc analysis evaluated the long-term efficacy of risankizumab (RZB) in improving patient-reported outcomes through week (wk) 96 of the ongoing COMMAND open-label extension (OLE) study.

Methods: COMMAND OLE is a 220-wk study enrolling patients with ulcerative colitis (UC) who completed 52-wks maintenance dosing or enrolled directly as responders to induction.[1,2] All patients received subcutaneous RZB180 Q8w starting at OLE wk 0, except patients who had prior rescue therapy who continued RZB360 in the OLE.

Results: Of the 1003 patients (RZB180 = 701; RZB360 = 302) who entered the OLE, 398 (39.7%) patients completed wk 96 at data cut-off date. In the as observed analysis, RZB180- or RZB360-treated patients showed sustained improvements from OLE wks 0 to 96 in the absence of abdominal pain (71.7% at wk 96 with RZB180), bowel urgency (71.7% at wk 96 with RZB180), nocturnal bowel movements, tenesmus and faecal incontinence, as well as in IBDQ response (95.3% at wk 96 with RZB180), MWPC in FACIT-Fatigue, and SF-36v2 PCS and MCS scores.

Conclusions: RZB-treated patients who completed OLE wk 96 (3 years of total maintenance therapy) experienced sustained improvement in quality of life and patient-reported outcomes.

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G9

Looking Back to Move Forward: Preliminary Real-World Guselkumab Outcomes in Pre-Approval-Treated IBD Patients with Psoriatic Comorbidity (SPHERE-IBD)

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Background: Guselkumab (anti-IL-23p19) recently gained IBD approval after years of routine use for psoriasis (PsO) and psoriatic arthritis (PsA). IBD patients with comorbid PsO and/or PsA constitute a unique pre-approval natural opportunity to explore concurrent intestinal and extraintestinal (EIM) effects. To date, these effects remain insufficiently characterised, as guselkumab was approved by Swissmedics for IBD only in June 2025.

Methods: Within multicentre SPHERE-IBD (Switzerland, within SIBDCS; Nordic collaboration; target 15-25 Swiss / pooled ~50), we longitudinally track IBD activity (HBI, partial Mayo, CRP, calprotectin, endoscopy), 15 EIM categories and safety in IBD patients exposed to guselkumab. We present a preliminary interim analysis of the University Hospital Zurich subcohort.

Results: 7 heavily pre-treated patients have been analysed so far (5 CD, 1 UC post-colectomy, 1 IBD-U; median 4 prior advanced therapies, range 3–6; exposure 2.5–83 months) with heterogeneous indications, including a rare CD-with-PSC case. Active baseline psoriasis cleared in all affected, joint manifestations became inactive in all evaluable, and 3 of 4 paired endoscopies showed new mucosal healing. Drug persistence 6/7; one discontinuation (mild sinusitis, patient preference); no SAE, serious infection or malignancy.

Conclusions: In this preliminary cohort, guselkumab produced concurrent improvement of skin, joint and intestinal disease with a favourable short-term safety profile. Continued recruitment (15–25 Swiss patients; pooled ~50) will enable the translation of this pre-approval natural experiment into evidence supporting the new era of targeted IL-23p19 inhibition in IBD.

G10

Patient-Reported Adherence To ECCO Guidelines Across The DACH Region

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Background & Aims: Real-world adherence to European Crohn's and Colitis Organisation (ECCO) recommendations for inflammatory bowel disease (IBD) care remains insufficiently characterised across the DACH region. We assessed patient-reported adherence to eleven ECCO monitoring and prevention recommendations in adult IBD patients in Switzerland, Germany and Austria, by treating physician and country.

Methods: A cross-sectional, anonymous online survey was distributed via the national IBD patient associations of Switzerland, Germany and Austria. Eleven ECCO-derived items were evaluated per patient using pre-specified rules. Bonferroni-corrected χ^2 tests and multivariable logistic regression (adjusted for subtype, disease duration, age, sex, country and therapy) were applied.

Results: Among 1,058 included patients, GP-led care was consistently associated with lower adherence to monitoring than gastroenterologist-led care. Preventive care was the largest gap overall: DEXA recommendation reached only 35%, nutrition counselling 37%, and vaccination counselling 61% of applicable patients. Monitoring adherence was generally higher in Austria, whereas Germany showed lower DEXA recommendation (aOR 0.18, 0.12–0.27) and nutrition counselling (aOR 0.46, 0.33–0.65) versus Switzerland; surveillance colonoscopy was lowest in Switzerland.

Conclusions: Significant gaps persist in preventive IBD care across the DACH region, particularly outside gastroenterologist-led care.

G11

Long-term Outcome after Endoscopic Ultrasound-Guided Main Pancreatic Duct Drainage

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Background Obstruction of the main pancreatic duct can lead to severe pain, recurrent pancreatitis, and pancreatic insufficiency. The standard first-line treatment is ERCP with pancreatic duct stenting, although this procedure may fail or be technically impossible in some patients. Endoscopic ultrasound-guided pancreatic duct drainage (EUS-PDD) has emerged as a minimally invasive alternative to surgery.

Methods This retrospective study evaluated the long-term outcomes of EUS-PDD in 35 patients treated between 2016 and 2022 at a tertiary referral center. All patients underwent either pancreatogastrostomy or pancreatojejunostomy and had at least 12 months of follow-up.

Results The mean patient age was 58 years, and 74% were male. Chronic pancreatitis was the main indication for the procedure (54%). Technical success was achieved in all patients. Clinical success, defined as significant pain relief (visual analog scale score ≤2) without recurrence of obstructive pancreatitis, was obtained in 80% of cases. Adverse events occurred in 17% of patients, including 6% severe complications. Reintervention was required in 29% of patients, mainly because of stent dysfunction. 26% of patients experienced recurrent pancreatitis, most often related to stent dysfunction. Two deaths occurred during follow-up, but neither was related to pancreatic disease or the procedure itself.

Conclusion EUS-guided pancreatic duct drainage appears to be a safe and effective long-term treatment option for selected patients with MPD obstruction or disruption when ERCP is not feasible. The procedure provides durable symptom control with an acceptable rate of complications.

G12

SpyGlass-assisted pancreatoscopic lithotripsy for main pancreatic duct stones in chronic calcific pancreatitis: a single-center retrospective cohort study

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Background: Main pancreatic duct (MPD) stones in chronic calcific pancreatitis contribute to pain and their clearance remains challenging. SpyGlass pancreatoscopy enables targeted intraductal lithotripsy under direct visualization, but published experience is limited. We evaluated technical and clinical success, safety, and differences between electrohydraulic (EHL) and laser modalities.

Methods: Single-center retrospective cohort of adults undergoing SpyGlass-ERCP lithotripsy for obstructive MPD stones in chronic calcific pancreatitis (January 2018–August 2025). Technical success was defined as complete stone extraction; clinical success as post-operative pain <2/10 on a visual analog scale (vs pre-procedural >5/10). Complications were recorded at <7 and <30 days.

Results: Of 22 screened patients, 15 were analyzed (mean age 65.4 ± 10.9 years; 53.3% male; 73.3% ASA II). Median stone size was 11.0 mm [IQR 9.5–14.0] and median MPD diameter 14.0 mm [9.5–16.0]. EHL was used in 11/15 (73.3%) and laser in 6/15 (40.0%). Median lithotripsy sessions and ductal calibrations were 1 and 3 [2.5–5.0]. Technical success was achieved in 14/15 (93.3%) and clinical success in 13/15 (86.7%). Opioid use decreased from 2/15 to 0/15. Median lipase decreased from 62 to 18 U/L at six months (p = 0.064). Early and late complications each occurred in 2/15 (13.3%); no procedure-related deaths occurred.

Conclusion: SpyGlass-assisted pancreatoscopic lithotripsy achieved high technical and clinical success with an acceptable safety profile. Larger studies are needed to clarify modality-specific outcomes.

G13

FLIP Measurements Predict Short-Term Outcomes After Singular EsoFLIP Dilation in Patients with Achalasia

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Background: Prediction of outcome after dilation is currently based on clinical characteristics and only provides rough estimates. This study aimed to identify FLIP measurements that could best predict short-term clinical outcomes after single-session EsoFLIP dilation in patients with achalasia.

Methods: We analyzed treatment-naïve achalasia patients undergoing single-session EsoFLIP dilation between 2017 and 2025. EGJ diameter (Dia) and cross-sectional area (CSA) were measured at 70 ml fill volume, and distensibility index (DI) and balloon pressure (BP) at 60 ml, before and after dilation. Symptomatic response at 4 weeks was defined as post-dilation Eckardt score (ES) ≤3 or a ≥3-point reduction from baseline, and as post-dilation ES ≤1. Objective response was defined as timed barium esophagogram at 5 minutes <5 cm.

Results: Eighty-three patients (37% female; type 1 n = 7, type 2 n = 71, type 3 n = 5; mean age 53 years) were included. Symptomatic response was 81% (ES ≤3 or Δ≥3) and 46% (ES ≤1); objective response 67%. Median ES improved from 6 to 2, median TBE from 5 cm to 2 cm. EGJ-Dia increased from 10 to 17 mm, EGJ-CSA from 72 to 214 mm², and EGJ-DI from 1 to 6 mm²/mmHg; EGJ-BP decreased from 31 to 23 kPa (all p<0.001). For ES ≤3/Δ≥3, FLIP metrics showed insufficient discriminative performance. For ES ≤1, changes in EGJ-Dia70 (cut-off ≥6.3 mm, AUROC 0.77) and EGJ-CSA70 (cut-off ≥129.3 mm², AUROC 0.75) best predicted symptomatic response. ΔEGJ-DI60 showed moderate predictive performance (AUROC 0.65), whereas ΔBP60 showed no discriminative ability (AUROC 0.45).

Conclusions: Within-subject changes in FLIP metrics, particularly ΔEGJ-Dia and ΔEGJ-CSA, predicted symptomatic response and may support real-time assessment of treatment adequacy during EsoFLIP dilation.

G14

Guideline Adherence In Coeliac Disease Care Across The DACH Region: A Patient-Reported Study

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Background & Aims: Adherence to coeliac disease (CeD) guidelines in routine care remains poorly characterised across the DACH region. We aimed to evaluate patient-reported adherence to DGVS S2k recommendations using a structured Guideline Adherence Score (GAS).

Methods: A questionnaire-based study (N = 392) assessed the diagnostic workup and management of patients with diagnosed CeD via patient organisations in Switzerland and Austria. A predefined 9-point Guideline Adherence Score (GAS) based on key DGVS S2k recommendations was applied. Adherence was compared across countries and physician specialties. A sensitivity restriction to active-physician patients (N = 317) tested specialty differences.

Results: Of 392 respondents (78.8% female), the mean GAS was 5.36 of 9 (median 6/9, SD 2.3). Adherence to dietary measures was high (gluten-free diet 90.1%, no intentional gluten 85.5%) but preventive care was the largest gap (23%): DEXA was recommended in only 33.2% of patients, and vaccination counseling in just 12.8%. Structured long-term follow-up was likewise inadequate, with regular antibody monitoring in 52.6% and follow-up at ≤12-month intervals in 45.9%. Adherence differed significantly across physician categories (Kruskal-Wallis p < 0.001), with higher scores in gastroenterologist-led care (6.04/9, 67.1%) than under general practitioners (5.79/9, 64.3%).

Conclusions: Preventive care and long-term follow-up remain major unmet needs in CeD management across the DACH region.

G15

Applicability of the Lyon ESD Score in a Swiss University Hospital : A Retrospective Analysis of colorectal ESD

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Background: The Lyon endoscopic submucosal dissection score (LEDS) [1] was recently developed and published to predict

the duration of colorectal ESD, particularly for longer procedures. It aims to facilitate scheduling, optimize resource utilization, and improve workflow in endoscopy units.

Methods: We used retrospective data on colorectal ESD performed between January 2024 to March 2026 in our university hospital by three different operators. For each case, the Lyon Endoscopic Submucosal Dissection Duration Score (LEDS) was calculated using the published scoring system (https://lyonesddurationscore.github.io/leds/). The predictive performance of the LEDS model was subsequently evaluated by comparing the predicted procedural duration with the actual duration.

Results: A total of 53 colorectal ESD procedures were included. The mean actual procedure time was 63.8 min (95% CI 54.1–73.6). The mean difference between actual and predicted duration was +5.2 minutes, indicating mild underestimation of procedure time, with wide limits of agreement (approximately −57 to +68 minutes), suggesting substantial inter-individual variability. Predicted procedural time demonstrated moderate correlation with observed procedural time (Pearson $r \approx 0.50$, corresponding to $R^2 \approx 0.25$). No statistically significant difference was observed between predicted and actual durations ($p \approx 0.16$).

Conclusion: We evaluated the applicability of a newly published score on retrospective ESD data from our university hospital. Although no statistically significant difference was observed between predicted and actual procedure durations, the model showed a mild underestimation of procedure time, with wide limits of agreement indicating substantial inter-individual variability and limited precision for exact patient-level prediction. While the model may be useful for overall procedural planning and scheduling, its predictive performance in our cohort was lower than that reported for the original validated LEDS model.

1 De Cristofaro et al. Lyon endoscopic submucosal dissection score: a preprocedure prediction model for operating time in colorectal endoscopic submucosal dissection. GASTROINTESTINAL ENDOSCOPY 2026

G16

VACstent XL ® as part of the endoscopic tools for complex esophageal dehiscence : a tertiary single-center swiss experience.

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Centre Hospitalier Universitaire Vaudois, Lausanne Background: Complex esophageal dehiscences with large longitudinal and circumferential defects are challenging. VACStent XL (Microtech®), a hybrid device combining fully-covered stenting with peripheral vacuum-assisted closure, is a new endoscopic option. We evaluated VACStent XL in multimodal management of complex esophageal perforations/anastomotic leaks, especially where conventional approaches were judged inadequate.

Methods: This is a retrospective analysis of five consecutive patients treated with VACStent XL at a Swiss tertiary referral center from January to October 2025. The primary focuses are the technical feasibility and the clinical efficacy in complex presentations.

Results: Five patients (60% male, median age 63) had complex defects: post-op anastomotic leaks (n = 3), Boerhaave (n = 1), iatrogenic perforation (n = 1). Technical and clinical success were both achieved in 100% of patients (5/5). One temporary technical failure occurred in a case of anastomotic stenosis with longitudinal gastric wall dehiscence, which was successfully performed at the subsequent endoscopic session. Median treatment duration was 15 days. There were no VACStent-related complications and no mortality. All successfully treated patients resumed oral intake within 6 days. Conclusions: VACStent XL demonstrates excellent technical and clinical efficacy, comparable to standard-sized VACStents, and should be integrated into the endoscopic tools, particularly for complex esophageal dehiscences involving large longitudinal and circonferential defects. Larger comparative studies are needed to establish optimal management strategies.

Table 1 Patients Characteristics

Patient	Age (yrs)	Sex	Etiology	Longitudinal Defect (cm)	Prior Therapy	VACStents XL (n)	Technical Success	Clinical Success	Treatment Duration (days)
1	64	F	Boerhaave Syndrome	5	SEMS,Esosponge, VACstent	3	Yes	Yes	119
2	63	M	Oesophagectomy	4	SEMS,Esosponge, VACstent	2	Yes	Yes	31
3	67	M	Oesophagectomy	5	VACstent	1	Yes	Yes	17
4	90	F	Iatrogenic	13	Clipping	1	Yes	Yes	5
5	70	M	Oesophagectomy	5	Esosponge	2	Yes	Yes	11
Median	67		-	5	-	2	100%	100%	17

G17

Mass-forming Fibromatosis-like Gallbladder Disease Mimicking Malignancy of the Bile Duct

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Background: Fibromatosis-like lesions of the gallbladder and hepatobiliary system are rare and may mimic malignancy clinically and radiologically. Differential diagnoses include inflamma-tory myofibroblastic tumor, IgG4-related disease, xanthogranu-lomatous cholecystitis, desmoid-type fibromatosis, and post-inflammatory fibrosis. We report a rare case associated with chronic portal vein thrombosis, portal hypertension, and obstruc-tive cholangiopathy.

Methods: We retrospectively reviewed the 5-year course of a 47-year-old woman presenting with pruritus and cholestasis in June 2020. Diagnostic workup included CT, MRI, PET-CT, liver biopsy, brush cytology, and exploratory laparotomy with tissue sampling. Histopathological and immunohistochemical analyses excluded malignant and inflammatory differential diagnoses.

Results: Imaging revealed a fibro-inflammatory lesion at the gallbladder hilum compressing the portal vein and common hepatic duct. Histopathology demonstrated a benign fibromatosis-like process without evidence of malignancy. The course was complicated by chronic portal vein thrombosis, portal hyperten-sion, and recurrent biliary obstruction requiring repeated ERCP and stent exchanges. Progressive portal hypertension ultimately required TIPS implantation, resulting in partial clinical stabiliza-tion.

Conclusion: Fibromatosis-like gallbladder lesions may cause severe hepatobiliary and vascular complications resembling ma-lignancy. Chronic portal vein thrombosis with obstructive cholan-giopathy is a rare complication requiring multidisciplinary mana-gement.

G18

A haircut before surgery: Endoscopic scissor-assisted fragmentation of a trichobezoar with Rapunzel syndrome

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Background: Rapunzel syndrome is a rare manifestation of gastric trichobezoar in which a hair tail extends through the pylorus into the small bowel. Endoscopic removal is technically challenging, and surgery is often required.

Methods: A 3-year-old girl presented with failure to thrive, weight loss and recurrent emesis. She had a history of congenital duodenal stenosis treated by duodeno-duodenostomy. Upper endoscopy revealed a trichobezoar extending from the pylorus beyond the ligament of Treitz into the proximal jejunum. The bezoar could be partially mobilized but not safely extracted because of resistance from the long distal extension. To avoid surgery, the strategy was changed to endoscopic fragmentation prior to endoscopic removal. The bezoar was divided using a through-the-scope loop cutter/scissor device (FS-410, Olympus) and subsequently removed piece by piece with grasping forceps. Complete endoscopic extraction was achieved.

Conclusions: This case highlights a key therapeutic challenge in Rapunzel syndrome: even when the gastric portion appears retrievable, the long distal tail may prevent safe extraction because of resistance within the small bowel. When endoscopic options are feasible, surgery should be avoided, especially in small children. Endoscopic scissor-assisted fragmentation may offer an effective minimally invasive alternative when conventional endoscopic extraction fails, following a simple principle: when hair cannot be pulled safely, it may need a haircut before removal.

G19

Patients prefer oral, Healthcare Professionals prefer subcutaneous: mode-of-delivery preferences in IBD differ by prior advanced-therapy exposure — the CHOOSE study

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Background: IBD treatment options include oral, subcutaneous (SC) and intravenous (IV) agents. Whether patient and Healthcare Professional (HCP) preferences converge, and how prior advanced therapy modifies them, is unclear.

Methods: National cross-sectional survey of Swiss adult IBD patients and HCPs. 585 patients (of 857 respondents; 57% Crohn's disease (CD), 43% ulcerative colitis (UC); 66% female; median age 49y) and 104 HCPs (of 127 respondents; 32% female; median age 45y) were analysed. Partial responders were excluded; they were more often female (74% vs 66%, p = 0.04) and tended to be older (median 52 vs 49y, p = 0.06). Participants ranked their preferred delivery mode: oral, SC and IV. Advanced-therapy exposure was defined as ≥1 month of biologic, JAK inhibitor or S1P modulator use; Group comparison was made with non-parametric and by chi-square testing.

Results: In patients the preferred mode was oral in 60.9%, SC in 22.1% and IV in 17.1%; HCPs preferred SC in 46.2%, oral in 28.8% and IV in 25.0% (p<0.001). Advanced-therapy-naïve patients (n = 185) preferred oral in 83.8%, with very few preferring SC (5.9%) or IV (10.3%). Among advanced-therapy-exposed patients (n = 400), oral remained the most common first choice but at a lower rate (50.3%), while SC (29.5%) and IV (20.3%) were chosen more often (p<0.001). Oral was the first choice for 70.3% of UC patients vs 53.9% of CD patients (p<0.001), and for 72.0% of male vs 55.9% of female patients (p<0.001).

Conclusions: IBD patients more often prefer oral administration, particularly those with UC and male sex, whereas HCPs most commonly prefer subcutaneous. Oral preference is lower among advanced-therapy-exposed patients. Mode-of-delivery priorities are currently misaligned between patients and HCPs and should be addressed explicitly in shared treatment decisions.

G20

High Shared Decision-Making Scores Mask Preference Gaps Between IBD Patients and Healthcare Professionals: The CHOOSE Study

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Background: Shared decision-making (SDM) is endorsed in IBD treatment strategies, but its value depends on whether patients

and healthcare professionals (HCPs) actually share preferences. We assessed whether reported SDM matches aligned prefer-ences.

Methods: National cross-sectional survey of Swiss adult IBD pa-tients and HCPs. 585 patients (of 857 respondents; 57% Crohn's disease (CD), 43% ulcerative colitis (UC); 66% female; median age 49y) and 104 HCPs (of 127 respondents; 32% female; me-dian age 45y) were analysed. Partial responders were excluded; they were more often female (74% vs 66%, p = 0.04) and tended to be older (median 52 vs 49y, p = 0.06). SDM involvement, treat-ment goals and decision factors were rated on a scale of 0–100 or forced ranking; groups compared by Mann-Whitney and chi-square tests. Data are reported as medians.

Results: Patients and HCPs rated SDM involvement comparably (median 76 vs 80, p = 0.08) and SDM adequacy identically (me-dian 86 vs 86, p = 0.44). While patients and HCPs ranked treat-ment goals in a similar order (Pearson's r = 0.72), they assigned significantly different absolute importance ratings to fatigue (85 vs. 68, p<0.001), endoscopic remission (90 vs. 76, p<0.001), and abdominal pain (90 vs. 81, p<0.001), with patients consistently rating these goals as more important than HCPs. Patients also placed greater importance on the location of treatment admin-istration (home vs. medical facility) (70 vs. 55, p<0.001). Among decision-relevant factors, patients rated their physician's recom-mendation as the most important (82), ahead of their own prefer-ence (76) and concern about side effects (78).

Conclusions: Patients and HCPs both feel that decisions are ideally made together, yet they value different treatment goals and a key decision factor. High SDM involvement scores therefore mask underlying preference gaps and should be complemented by direct assessment of patient priorities.

G21

Major Adverse Cardiovascular Events During Pregnancy and Postpartum in Women With Inflammatory Bowel Disease: A Swiss Population-Based Cohort and Case-Control Study

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Background: IBD often affects reproductive-age women, yet peripartum MACE risk in this population is poorly characterized.

Methods: Using nationwide Swiss data from all inpatient deliveries between 2012 and 2022, we conducted a population-based cohort study (postpartum follow-up [≤3 months and long-term]) and case-control study (pregnancy [10 months preceding delivery] and delivery hospitalization) to assess peripartum MACE risk in women with IBD. Stabilized IPTW logistic and Cox regression estimated odds ratios and hazard ratios respectively.

Results: Among 658,776 women, 1,831 had IBD (CD, n = 1,021; UC, n = 810). During a median follow-up of 3.4 years, MACE occurred in 9 women with IBD (IR, 8.7 per 100,000 PY) and 1,398 women without IBD (IR, 3.9 per 100,000 PY), yielding a weighted HR of 2.21 (95% CI, 1.05-4.64). Most events occurred beyond 3 months after delivery in both groups (women with IBD: 89%; women without IBD: 84%). In the case-control analysis, IBD was not associated with increased MACE risk during pregnancy (OR, 0.73; 95% CI, 0.10-5.26) or at delivery hospitalization (OR, 1.62; 95% CI, 0.30-8.73).

Conclusions: IBD was not associated with acute peripartum MACE risk but conferred a more than twofold higher long-term risk after delivery, supporting consideration of long-term cardiovascular risk assessment in women with IBD after pregnancy.

G22

Disease burden measured by the IBD-Disk shows sex-specific differences in Ulcerative Colitis and is reduced by upadacitinib – Interim results from the IBD-DACH Study

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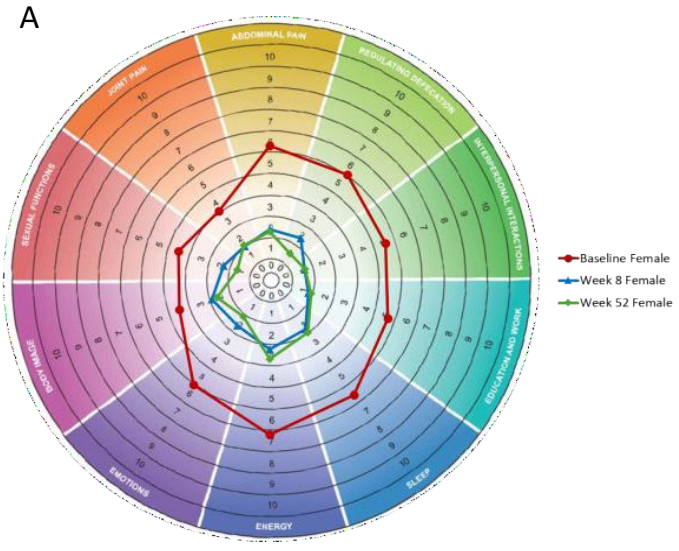
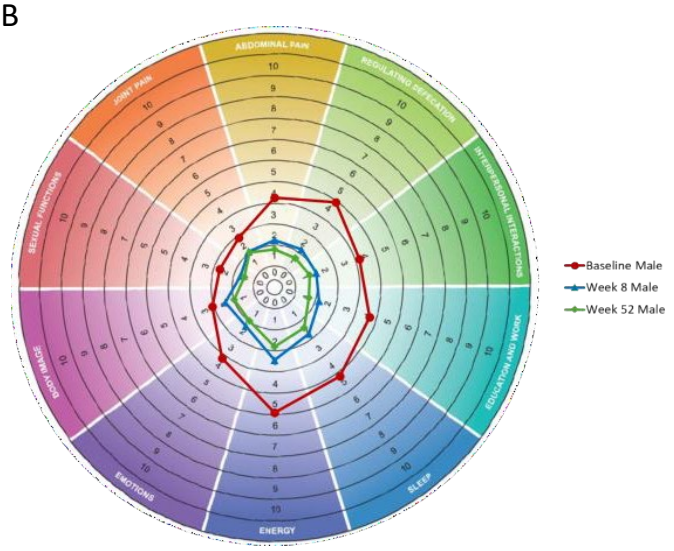
Background: EUROPE is an ongoing, prospective, non-interventional, multicenter study of upadacitinib (UPA) in adult patients with moderate to severe ulcerative colitis in Germany, Austria and Switzerland (DACH).

Methods: Here, we present data on patient-reported disease burden, stratified by sex, as measured with the IBD-Disk. Patients with both a documented visit at week (wk) 52 and ongoing treatment with UPA were included in this analysis. Safety data was available for 364 patients (≥1 dose of UPA).

Figure 1: Changes in IBD-Disk Score Dimensions over time in female (A) and male (B) UPA-treated patients. Higher Scores indicate higher disease burden.



B



Results: IBD-Disk total scores and scores for all individual dimensions of IBD-Disk were higher in women at baseline. At wk 8 and 52, IBD-Disk scores were comparable between women and men, thus decreasing more substantially in women (Figure 1). By wk 8, rates of symptomatic remission (stool frequency score 0/1 and rectal bleeding score = 0) for women vs. men were 70.3% and 74.2%, increasing to 87.5% and 81.7% by wk 52, respectively. No new safety signals were detected.

Conclusions: Disease burden improved substantially in response to UPA and was similar in women and men at wk 8 and 52 of treatment.

G23

Long-term monitoring of colonic function in-vivo: from preclinical application to clinical translation

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The lack of solutions for long-term monitoring of colon function is an unmet clinical need mirrored in preclinical neurogastroenterology research. As a result, the field has been limited in identifying biomarkers and pathways involved in disorders of gut brain interaction, whose understanding is required to ultimately improve patient management.

To this end, we developed a mini-endoscope for minimally invasive intraluminal monitoring of function and deep-tissue morphology in the colon of anesthetized mice. With 128 electrodes over 3 cm, we achieve high resolution spatiotemporal mapping of myogenic electrical activity. Simultaneously, optical coherence tomography confirms tissue contact, measures motility, and visualizes internal morphology.

In a model of localized benzalkonium chloride-induced aganglionosis, 8 animals showed disrupted electrophysiology patterns and consistent thickening of the mucosal layer of the colon wall. Longitudinal monitoring before and after damage identified induced disruption of electrophysiology, motility and morphology. To further elucidate functional dynamics in-vivo, current efforts are focused on local electrical stimulation.

Thus, long-term monitoring has the potential to offer valuable new insights on the gut-brain axis in animal models. To meaningfully translate this approach to humans, we aim to develop a solution based on ambulatory intraluminal monitoring over multiple digestive cycles. For this, clinician input will be invaluable.

G24

Peroral Endoscopic Myotomy after surgical fundoplication: A single-center retrospective experience

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Background: Management of dysphagia after fundoplication or Heller myotomy combined with fundoplication remains challenging. We evaluated the safety and efficacy of peroral endoscopic myotomy (POEM) in this setting.

Methods: Consecutive patients undergoing POEM after fundoplication between June 2019 and June 2025 were retrospectively analyzed. Clinical success was defined as an Eckardt score ≤3 without the need for reintervention.

Results: Nine patients (67% female, mean age 60.1 ± 14.5 years) were included. Three underwent POEM for post-fundoplication dysphagia (Nissen n = 2, Toupet n = 1), while six had salvage POEM for recurrent or persistent symptoms after Heller myotomy with fundoplication for achalasia (Dor n = 5, Nissen n = 1). Median time from surgery to POEM was 60 months (7–374), and mean pre-procedural Eckardt score was 5.4 ± 3.2. Technical success was achieved in all patients (100%) and clinical success in 7/9 (78%); median follow-up 16 months (4–38). One patient developed a para-oesophageal hematoma managed conservatively; four patients had mild post-procedural pain requiring only step-1 analgesics. No severe adverse events (Clavien-Dindo ≥III) occurred.

Conclusions: Despite technical challenges associated with prior foregut surgery, POEM appears to be a safe and effective therapeutic option for dysphagia after fundoplication or Heller myotomy combined with fundoplication.

G25

Guselkumab Real-World Experience in Switzerland: Which Dose, Which Formulation, and For Whom? A Swiss Multicenter Report of 72 IBD Patients.

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Background Guselkumab (Tremfya®) offers both IV and SC induction and has shown efficacy in inducing and maintaining remission in Inflammatory Bowel Diseases (IBD). We report the largest real-world Swiss cohort since Swissmedic approval in June 2025.

Methods Retrospective chart review of 72 IBD patients across three centers (Bern, Fribourg, Bulle), assessing indications, treatment history, and induction modality choice (SC vs. IV, in Crohn's disease (CD) only).

Results Between November 2025 and May 2026, 72 patients were identified: 49 CD (68%) and 23 ulcerative colitis (UC) (32%), 60% female, median age 48 years (range 18–81), median disease duration 8 years (IQR 0.5–15). Guselkumab was most initiated as a second- or third-line biologic (51% CD, 61% UC). In CD, it was used as first-line biologic therapy in 29% of cases, predominantly in patients with isolated ileal disease (L1), often in the postoperative setting. In UC, 22% had refractory pancolitis with ≥3 prior biologic lines. One quarter were biologic-naïve; more than half had prior anti-TNF exposure; 30% had received ustekinumab, 15% another IL-23 inhibitor, and 18% a small molecule. SC induction in CD was favored in earlier

treatment lines, L1 disease, postoperative settings, and absence of extraintestinal manifestations. For maintenance, 61% received the standard regimen (100 mg SC q8w); dose intensification (200 mg SC q4w) was more frequent after IV induction, in extensive or refractory disease, and with prior anti-TNF exposure.

Conclusions Guselkumab is rapidly adopted in Swiss IBD practice. Emerging real-world patterns in induction route selection and maintenance intensification may inform future positioning of this flexible IL-23 inhibitor.

G26

A Postmarketing, Prospective, Noninterventional Study Evaluating the Real-World Clinical Effectiveness and Safety of Risankizumab in Patients with Crohn's Disease: Interim Results from the APPRISE Study

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Background: Pivotal clinical trials have shown the efficacy of the anti-interleukin-23 p19 antibody risankizumab (RZB) for treatment of moderate-to-severe Crohn's disease in adults. Here, efficacy and safety in a real-world setting were evaluated.

Methods: APPRISE is an ongoing prospective, single arm, noninterventional, postmarketing, observational study. The first 500 enrolled patients (pts) were included in this interim analysis. Data are as observed after handling of intercurrent events.

Results: Of pts who received ≥1 dose of RZB (483 pts), 51% were advanced therapy-exposed, 17% used Corticosteroids (CS) at baseline (BL), and 74 pts had ustekinumab (UST) failure at BL. Sustained clinical remission at 6 months (mo) was achieved by 84.1% of pts who were in clinical remission at 3mo. CS-free clinical remission at 3mo was achieved by 60.3% of pts. Among pts who had failure of UST at BL, 95.5% achieved clinical remission at both 3mo and 6mo. In 41.6% of pts, ≥ 1 treatment emergent adverse event (TEAE) was reported, 8.9% of pts reported serious TEAEs, and 2.9% discontinued RZB treatment.

Conclusions: Most pts treated with RZB achieved and sustained clinical and CS-free clinical remission, and the durability of effect was observed regardless of prior UST failure.

G27

Gastritis Cystica Profunda: Diagnostic Challenges and Management Algorithm– A Systematic Review

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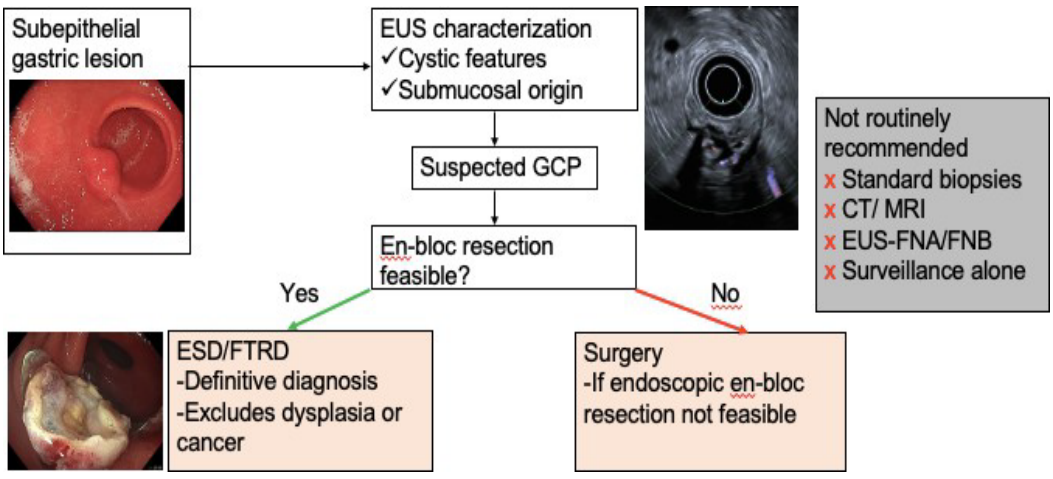
Background: Gastritis cystica profunda (GCP) is a rare gastric lesion characterized by cystically dilated gastric glands extending into the submucosa. Given the limited evidence on its diagnosis and management, we aimed to identify clinically relevant phenotypes and develop a management algorithm.

Methods: Following PRISMA 2020 guidelines, MEDLINE, EMBASE, Web of Science, and CENTRAL were searched from inception to April 2026. Studies with histologically confirmed GCP were included.

Results: We included 124 studies comprising 823 GCP patients. Two phenotypes were identified: a postoperative type associated with Billroth II reconstruction and anastomotic localization, and a non-postoperative type occurring throughout the stomach. Clinical and imaging findings were nonspecific, biopsies and EUS-guided sampling showed limited diagnostic yield, often requiring resection for diagnosis. ESD and surgery achieved the highest rates of complete resection. Coexisting carcinoma was more frequent in postoperative than in non-postoperative cases.

Conclusions: Two clinically distinct GCP phenotypes exist. Due to the limited diagnostic yield of tissue sampling, EUS-based characterization and en-bloc resection are central to diagnosis and management.



G28

EUS-Guided Gastroenterostomy for Benign Gastric Outlet Obstruction: Long-Term Efficacy and Safety

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Background: EUS-guided gastroenterostomy (EUS-GEA) using lumen-apposing metal stents (LAMS) is an established technique for malignant gastric outlet obstruction (GOO). This study evaluated the clinical efficacy and safety of EUS-GEA in patients with benign GOO, particularly regarding long-term outcomes and LAMS management.

Methods: Single-centre retrospective study with patients who had EUS-GEA for a benign indication with a follow-up >6 months. Primary endpoint: clinical success (GOOSS improvement ≥2 points or GOOSS = 3 at last follow-up). Secondary endpoints: technical success, complication rates, and need for endoscopic reintervention.

Results: 25 patients included (48% female, mean age 58 ± 16 years). Technical success: 100%; mean follow-up: 21.9 ± 10.8 months. No procedure-related deaths or immediate complications. One delayed complication (4%): LAMS occlusion by mucosal overgrowth at 10 months, managed endoscopically. Clinical success: 84% (21/25). Stent removal at 9.5 ± 5.3 months in the first 10 patients led to 50% symptom recurrence, treated with a new LAMS with resolution of the symptoms.

Conclusions: EUS-GEA is safe and effective for benign GOO. We propose a long-term LAMS management algorithm. In case of a reversible cause of GOO, LAMS removal is planned at 6–12 months; in case of a persistent cause, the Hot AXIOS is replaced at one year by a 15 mm Cold AXIOS.

G29

Diagnosis of colorectal cancer in pregnancy – A case series

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Background Colorectal cancer (CRC) during pregnancy is rare (ca. 0.002% of pregnancies) but the rising incidence of early-onset CRC and delayed childbearing may increase its occurrence. We present four cases highlighting the diagnostic challenges of CRC in pregnancy, as symptoms such as anemia, hematochezia and altered bowel habits may overlap with common pregnancy-related changes while endoscopic evaluation carries potential risks. High-quality evidence and specific guidelines for endoscopy and CRC management during pregnancy remain limited, complicating timely and accurate diagnosis.

Case series From 2019 to 2026, we diagnosed CRC in four patients under 40 years of age at our tertiary center: three during pregnancy (at 30+6 and 28+0 weeks of gestation (WGA)) and two postpartum. Patients presented with fatigue, anemia or altered bowel habits with abdominal or rectal discomfort and rectal bleeding, that led to an emergency C-section in one patient in 37 WGA. A l underwent colonoscopy after careful assessment without complications. In three patients, the lesion was located in the rectum; in one in the ascending colon. One patient had localized disease and was successfu ly treated with R0-polypectomy. One showed local invasive disease (cT4 with infiltration of the vagina). The remaining two presented with metastatic disease (cT3, N+, M+) involving the liver and bones. The last three patients needed systemic therapy. All patients delivered healthy children at ≥37 weeks' gestation. One patient with systemic disease died 6 months postpartum. Genetic testing has been performed to date in 3 patients and revealed no hereditary polyposis syndromes. None of the patients had positive family history of colorectal cancer.

Conclusion These cases highlight the diagnostic challenges of CRC during pregnancy, where nonspecific symptoms and concerns about procedural safety can delay diagnosis. Improved outcomes require greater clinical awareness, clearer diagnostic guidance that balances maternal-fetal safety with timely and accurate diagnosis.

POSTER: HEPATOLOGY

H1

Body Mapping Reveals Distinct Topographical Patterns of Hepatobiliary Pruritus

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Background and aims: Pruritus is a common and burdensome symptom in chronic liver diseases that substantially impairs quality of life. However, its anatomical distribution across different disease etiologies remains insufficiently characterized. Standardized body mapping represents a patient-friendly and language-independent tool for the systematic assessment of itch distribution and may facilitate the identification of disease- or patient-specific pruritus localizations. We therefore aimed to characterize the anatomical distribution of pruritus in patients with chronic liver diseases and to explore differences between etiological subgroups.

Methods: In this cross-sectional study conducted at a tertiary hepatology center, patients with pruritus completed standardized front- and back-view body maps to indicate current and habitual itch locations. Demographic, clinical, and etiological data were collected. Patients were categorized into immune-mediated and cholestatic liver diseases (ICLD), steatotic liver diseases including MASLD, MetALD, and ALD (SLD), and viral liver diseases (VLD). Itch severity and disease burden were assessed using mean and worst itch numeric rating scales (NRS) as well as the 5-D Itch Scale. Body maps were digitized and analyzed using automated, observer-independent quantitative image analysis.

Results: Among 656 participants, 173 (26.4%) reported pruritus, and complete body maps were available for 150 patients (67.7% female). ICLD constituted the largest subgroup (n = 71; 40.7%). Mean itch intensity was 3.8 ± 2.7, worst itch intensity 4.4 ± 2.9, and the median 5-D Itch Scale score was 11 (IQR 8.5–15). Pruritus predominantly affected the extremities, particularly the volar forearms and anterior lower legs, followed by the back. In contrast to previous reports, involvement of the palms and soles was uncommon. Current and habitual itch distributions showed high concordance. Patients with cirrhosis reported less frequent involvement of the upper body compared with non-cirrhotic patients, while female patients reported itch affecting a greater number of anatomical regions than males. Although no disease-specific exclusive distribution patterns were identified, an extremity-predominant pattern was consistently observed across all etiological subgroups.

Conclusions: Standardized body mapping identified a reproducible, extremity-predominant pruritus pattern across chronic liver diseases that was largely independent of etiology, with the most extensive involvement observed in ICLD. These findings support shared mechanisms underlying hepatobiliary pruritus and highlight body mapping as a robust, patient-friendly tool for spatial itch phenotyping beyond conventional intensity-based assessments.

H2

Regional Heterogeneity in Primary Biliary Cholangitis: GLOBE and UK-PBC Score Performance in German- Versus Italian-Speaking Swiss Patients

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Background: Primary Biliary Cholangitis (PBC) is a chronic cholestatic liver disease with a highly variable natural history. The GLOBE and UK-PBC scores are prognostic tools, validated internationally to predict liver-related outcomes. The aim of our study is to compare the clinical characteristics and predicted outcomes of Swiss PBC patients with the original international GLOBE and UK-PBC derivation cohorts in different Swiss cantons.

Methods: We performed a retrospective analysis of 159 Swiss PBC patients treated with UDCA, of which 108 belong to the German-speaking Swiss (group 1) and 51 to the Italian-speaking Swiss (group 2). Baseline demographics and biochemical markers (ALP, bilirubin, albumin, platelets) were analyzed. The GLOBE and UK-PBC risk scores were calculated after 12 months of UDCA therapy.

Results: For both groups, we calculated both the GLOBE and UK-PBC score. %). In the GLOBE cohort: group 1 mean age is 54.1, in group 2 57, with a high prevalence of females (81 vs 88). Group 1 showed a higher ALP ratio (2.2 vs 0.8), and a lower bilirubin (7.2 vs 14.4 umol/l), albumin ratio (0.99 vs 1.04) and platelets ratio (1.71 vs 1.75); the results of the score is 0.7 for group 1 vs 3.1 for group 2. As for the UK-PBC cohort: group 1 mean age is 50.7, in group 2 55.6, with a high prevalence of females (79 vs 90%). Group 1 showed a higher ALP ratio (1.3 vs 0.67), a lower and bilirubin (0.6 vs 0.48 umol/l), albumin ratio (1.1 vs 1.15) and platelets ratio (1.65 vs 1.63); the results of the score is 0.06 for group 1 vs 0.04 for group 2.

Globe Score Cohort		
	German-speaking part	Italian-speaking part
Variables	N = 108	N = 51
Age, years	54.1 (46-64)	57 (51-64)
Female, n (%)	88 (81.5)	45 (88.2)
ALP Ratio	2.2 (0.9-2.3)	0.8 (0.46-0.91)
Total Bilirubin	7.2(0.45-17)	14.4 (0.51-26.9)
Albumin Ratio	0.99 (0.85-1.1)	1.04 (0.85-1.18)
Platelets Ratio	1.71 (1.44-1.97)	1.75 (1.43-1.96)

UK Score Cohort

	German-speaking part	Italian-speaking part
Variables	N = 85	N = 30
Age, years	50.7 (46-56)	55.6 (44-64)
Female, n (%)	67 (79)	27 (90)
ALP Ratio	1.3 (0.7-2.7)	0.67 (0.46-0.91)
Total Bilirubin	0.6 (0.45-0.76)	0.48 (0.41-0.59)
Albumin Ratio	1.1 (1-1.15)	1.15 (1.08-1.2)
Platelets Ratio	1.65 (1.3-1.9)	1.63 (1.25-1.87)

Median Scores	German-speaking part	Italian-speaking part
UK-PBC	0.06	0.04
Globe	0.78	3.1

Conclusions: Swiss PBC patients show significant regional variation in biochemical profiles and predicted outcomes. Despite higher baseline ALP ratios indicating greater cholestatic activity, German-speaking Swiss patients demonstrated better predicted long-term prognosis (lower GLOBE scores) compared to Italian-speaking Swiss patients. Both groups showed favorable UK-PBC risk scores. These findings suggest that regional differences in disease phenotype or treatment patterns may influence PBC presentation in Switzerland, and highlight the need for validation of international prognostic scores in distinct Swiss populations to ensure accurate risk stratification and clinical decision-making.

H3

Bioequivalence of Trientine Dihydrochloride Capsules

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Background: Trientine dihydrochloride is a copper chelator for Wilson disease. Because treatment is lifelong, bioequivalent generic formulations are clinically relevant. This study assessed pharmacokinetics and safety of a 250 mg test capsule versus a 300 mg reference product.

Methods: In this randomized, open-label, balanced, two-period crossover study, 36 healthy adults aged 18-45 years and BMI 18.5-30 kg/m² received single oral test and reference doses under fasting conditions, separated by a 7-day washout. In each period, 28 blood samples were collected up to 48 h. Trientine and N1-acetyl-triethylenetetramine were quantified by validated LC-MS/MS. Bioequivalence was assessed using ANOVA of log-transformed C_{max} and AUC values.

Results: Overall, 35/36 subjects were included in pharmacokinetic and statistical analyses; 1/36 withdrew for personal reasons. Trientine Tmax was significantly earlier with test versus reference: median 1.25 h (range 0.25-2.50; mean 1.32 +/- 0.60) versus 2.25 h (0.75-3.50; mean 2.14 +/- 0.69; p<0.0001). Cmax was 934.0 +/- 345.0 versus 832.3 +/- 370.9 ng/mL. AUC0-t was 4,525.4 +/- 2,354.6 versus 3,503.7 +/- 1,898.0 h*ng/mL, and AUC0-inf was 4,771.2 +/- 2,450.1 versus 3,684.7 +/- 1,968.7 h*ng/mL. Terminal half-life was 11.3 +/- 7.5 versus 9.5 +/- 5.8 h. Unadjusted test/reference ratios were 114.96% (90% CI 104.40-126.60) for Cmax and 109.36% (98.40- 121.55) for AUC0-t. Five mild adverse events occurred; none was drug-related or serious.

Conclusions: The 250 mg test capsule showed faster absorption and higher trientine exposure per mg than the 300 mg reference. AUC_{0-t} at marketed strengths fulfilled the 80-125% range, while C_{max} marginally exceeded it. Both formulations were well tolerated.

H4

Borrelia afzelii Hepatitis: a rare manifestation of Lyme borreliosis in two immunocompromised patients

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Background: Lyme borreliosis has a wide range of clinical manifestations, most commonly dermatological, neurological, or rheumatological. Direct hepatic infection is extremely rare and mainly described in immunocompromised patients. We report two cases of Borrelia afzelii hepatitis in immunocompromised patients.

Case description: Case 1: a patient with MOG antibody-associated encephalomyelitis receiving rituximab presented with fatigue, arthralgia and weight loss. Laboratory tests showed elevated cholestatic liver enzymes and inflammatory markers. Imaging demonstrated accentuated intrahepatic bile ducts and increased liver stiffness. Liver biopsy revealed florid cholangitis, metagenomic next-generation sequencing identified Borrelia afzelii infection.

Case 2: a patient with mantle cell lymphoma treated with rituximab and ibrutinib presented with elevated cholestatic liver enzymes and inflammatory markers. PET-CT showed increased metabolic activity in the central bile ducts. Liver biopsy revealed portal-predominant mixed inflammatory infiltrates and PCR detected Borrelia afzelii DNA within the hepatic tissue. In both cases additional serological testing for Borrelia spp. was negative. Antimicrobial therapy with doxycycline was initiated. This resulted in a marked clinical and laboratory improvement

Conclusion: These cases highlight the limited diagnostic value of serology in immuncompromised patients and the importance of liver biopsy with molecular testing in unexplained cholestatic hepatitis. Early recognition is crucial, as treatment results in rapid clinical and biochemical improvement

H5

Breaking the Itch: IBAT Inhibitors in Adults with Refractory Cholestatic Pruritus

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Background: Ileal bile acid transporter (IBAT) inhibitors are approved for paediatric indications. Systematic data on their use in adults are lacking, limiting their clinical use despite promising therapeutic potential. We report a Swiss case series on in- and off-label use of IBAT inhibitors in adult patients with treatment-refractory cholestatic pruritus.

Methods: Three adult patients from two tertiary referral centers in Switzerland with genetically confirmed cholestatic disorders received IBAT inhibitor therapy for severe treatment-refractory pruritus. Clinical response was assessed using the pruritus numeric rating scale (NRS) and biochemical parameters.

Results: Two out of three patients showed clinically meaningful improvement within 4 weeks of treatment. Remission persisted after treatment discontinuation. Patient 1 (ATP8B1/ABCB11 variants) experienced a reduction in pruritus from NRS 4/4 to 1/4, accompanied by decreases in serum bile acids (224 to 111 µmol/L). Patient 2 (ABCB11 variants) achieved near-complete

resolution of pruritus (NRS 10/10 to 1/10), associated with a reduction in serum bile acids (159 to 21 µmol/L). Patient 3 (PFIC3 with ABCB4 variants) exhibited improvement in pruritus (NRS 5/10 to 1/10), although no biochemical response was observed. Long-term follow-up for this patient was unavailable due to subsequent liver transplantation. Reported adverse events included moderate nausea with reduced appetite (Patient 1) and transient moderate diarrhea (Patient 2).

Conclusion: This case series suggests that IBAT inhibitors represent an effective and well-tolerated treatment option for adults with refractory cholestatic pruritus. Sustained and rapid remission of severe morbidity in adult BRIC/PFIC is noteworthy and warrants further investigation in larger prospective studies.

H6

Real-world use and metabolic trajectories of liver transplant recipients treated with GLP-1 receptor agonists: A single-centre retrospective cohort study

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Background: Metabolic complications are frequent after liver transplantation (LT) and contribute substantially to long-term morbidity and mortality. Glucagon-like peptide-1 receptor agonists (GLP-1 RA) are increasingly used in patients with type 2 diabetes and obesity, but evidence in LT recipients remains limited.

Methods: We conducted a retrospective single-centre study including all adult recipients followed at Lausanne University Hospital after LT between January 2015 and December 2024. Patients treated with GLP-1 RA were compared with a control group of LT recipients with diabetes and/or obesity who did not receive GLP-1 RA. Within-group trajectories were described and adjusted between-group comparisons were performed using baseline-adjusted models and propensity score methods, with multiple imputation for missing data.

Results: Among 166 LT recipients, 29 received GLP-1 RA, most commonly semaglutide. In the GLP-1 RA group, BMI decreased from 32.2 ± 4.5 kg/m² at treatment initiation to 30.2 ± 3.8 kg/m² after one year (p = 0.004) and 29.0 ± 3.5 kg/m² after three years (p = 0.05). HbA1c improved during the first year from 6.2 ± 1.0% to 5.9 ± 1.1% (p = 0.008). Favourable trends in lipid parameters were also observed, while renal function and liver biochemistry remained stable. Adjusted comparative analyses did not show statistically significant differences between 25 GLP-1 RA-treated patients and 18 controls. However, treatment effects remained directionally favourable for BMI [geometric mean ratio (GMR) 0.938, 95% CI 0.857-1.028; p = 0.161] and HbA1c (GMR 0.873, 95% CI 0.720-1.059; p = 0.154).

Conclusion: In this real-world LT cohort, GLP-1 RA therapy was safe and associated with significant weight loss, improved glycaemic control and favourable metabolic trajectories without kidney or graft-related safety concerns. Adjusted comparative analyses were inconclusive because of limited sample size, baseline differences, and missing data, supporting the need for larger prospective studies.

H7

Chronic viral hepatitis and pregnancy outcomes: a retrospective study

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Background: Chronic hepatitis B (HBV) and C (HCV) during pregnancy carry risks of gestational complications and mother-to-child transmission (MTCT). Few data are available regarding HBV and HCV outcomes or assessed real-world adherence to MTCT prevention guidelines. We aimed to compare HBV and HCV pregnancy outcomes, and to evaluate MTCT prevention practices and guideline adherence.

Methods: We retrospectively included all pregnancies with documented HBsAg and/or HCV RNA positivity who delivered between 2012-2024. A composite endpoint (gestational diabetes, preeclampsia/eclampsia, intrahepatic cholestasis, gestational hypertension, late miscarriage/stillbirth, preterm delivery) and the rate of caesarean section were compared between HBV and HCV groups. Multivariable logistic regression adjusted for age and smoking was performed. Adherence to EASL guidelines for antiviral prophylaxis was assessed.

Results: A total of 117 pregnancies in 80 women were included: 104 HBV and 13 HCV. HCV pregnancies showed significantly higher rates of gestational complications (53.8% vs 24.0%, p = 0.042), preterm delivery (46.2% vs 11.8%, p = 0.006), and caesarean section (76.9% vs 32.4%, p = 0.004). After adjustment, HCV remained independently associated with complications (aOR 4.59, p = 0.034) and preterm delivery (aOR 8.39, p = 0.009). Among HBV pregnancies, neonatal immunoprophylaxis improved significantly over time (58.3% in 2012–2017 vs 82.5% in 2018–2024, p = 0.016). Of 4 pregnancies meeting EASL criteria for antiviral prophylaxis, 2 were treated (2018–2024). Immunization timing was documented in fewer than 10% of cases.

Conclusions: HCV infection was independently associated with worse pregnancy outcomes compared to HBV. MTCT prevention practices improved significantly over the study period, but gaps persist in antiviral prophylaxis implementation and documentation of immunization timing, highlighting areas for improvement.

Figure 1. Comparison of gestational complications and delivery outcomes between HBV and HCV pregnancies. Abbreviations: HBV: hepatitis B virus; HCV: hepatitis C virus; GDM: gestational diabetes mellitus; ICP: Intrahepatic cholestasis of pregnancy

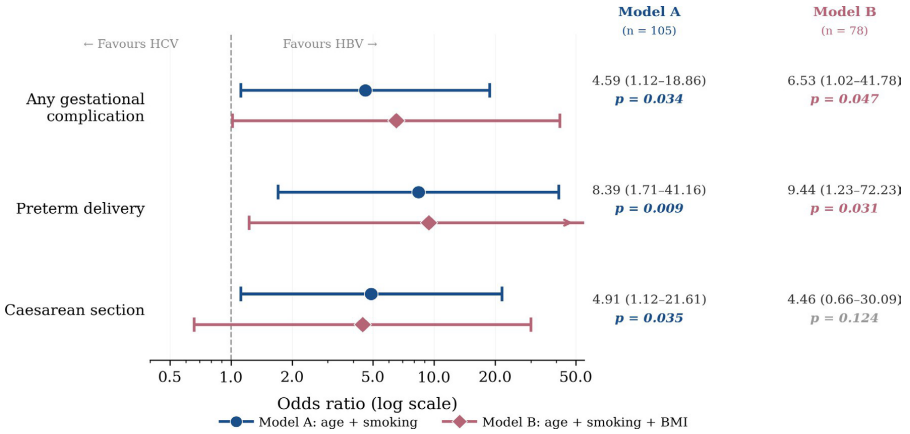
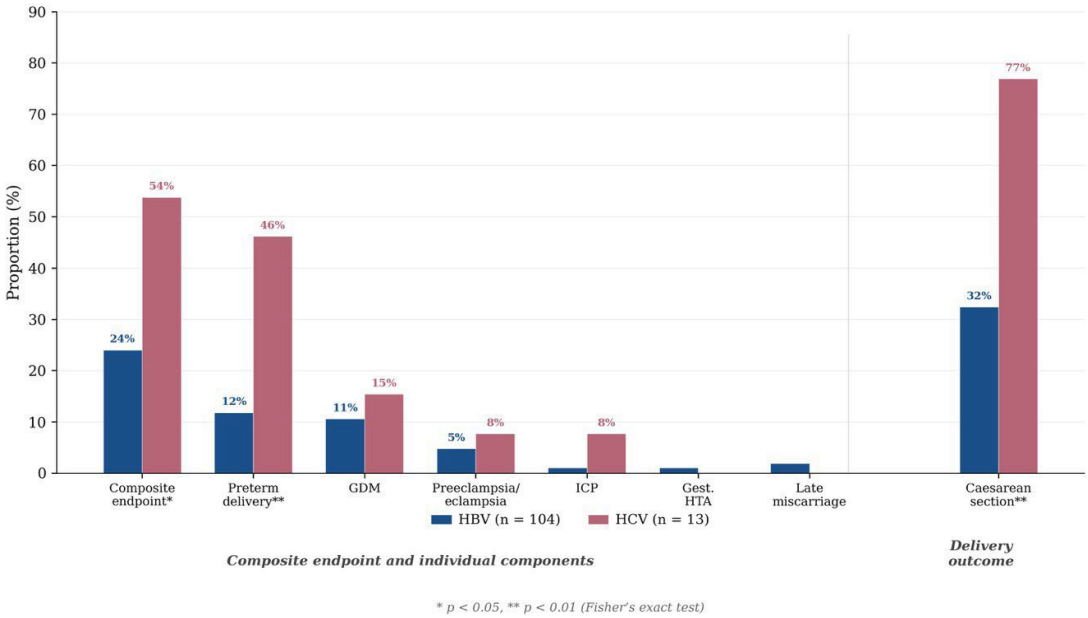


Figure 2. Forest plot of adjusted odds ratios for HCV versus HBV infection and adverse pregnancy outcomes. Circles (Model A) represent odds ratios adjusted for age and smoking (n = 105); diamonds (Model B) additionally adjusted for body mass index (n = 78). Horizontal lines represent 95% confidence intervals.



H8

Effect of ANIT-induced cholestasis on liver inflammation and fibrosis

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Background: Primary sclerosing cholangitis (PSC) is a chronic cholestatic liver disease characterized by biliary injury, inflammation and fibrosis. However, suitable mouse models to study PSC progression remain limited. Here, we established a novel ANIT-milk feeding mouse model to induce progressive cholestatic liver injury and fibrosis.

Methods: Cholestatic liver injury was induced by daily oral administration of ANIT in condensed milk at 20 mg/kg for 1, 2 or 6 consecutive weeks. Liver injury and fibrosis were evaluated by H&E and Masson's Trichrome staining. RT-qPCR analysis was performed for collagen-related genes, Tgfb1 and Tnfα. Serum liver enzyme markers and Imaging Mass Cytometry (IMC) were additionally used to evaluate immune cell accumulation, collagen deposition and structural changes within portal regions.

Results: ANIT-milk feeding induced progressive cholestatic liver injury with increasing severity over time. Histological analysis revealed increased inflammatory infiltrates and fibrosis in ANIT-treated mice compared to controls. RT-qPCR analysis showed progressive upregulation of collagen-related genes, Tgfb1 and Tnfα, while serum liver enzyme markers also increased with prolonged ANIT exposure. IMC analysis further demonstrated increased immune cell accumulation and collagen deposition within portal regions, together with increased CD44-, Ki67- and MARCO-positive cells.

Conclusion: The ANIT-milk feeding model represents a reproducible approach to induce progressive cholestatic liver injury and fibrosis in mice and provides an important platform to study PSC-associated liver damage.

H9

Lymphocyte Transformation Testing as an Adjunctive Tool for Causality Assessment in Drug-Induced Liver Injury: The Largest Histologically Characterized Cohort to Date

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Background: Establishing causality in drug-induced liver injury (DILI) remains challenging, particularly in patients exposed to multiple potentially hepatotoxic medications. The lymphocyte transformation test (LTT) has been proposed as an adjunctive tool to identify culprit drugs, but evidence supporting its use in DILI is limited and conflicting. We aimed to evaluate the clinical utility of LTT in a large, histologically characterized DILI cohort.

Methods: We performed a retrospective analysis of consecutive patients undergoing LTT for suspected DILI at a tertiary hepatology centre between 2018 and 2025. Demographic, clinical, laboratory, histological, and LTT data were collected. Patients with positive and negative LTT results were compared regarding disease severity, biochemical phenotype, liver histology, and suspected causative agents. Histological findings were reviewed when liver biopsy was available.

Results: Forty-eight patients with DILI were included (54% female; mean age 56 years). The most frequently suspected agents were non-steroidal anti-inflammatory drugs, penicillins, cephalosporins, paracetamol, and metamizole. Liver injury was predominantly hepatocellular (54%), followed by cholestatic (27%) and mixed (19%) patterns. According to DILIN severity criteria, 52% had mild, 37% moderate, and 11% severe disease. Liver biopsy was performed in 32 patients (67%). Histology most commonly demonstrated acute hepatitis (59%), followed by predominant cholestasis (18%) and extensive necrosis (9%). Only one patient showed a drug-induced autoimmune hepatitis-like pattern. Overall, 34 positive LTT results were identified in 26 patients (54%), including eight patients with reactivity to more than one drug. Positive tests were most frequently observed for non-steroidal anti-inflammatory drugs (24%), amoxicillin (18%), and cephalosporins (12%). Patients with positive LTT results numerically more often experienced severe DILI (15% vs. 5%) and less frequently exhibited a cholestatic phenotype (19% vs. 36%), although these differences did not reach statistical significance. No specific histological feature, including eosinophilic infiltrates or necrosis, was significantly associated with LTT positivity.

Conclusions: In this largest reported DILI cohort undergoing systematic LTT evaluation, more than half of patients demonstrated drug-specific lymphocyte reactivity. Although no distinct histological signature of LTT positivity was identified, positive results were more frequently observed in severe and hepatocellular forms of DILI. LTT may represent a valuable adjunct to clinical assessment, particularly in patients exposed to multiple suspected drugs, and could help strengthen causality attribution in selected cases. Prospective studies are warranted to further define its diagnostic performance and role within contemporary DILI algorithms.

H10

Biochemical–Structural Discordance in Hepatic Sarcoidosis: A Single-Center Cohort Study

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Background: Monitoring of hepatic sarcoidosis relies on biochemical parameters, although disease progression may occur despite biochemical improvement. We assessed the relationship between biochemical response, liver stiffness, and disease evolution.

Methods: In this retrospective cohort study, structural disease evolution was assessed by serial liver elastography and related to biochemical response and clinical outcome.

Results: Twenty-two patients were followed for a median of 9 years. Biochemical improvement was generally associated with decreasing liver stiffness, whereas non-response was associated with increasing stiffness. All patients with worsening liver stiffness showed clinical progression, while all patients with improving stiffness remained clinically stable. Two patients (9%) showed biochemical improvement despite progressive structural liver disease.

Conclusion: Biochemical response reflects structural improvement in most patients but may not fully capture disease evolution. Longitudinal liver elastography may improve disease monitoring.

H11

B-Cell Activation Signatures Are Independently Associated With Adverse Clinical Outcomes in Primary Biliary Cholangitis

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Background: Primary biliary cholangitis (PBC) has a heterogeneous clinical course. While cholestatic markers predict outcome, the role of systemic immune activation remains unclear. We assessed associations between immune signatures and clinical outcomes in PBC.

Methods: In this retrospective cohort, inflammatory markers were grouped into B-cell activation (CXCL13, BAFF, APRIL), IFN-related (CXCL9, CXCL10, CXCL11), and innate inflammatory (IL-6, TNF-α, S100A9) signatures. The primary endpoint was liver transplantation or liver-related death. Cox models were adjusted for age, sex, and alkaline phosphatase.

Results: Among 63 patients, 11 events occurred over a median follow-up of 4.6 years. The B-cell activation signature was associated with outcome in univariable analysis and remained independently associated after adjustment (~25% higher risk per 100-point increase). IFN-related and innate inflammatory signatures were not associated with outcome.

Conclusion: A B-cell activation signature, but not IFN-related or innate inflammatory signatures, is independently associated with adverse outcomes in PBC, supporting a role for B-cell–driven mechanisms in disease progression.

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