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Abstracts of the annual meeting 2025

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Outlook: Our approach may complement and enhance the analysis of peripheral blood samples, which is known as “liquid biopsy” that has recently emerged as a promising tool for diagnosis, risk stratification, disease monitoring, and ultimately, personalized treatment recommendations.

- Trikudanathan G et al. Gastrointestinal endoscopy 2017
- Christopher G. Chapman, Irving Waxman et al. Pancreatology 2020

Endo4

Practices and Perspectives on Prophylactic Pancreatic Stent Placement: The PIRATE Survey

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Background: Prophylactic pancreatic stent placement (PPSP) is recommended in high-risk patients during endoscopic retrograde cholangiopancreatography (ERCP) to prevent post-ERCP pancreatitis (PEP). However, only two guidelines, including the European Society of Gastrointestinal Endoscopy (ESGE), provide advice on how, when, and if PPS should be removed. The ESGE recommends evaluating stent passage within 5–10 days and endoscopic removal, with stents remaining in place for a minimum of 12–24 hours. Literature indicates that 80–90% of PPS pass spontaneously, with few complications of non-removal reported. Documented complications of PPS removal, although rare, include perforation, bleeding, stent fracture, migration, and occlusion. This survey aimed at interrogating practice of PPSP and removal.

Methods: A 13 item online survey distributed via social media was conducted between November 2024 and February 2025.

Results: 322 valid responses were collected (Europe: 190; International: 15). Respondents were categorized by annual ERCP volume: <300 (31.2%), 300–500 (30.7%), and >500 (38%). 80% of respondents did not routinely place a PPS in high-risk patients or after unintentional PD cannulation. PPS placement was most indicated after multiple PD cannulations (80%) or papillectomy (58%). Additional indications included precut sphincterotomy, accidental PD opacification, and therapeutic PD interventions. Straight stents were used by 75%, with monopigtails utilized by 41.2%. The most commonly utilized stents were 5 French (85%) and 5 cm in length (60.2%). Survey respondents reported removal times ranging from within one week (45.6%) to up to four weeks (44.8%), with 60% using gastroscopy after radiographic confirmation of lack of spontaneous passage. Only 13.6% employed ultrasound. Over half (56%) did not schedule fixed appointments for stent retrieval. 22% of respondents reported complications of non-removal, including pancreatitis (67%), perforation (11.9%), PD aberrations (39%), and stent migration (4%). Despite these findings, 97.8% considered complications of PPS to be rare. While 75% followed ESGE or internal guidelines and believed that PPS should be removed despite spontaneous passage occurring in 80–90% of cases. 25% of respondents did not refer to any guidelines.

Conclusions: This survey underscores the variability in PPSP practices and the limited guidance on removal timing and strategies. While with minimal complications, adherence to standardized practices could further improve patient outcomes and reduce complications.

Endo5

Endoscopic remission prevents development of complicated disease course in eosinophilic esophagitis patients

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Background: Eosinophilic esophagitis (EoE) is a chronic T2 esophageal inflammation that progresses to fibrostenosis when left untreated. Treatment options aim at controlling clinical and histological activity. It remains elusive whether (long-term) endoscopic disease control, can prevent development of disease complications, and if endoscopy could substitute histological assessment.

Methods: We evaluated prospectively included patients in the Swiss EoE cohort. Data on all patients with ongoing maintenance treatment, no concomitant gastroesophageal reflux, no strictures at baseline, and >2 follow-up visits were analyzed. We compared patients with ongoing endoscopic activity vs patients with endoscopic disease control, with regards to development of disease complications over time (strictures, bolus impactions and need for treatment escalation). Ongoing endoscopic activity was defined by an EREFS score of >2 during all follow-up visits.

Results: We included a total of 155 patients with a median follow-up of 55.0 months (69.0% males, median age 39.0 years). 112 patients were classified as having disease control during follow-up (72.3%), while 43 patients (27.7%) showed ongoing endoscopic activity. Development of complications occurred in a total of 113 patients (72.9%), significantly more often in patients with ongoing endoscopic activity compared to patients with disease control (93.0% vs 65.2%, $p < 0.001$). This difference was mainly due to higher rates of stricture formation and need for treatment escalation. Multivariate Cox regression models revealed ongoing endoscopic activity as a significant predictor for the development of complications (HR 2.42, $p < 0.001$), particularly development of strictures (HR 5.12, $p = 0.002$). Trajectories according to disease activity were more distinct when assessed by endoscopy compared to histology.

Conclusion: Ongoing endoscopic activity predicts development of complicating disease course in EoE patients. Treatment strategies should aim at controlling endoscopic activity to prevent disease complications. Endoscopy could potentially substitute histological assessment.