DIGESTIVE DISEASE DAYS

2026

PROGRAMMA

9 en 10 september 2026

Congrescentrum NH Koningshof

Veldhoven

NVGE
NEDERLANDSE VERENIGING
VOOR GASTRO-ENTEROLOGIE

Het programma werd samengesteld met inbreng van:

Nederlandse Vereniging voor Gastro-enterologie
Nederlandse Vereniging voor Gastrointestinale Chirurgie
Nederlandse Vereniging voor Hepatologie
Nederlandse Vereniging van Maag-Darm-Leverartsen

Secties:
Sectie Gastrointestinale Endoscopie
Sectie Experimentele Gastroenterologie
Sectie Neurogastroenterologie en Motiliteit
Sectie Gastrointestinale Oncologie
Sectie Inflammatoire Darmziekten IBD
Sectie Kinder-MDL
Verpleegkundigen & Verzorgenden Nederland – MDL
PhD Netwerk

Inhoudsopgave

Woensdag 9 september

Symposium Sectie Gastrointestinale Oncologie 7
Plenaire opening DDD - President Select 8
Abstractsessie Sectie Gastrointestinale Endoscopie 10
Symposium Sectie Gastrointestinale Endoscopie (How do I do it) 11
Symposium Werkgroep Ischemie: Onbegrepen buikpijn 12
Symposium Sectie Inflammatoire Darmziekten 13
Abstractsessie Sectie Inflammatoire Darmziekten 14
Symposium NVMDL: cie. Digitalisering 16
NVMDL Symposium: Less is more 17
Abstractsessie Nederlandse Vereniging voor Hepatologie 18
NVH Symposium: Non-cirrotische portale hypertensie 21
MDL Fonds, informatie bijeenkomst NWO call 22
Symposium NVMDL: Preventie 23
Symposium Crohn en Colitis NL 24
Seniorenprogramma 25
Gemodereerde postersessie 26

Tijdstip ledenvergadering Woensdag 9 september:
ALV Nederlandse Vereniging voor Gastroenterologie 9 september, 12:15 uur Brabantzaal
ALV Nederlandse Vereniging voor Hepatologie 9 september, 14:35 uur Baroniezaal

Inhoudsopgave

Donderdag 10 september

Ochtendprogramma V&VN MDL algemeen 27

Symposium Werkgroep Voeding 28

Symposium MDL Fonds: Gepersonaliseerde aanpak bij IBD 29

Symposium Sectie Inflammatoire Darmziekten 30

Symposium Sectie Inflammatoire Darmziekten: Pro en Con 31

Abstractsessie HPB 32

Videosymposium Sectie Gastrointestinale Endoscopie 34

Collegetour NVMDL i.o. 35

Gecombineerde abstractsessie 36

Symposium NVMDL: cie. Kwaliteit 38

Symposium Sectie Neurogastroenterologie en Motiliteit en Werkgroep Voeding 39

Middagprogramma V&VN MDL 40

Symposium PhD netwerk 41

Gemodereerde postersessie 42

Tijdstip ledenvergadering Donderdag 10 september:
ALV Nederlandse Vereniging van Maag-Darm-Leverartsen 10 september, 08:00 uur Zaal 80

Oncologie

Dinsdag 8 september 2026, Brabantzaal NH Conference Center Koningshof te Veldhoven

10.30-11.00	Registratie, koffie
11.00-11.15	Opening door voorzitters *Pre-test vragen met behulp van Mentimeter*
Voorzitters:	Dr. R.J. de Knegt en aios

Diverse aspecten van oncologie binnen de MDL

11.15-11.45	Voeding en kanker De relatie tussen leefstijl, voeding en het ontstaan of de behandeling van tumoren *Prof. dr. J. Seidell, Emeritus hoogleraar Voeding en Gezondheid, Vrije Universiteit Amsterdam*
11.45-12.15	Colonpoliepen: het herkennen van goed en kwaad *Dr. L. Moons, MDL-arts, UMC Utrecht*
12.15-12.45	Colorectaal carcinoom: overeenkomsten en verschillen in benadering van oude en jonge patiënten *Prof. dr. G.L. Beets, Afdelingshoofd & Oncologisch colorectaal chirurg, MUMC+*
12.45-13.45	**Lunch in de Limburgfoyer**
13.45-14.15	Erfelijke gastrointestinale tumoren *J.E.G. Ijspeert, MDL-arts, NKI, Antoni van Leeuwenhoek, Amsterdam*
14.15-14.45	Vroegdiagnostiek hepatocellulair carcinoom bij levercirrose en leverziekte Wie wel en wie niet, en met welke modaliteit (echo, CT, MRI). Rol tumoreiwitten (AFP) en scores (GAAD) *Dr. D. Sprengers, MDL-arts, Erasmus MC, Rotterdam*
14.45-15.15	Neoadjuvante immunotherapie colorectaal carcinoom, anno 2026 *M. Foppen, internist-oncoloog, Antoni van Leeuwenhoek, Amsterdam*
15.15-15.45	**Pauze**

15.45-16.15	Chirurgische behandeling van pancreascarcinoom *Prof. Dr. F. Berrevoet, chirurg, UZ Gent*
16.15-16.45	Prehabilitatie Het effect van meer bewegen en gezonder eten voorafgaand aan een oncologische behandeling *Dr. G. Slooter, Oncologisch chirurg, Maxima MC*
16.45-17.10	Bevolkingsonderzoek dikke darm kanker in Nederland, update 2026 *Prof. dr. M. Spaander, MDL-arts, Erasmus MC, Rotterdam*
17.35-17.50	Eind-test vragen met behulp van Mentimeter
17.50-18.00	Afsluiting door de voorzitters en prijsuitreiking hoogste score

Het aansluitende (vegetarische) buffet vindt plaats in restaurant Binnenhof, nabij de hoofdingang.

Deelname is verplicht voor aios MDL.
Voor aios heelkunde differentiatie GE geldt: eenmaal verplicht in het differentiatiejaar.

Symposium Sectie Gastrointestinale Oncologie

Woensdag 9 september | Brabantzaal
Voorzitters: Dr. A.U.G. van Lent, C.V. Hoge

09:30 uur **Behandelkeuzes bij Rectumcarcinoom**

Dr. L. Valkenburg, Medisch Oncoloog, Maastricht Universitair Medisch Centrum, Maastricht
Dr. M. Verseveld, Chirurg, Franciscus Gasthuis & Vlietland, Rotterdam
Dr. T.R. van Oudheusden, Radioloog, Catharina Hospital Eindhoven, Eindhoven
Prof. dr. M. Intven, Radiotherapeut-oncoloog, Universitair Medisch Centrum Utrecht, Utrecht
M. Schilders, Verpleegkundig specialist, Catharina Hospital Eindhoven, Eindhoven

Welke behandeling biedt voor welke patiënt de beste uitkomst?

In dit interactieve MDO-symposium bespreken experts vanuit de radiotherapie, MDL, chirurgie, radiologie en medische oncologie actuele behandelvraagstukken bij het rectumcarcinoom.
Aan de hand van praktijkcasussen komen onderwerpen aan bod zoals Total Neoadjuvant Therapy (TNT), orgaansparende behandelstrategieën, STARTREC en de aanpak van gemetastaseerde ziekte.
Ook wordt de nieuwe Rectumcarcinoom Keuzehulp belicht en de rol hiervan in gezamenlijke besluitvorming besproken.

Wat zal er aan bod komen?
Wel/ geen TNT bij locally advanced rectumca?
Wel/ geen STARTREC bij orgaansparende wens?
Wel/ geen TNT bij orgaansparende wens (ipv CRT)?
Wat bij M1 ziekte bij locally advanced rectumca?

10:45 uur **Koffiepauze in de expositiehal**

Plenaire opening DDD - President Select

Woensdag 9 september | Brabantzaal

11:15 uur

One day of antibiotic treatment is non-inferior to 4-7 days in patients with acute cholangitis after adequate biliary drainage: a multi-centre randomised controlled trial (COBRA)

A.G. Overdevest[1] , E. Sieswerda , S. Haal[2] , M.G.W. Dijkgraaf[2] , K.S. Boparai , F. Ter Borg[3] , M.A. Brink[4] , F. van Delft[5] , V.K. Dik[6] , L.P.L. Gilissen[7] , M. Hadithi[8] , W.L. Hazen[9] , F. van der Heide[10] , W.J. den Hollander[11] , A. Inderson[12] , P.J. de Jonge[13] , S.D. Kuiken[14] , J.M. Munneke[15] , B. Opsteeg[16] , L. Perk[17] , E.J.G. Peters[1] , A.C. Poen[18] , J.W. Poley[19] , R. Quispel[20] , W.O.A. Rohof[14] , R.C.H. Scheffer[21] , D.W. Schölvinck[22] , E.J. van Soest[23] , A. Tan[24] , W.J. Thijs[25] , N.G. Venneman[26] , R.C. Verdonk[27] , F.P. Vleggaar[28] , W. van de Vrie[29] , J.M. Vrolijk[30] , R.L.J. van Wanrooij[1] , P.W. Weijenborg[31] , M.C.B. Wielenga[2] , R. Zoutendijk[27] , J.A. Bogaards[1] , J.M. Prins[2] , R.P. Voermans[2] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Amsterdam UMC, loc. AMC, Dept. of Gastroenterology and Hepatology , [3] Deventer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [4] Meander MC, Dept. of Gastroenterology and Hepatology , [5] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [6] Frisius MC, Dept. of Gastroenterology and Hepatology , [7] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [8] Maasstad Ziekenhuis, Dept. of Gastroenterology and Hepatology , [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology , [11] Alrijne Ziekenhuis, Dept. of Gastroenterology and Hepatology , [12] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [13] Erasmus MC, Dept. of Gastroenterology and Hepatology , [14] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [15] Flevoziekenhuis, Dept. of Gastroenterology and Hepatology , [16] Groene Hart Ziekenhuis, Dept. of Gastroenterology and Hepatology , [17] Haaglanden Medisch Centrum, Dept. of Gastroenterology and Hepatology , [18] Isala, Dept. of Gastroenterology and Hepatology , [19] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [20] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [21] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [22] Zaans Medisch Centrum, Dept. of Gastroenterology and Hepatology , [23] Spaarne Gasthuis, Dept. of Gastroenterology and Hepatology , [24] Canisius Wilhelmina Ziekenhuis, Dept. of Gastroenterology and Hepatology , [25] Martini Ziekenhuis, Dept. of Gastroenterology and Hepatology , [26] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology , [27] Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [28] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology , [29] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [30] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology , [31] Dijklander Ziekenhuis, Dept. of Gastroenterology and Hepatology

11:23 uur

Factors influencing patient acceptance of less intensive surveillance strategies for low-risk pancreatic cysts: a cross-sectional questionnaire study

B. van Hooijdonk[1] , M.L.J.A. Sprij[1] , B. Nix[1] , J. Meziani[1] , F. van Delft[2] , P. Appelhof[2] , M.C.B. Wielenga[3] , R.P. Voermans[3] , C. Hoge[4] , P. Honkoop , K.V. Grooteman , W.L. Curvers , I.C.A.W. Konings , L.A. van der Waaij , M.P. Schwartz , J.F. Bergmann , N.G. Venneman , R. Quispel , A.M. van Berkel , F.G.I. van Vilsteren , R.C. Verdonk , A.C. Tan , E. Kouw , I.M.C.M. de Kok , M.J. Bruno , I.J. Korfage , D.L. Cahen , [1] Erasmus MC, Not applicable , [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [4] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

11:31 uur **Comparison of four meld-based scores and assessment of sex equity in waiting listoutcomes in patients awaiting liver transplantation in the netherlands**

D. van der Helm[1] , R.F. van Golen[2] , W. Polak[2] , I.P.J. Alwayn[1] , H. Lam[1] , B. Goudsmit[1] , H.A.N.S. Blokzijl[3] , V.E. de Meijer[3] , M. Fiocco , C.M. den Hoed[2] , M.J. Coenraad[1] , [1] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [2] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [3] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

11:35 uur **Uitreiking gastrostart (vervolg)subsidies**

11:45 uur **Keynote: MASLD, een omvangrijk probleem**

Dr. M.E. Tushuizen, MDL-arts, Leids Universitair Medisch Centrum, Leiden

12:15 uur **ALV Nederlandse Vereniging voor Gastroenterologie**

Abstractsessie Sectie Gastrointestinale Endoscopie

Woensdag 9 september | Brabantzaal

Voorzitters: Dr. R.P. Voermans, Dr. R. Krol

13:30 uur **Vacuum-stent therapy for colorectal transmural defects: initial experience and lessons learned**

Z. Weerts[1] , D. Ramsoekh[1] , R. Hompes[1] , W. Laméris[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Surgery

13:38 uur **High closure rates after Endoscopic Vacuum Therapy for upper GI transmural defects.**

V. Bos[1] , L.M.D. Pattynama[1] , A.B. Van Nunen[2] , W.L. Curvers[3] , Y.J. Van Herwaarden[4] , P.J.F. De Jonge[5] , J. van Dieren[6] , A. Inderson[7] , D.B. De Koning[8] , R.J.F. Laheij[9] , P.R. Oosterwijk[10] , K. Soufidi[2] , G.A.P. Nieuwenhuijzen[3] , M. Hutteman[4] , J.W. Van Sandick[6] , K. Basiliya[7] , N. Beekmans[8] , E.H.J. Belgers[2] , W.J. Eshuis[1] , R.E. Pouw[11] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [3] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [4] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [5] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [6] NKI Antoni van Leeuwenhoek, Dept. of Gastroenterology and Hepatology , [7] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [8] Gelre Ziekenhuizen, Dept. of Gastroenterology and Hepatology , [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] Ziekenhuisgroep Twente, Dept. of Gastroenterology and Hepatology , [11] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

13:46 uur **Percutaneous Endoscopic Colostomy; a retrospective analysis on success, complications and patient experiences.**

G.J.L. van Neerven[1] , Y. van Dillen[1] , A. Baars[1] , T. van Bommel[1] , J. van Liempd[1] , H. Flink[1] , L.P.L. Gilissen[1] , [1] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology

13:54 uur **High sensitivity of Next-Generation Sequencing on bile-derived cell-free DNA for mutation-based diagnosis of perihilar cholangiocarcinoma: first results from the prospective BAMBI study**

E. Smit[1] , J.A. Fritzsche[1] , J.B.G. Halfwerk , R.L.J. van Wanrooij[1] , M.C.B. Wielenga[1] , Y.S. de Boer[1] , G. Kazemier[1] , T. le Large[1] , R. Lameris[1] , S.A.G.M. Cillessen[1] , M.P.M. Noë[1] , J. Verheij[1] , C.Y. Ponsioen[1] , F. Dijk[1] , R.P. Voermans[1] , [1] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology

14:02 uur **Endoscopic drainage of potentially resectable perihilar cholangiocarcinoma using a suprapapillary plastic stent with retrieval string (CHORDA-plastic); a prospective pilot study**

E. Smit[1] , J.A. Fritzsche[1] , M.C.B. Wielenga[1] , Y.S. de Boer[1] , P. Fockens[1] , G. Kazemier[1] , J.I. Erdmann[1] , O.M. van Delden[1] , I.J.A.J. Zijlstra[1] , R. Lameris[1] , C.Y. Ponsioen[1] , R.L.J. van Wanrooij[1] , R.P. Voermans[1] , [1] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology

14:10 uur **Einde van deze sessie**

Symposium Sectie Gastrointestinale Endoscopie (How do I do it)

Woensdag 9 september | Brabantzaal

Voorzitters: Dr. A.C.G. van Baar, Dr. A. Inderson

14:30 uur **Promotie en mogelijkheden DLO**
Dr. A.C.G. van Baar, Aios MDL, Universitair Medisch Centrum Utrecht, Utrecht

14:45 uur **Standaardisering van opslaan videobeelden**
Dr. G. Kramer, Aios MDL, Amsterdam UMC, loc. AMC, Amsterdam

15:00 uur **Hoe maak je een goede video (editen)**
Dr. A. Inderson, MDL-arts, Leids Universitair Medisch Centrum, Leiden

15:15 uur **How I do it: EMR en cold snare poliepctomie**
Dr. L.M.G. Moons, MDL-arts, University Medical Center Utrecht, Utrecht

15:27 uur **How I do it: Fistulotomie**
Dr. L.A. van der Waaij, MDL-arts, Martini Ziekenhuis, Groningen

15:39 uur **How I do it: Upper GI bloedingen**
Dr. V. Rijckborst, MDL-arts, Erasmus MC, Rotterdam

Symposium Werkgroep Ischemie: Onbegrepen buikpijn

Woensdag 9 september | Brabantzaal
Voorzitters: Dr. D. Leemreis-van Noord, Dr. L.G. Terlouw

Onbegrepen buikklachten in Nieuwsuur, de experts aan het woord

16:30 uur **Median Arcuate Ligament Syndrome (en de RCT CAROSO: TC release versus sham)**
F. Metz, Aios Heelkunde, Medisch Spectrum Twente, Enschede

17:00 uur **Syndroom van Wilkie en Nutcracker Syndrome**
Prof. dr. R.H. Geelkerken, Chirurg, Medisch Spectrum Twente, Enschede

17:30 uur **Gastroparese**
Prof. dr. J. Tack, MDL-arts, UZ Leuven, Leuven

18:30 uur **Informele afsluiting in expositiehal**

Symposium Sectie Inflammatoire Darmziekten

Woensdag 9 september | Auditorium
Voorzitters: Dr. M.M.C. Hirdes, Dr. R. Goetgebuer

09:30 uur **Jongvolwassenen**
Dr. L.A.A.P. Derikx, MDL-arts, Erasmus MC, Rotterdam

09:55 uur **Ouderen (en co-morbiditeit)**
Dr. V.E.R. Asscher, Aios MDL, Leids Universitair Medisch Centrum, Leiden

10:20 uur **Invloed van sociale determinanten in IBD zorg**
Dr. P.W.J. Maljaars, MDL-arts, Leids Universitair Medisch Centrum, Leiden

10:45 uur **Koffiepauze in de expositiehal**

Abstractsessie Sectie Inflammatoire Darmziekten

Woensdag 9 september | Auditorium

Voorzitters: Dr. N.G.M. Rossen, Dr. A. Rezazadeh Ardabili

13:30 uur **Ozanimod in patients with ulcerative colitis - Real-world evidence from the Dutch ICC Registry**

L.M.M. Verleye[1,2] , D. Erven[1] , Z. Mujagić[1] , M.R. Naber[3,4] , D.G. Bouwknegt[5] , T.E.H. Römkens[6] , L.F. Wymenga[5] , R.L. Goetgebuer[4] , P.B.F. Mensink[7] , F.D.M. van Schaik[8] , B. Oldenburg[3] , M.C. Visschedijk[5] , A.A. van Bodegraven[9] , A.G.L. Bodelier[10] , M. Löwenberg[4] , M. Duijvestein[2] , M.J. Pierik , [1] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [3] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology , [4] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [5] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology , [6] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [7] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology , [8] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology , [9] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [10] Amphia Ziekenhuis, Dept. of Gastroenterology and Hepatology

13:38 uur **Who benefits from telemonitoring in Inflammatory Bowel Disease? A qualitative study of patients' ability and willingness to telemonitoring**

S.W. Lathouwers[1,2] , M. van Schijndel[2] , J.P.H. Drenth[3] , C.J. van der Woude[4] , L.M.W. Nahar-van Venrooij[2] , R.L. West[1] , T.E.H. Römkens[2] , A. Sponselee , E.J.M. Wouters , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [2] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [3] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [4] Radboud University Medical Center, Not applicable

13:46 uur **Long-term outcomes after appendectomy for maintenance of remission in ulcerative colitis: Five-year results from the ACCURE randomized controlled trial.**

I.D. van Dijk[1] , E. Visser[2] , G.R.A.M. D'Haens[2] , T.D. Pinkney , C.J. Buskens[2] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Surgery

13:54 uur **Effectiveness and safety of Ustekinumab and Filgotinib in ulcerative colitis: Comparative analysis from the Dutch ICC Registry**

M.R. Naber , Z. Mujagic[1] , M. Pierik[1] , L.M.M. Verleye[1] , D.G. Bouwknegt[2] , M.C. Visschedijk[2] , A.E. van der Meulen[3] , R.L. West[4] , M. Duijvestein[5] , A.A. van Bodegraven[6] , A. Bodelier[7] , S. van der Marel[8] , A.C. de Vries[9] , B. Oldenburg[10] , M. Löwenberg[11] , F.D.M. van Schaik[10] , [1] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [2] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [4] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [5] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [6] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [7] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [8] Haaglanden Medisch Centrum, Dept. of Gastroenterology and Hepatology , [9] Erasmus MC, Dept. of Gastroenterology and Hepatology , [10] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology , [11] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology

14:02 uur **Risk of relapse after cessation of anti-TNF therapy in ulcerative colitis in corticosteroid-free clinical remission: an individual participant data meta-analysis (IPD-MA) on 654 patients from 8 studies**

M.J.C. Devillers[1] , J.S. Staal[2] , T. Hackmann[3] , S. Ten Bokkel-Huinink[4] , K. Farkas , P. Molander , G. Fiorino , M.J. Casanova , S.N. Hong , B. Oldenburg[5] , R. Mahmoud[5] , N. Dussias , J.P. Gisbert , M. Chaparro , E.W. Steyerberg[3] , A.C. de Vries[4] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Sophia Kinderziekenhuis, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum , [4] Erasmus MC , [5] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology

14:10 uur **Location and activity of inflammatory bowel disease are associated with colectomy, but not with liver transplant-free survival in patients with primary sclerosing cholangitis**

D. Sneek[1] , B. Mol[2] , M. de Jong[1] , A.J. van der Meer[1] , P. Miranda-Afonso[1] , A. Inderson[3] , R.K. Weersma [4] , C.Y. Ponsioen[2] , B.E. Hansen[1] , A.C. de Vries[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [4] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology

14:18 uur **Einde van deze sessie**

Symposium NVMDL: cie. Digitalisering

Woensdag 9 september | Auditorium
Voorzitters: Dr. G. Veldhuijzen

14:30 uur **Opening en update roadmap**
Dr. G. Veldhuijzen, MDL-arts, Gelre Ziekenhuizen, Apeldoorn

14:40 uur **Real time revisie richtlijnen door AI**
T. Stehmann, Kinderarts, Noordwest Ziekenhuisgroep, Alkmaar

15:05 uur **Best practices uit het veld**

15:30 uur **Hoe trainen we de co, aios en MDL-arts in gebruik AI**
Prof. dr. A. Langers, MDL-arts, Leids Universitair Medisch Centrum, Leiden

16:00 uur **Theepauze in de expositiehal**

NVMDL Symposium: Less is more

Woensdag 9 september | Auditorium
Voorzitters: Dr. M.P. Schwartz, Dr. M.J.M. Groenen

“Less is More: Het IJs is Gebroken”

16:30 uur **De IJsbreker: Stand van zaken én prijswinnaars**
Dr. S.N. van Munster, MDL-arts, Universitair Medisch Centrum Utrecht, Utrecht
M.T.P.M. Houben, PhD candidate, Amsterdam UMC, loc. AMC, Amsterdam

16:35 uur **SLIM: slimmer surveilleren in IBD**
Dr. M. Severs, MDL-arts, Radboud University Medical Center, Nijmegen

16:50 uur **Meer less, minder stress: tijd om IPMN surveillance af te schalen**
Dr. D.L. Cahen, MDL-arts, Ziekenhuis Amstelland, Amstelveen
B. Nix, Arts-onderzoeker, Erasmus MC, Rotterdam

17:05 uur **Poliepbeleid 2.0: Less Surveillance & More Kwaliteit**
Prof. dr. E. Dekker, MDL-arts, Amsterdam UMC, loc. AMC, Amsterdam

17:20 uur **Het Buikpijndossier; Ook Dat Gaan We Aanpakken**
Dr. M.P. Schwartz, MDL-arts, Meander MC, Amersfoort

17:45 uur **Van Less naar MORE: de toekomst van passende MDL-zorg**
Dr. J.J.G. Bergman, MDL-arts, Amsterdam UMC, loc. AMC, Amsterdam

Abstractsessie Nederlandse Vereniging voor Hepatologie

Woensdag 9 september | Baroniezaal

Voorzitters: Dr. M.J. Sonneveld, D.J. van Doorn

13:30 uur **Azathioprine versus mycophenolate mofetil in combination with prednisolone in patients with treatment-naïve autoimmune hepatitis: 3-year follow-up of the CAMARO-trial.**

C.D. Slooter[1] , R.J.A.M. Snijders[2] , A.E.C. Stoelinga[3] , K.M.A. Gerrits[1] , T.J.G. Gevers[4] , S. Pape[2] , M. Biewenga[5] , M.E. Tushuizen[3] , R.C. Verdonk[6] , H.J.M. De Jonge[7] , J.M. Vrolijk[8] , S.F. Bakker[9] , T. Vanwolleghem , M.A.M.C. Baven-Pronk[10] , U. Beuers[1] , A.J. van der Meer[5] , N.M.F. van Gerven[11] , M.G.M. Sijtsma[12] , B.C. van Eijck[13] , M.C. van Ijzendoorn[14] , M. van Herwaarden[15] , F.F. van den Brand[1] , K. Sebib Korkmaz[16] , A.P. dan ven Berg[17] , M.M.J. Guichelaar[18] , M. Kramer[4] , F. Govaert[19] , S. Jansen[20] , S.K. van der Wiel[20] , L.H. Oterdoom[21] , I.M. Kerkhof[12] , M. Bartelink[15] , D.M. Hotho[22] , A.D. Levens[3] , B. van Hoek[3] , Y.S. de Boer[1] , J.P.H. Drenth[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [4] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [5] Erasmus MC, Dept. of Microbiology and Immunology , [6] Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [7] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [8] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology , [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] Groene Hart Ziekenhuis, Dept. of Gastroenterology and Hepatology , [11] Rode Kruis Ziekenhuis, Dept. of Gastroenterology and Hepatology , [12] St. Jans Gasthuis, Dept. of Gastroenterology and Hepatology , [13] Spaarne Gasthuis, Dept. of Gastroenterology and Hepatology , [14] Bernhoven Hospital, Dept. of Gastroenterology and Hepatology , [15] Deventer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [16] IJsselland Ziekenhuis, Dept. of Gastroenterology and Hepatology , [17] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology , [18] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology , [19] Slingeland Ziekenhuis, Dept. of Gastroenterology and Hepatology , [20] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [21] HagaZiekenhuis, Dept. of Gastroenterology and Hepatology , [22] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

13:38 uur **Peg-IFN add-on versus nucleos(t)ide analogue withdrawal in patients with chronic hepatitis B – a pooled analysis of two global cohorts (RETRACT-B and PROSPER)**

E.J. Dongelmans[1] , L.A. Patmore[1] , B.E. Hansen[1] , R.A.J. Post[1] , H.L.A. Janssen[1] , M.J. Sonneveld[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

13:46 uur **Anti-HDV reflex testing among HBsAg positive individuals in the Netherlands**

E. Fath el Bab[1] , A.A. van der Eijk[1] , L.A. Patmore[1] , J.J.C. Voermans[1] , T.J.W. van der Laar[2] , H.L. Zaaijer , A. Riezebos-Brilman , H.L.A. Janssen[1] , K.T.D. Thai , M.J. Sonneveld[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] OLVG Hospital, Dept. of Medical Microbiology

13:54 uur **The utility of biochemical non-invasive tests for fibrosis as compared to liver stiffness measurements in the population with Primary Biliary Cholangitis**

E. Werner[1] , T.D. Blom[1] , G.H.X. Weijsters[1] , M.M.F. Vos[1] , M.C.B. van Hooff[1] , R.C. de Veer[1] , U.H.W. Beuers[2] , J.P.H. Drenth[2] , F.J.C. Cuperus[3] , R. van Dijk[4] , B.J. Veldt[5] , M. Klemt-Kropp[6] , S. van Meer[7] , R.C. Verdonk[8] , H.J. Flink[9] , J.M. Vrolijk[10] , C.Y. Ponsioen[2] , M. Kramer[11] , J. van Kemenade[12] , E.M.M. Kuiper[13] , M. Beukema[14] , K. Boonstra[15] , F. Boersma[16] , E.S. de Vries[17] , H.J.M. de Jonge[18] , F.H.J. Wolfhagen[19] , L.C. Baak[20] , S.L. Onderwater[21] , H.L.A. Janssen[1] , B.E. Hansen[1] , A.J. van der Meer[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology , [4] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [5] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [6] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology , [7] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology , [8] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [9] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [10] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology , [11] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [12] Van Weel Bethesda Dirksland, Dept. of Gastroenterology and Hepatology , [13] Maasstad Ziekenhuis, Dept. of Gastroenterology and Hepatology , [14] Streekziekenhuis Koningin Beatrix, Dept. of Gastroenterology and Hepatology , [15] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [16] Gelre Ziekenhuizen, Dept. of Gastroenterology and Hepatology , [17] Isala, Dept. of Gastroenterology and Hepatology , [18] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [19] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [20] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [21] Diakonessenhuis Utrecht, Dept. of Gastroenterology and Hepatology

14:02 uur **Recapitulating cirrhosis in vitro using a primary liver microphysiological system and patient plasma profiling**

L.M. de Jong[1] , L. de Haan , V. van Duinen , I. Schildt , S. de Ruiter , L. Cuzi , L. van den Broek , M.J. Coenraad[1] , [1] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

14:10 uur **Clinical significance of early rises in aspartate- and alanine aminotransferase on hepatic encephalopathy post-transjugular intrahepatic portosystemic shunt**

S. de Reus[1] , E. Werner[1] , D.J. van Doorn[2] , M. Spaan[2] , D. Bijdevaate[1] , K. Pieterman[1] , F. Piecha[3] , P. Hübener[3] , R.B. Takkenberg[2] , A.J. van der Meer[1] , H.L.A. Janssen[1] , B.E. Hansen[1] , R. Maan[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center , [3] University Medical Center Hamburg-Eppendorf

14:18 uur **Trends in and determinants of hcc surveillance adherence: A nationwide cohort study**

M. Moussa[1] , D. Sprengers[1] , W.P. Brouwer[1] , R. Maan[1] , H.L.A. Janssen[1] , A.J. van der Meer[1] , M.J. Sonneveld[1] , [1] Erasmus MC, Dept. of Gastroenterology and Hepatology

14:26 uur **An individual participant data meta-analysis assessing the performance of clinical care pathways for detecting significant fibrosis in Metabolic dysfunction-Associated Steatotic Liver Disease (MASLD)**

K.M.A. van Eekhout[1] , L.N.D. Broekman , L.A.M. Konings , A.N. Saidi , S. Driessen , K.C. van Son , A.M. van Dijk , A.L. Mak , M.C. Cabezas , M. Michel[2,3] , E. Mentsiou-Nikolaou[4] , J.P. Kalafati[4] , R. Gallego-Durán[5] , A. Liguori[6,7] , A.M. Tudor[7,6] , M. do Mar d'Orey[8,9] , S. Carvalhana[8,9] , H. Cortez-Pinto[8,9] , M. Romero-Gómez[5] , L. Miele[6,7] , G.V. Dedoussis[4] , J.M. Schattenberg[3,2] , L. Vonghia[10,11] , S.M. Francque[10,11] , O.H. Franco[12] , Y. Vali[13] , D. Maya-Miles[5] , M.E. Tushuizen[14] , A.G. Holleboom[13] , [1] Amsterdam UMC, loc. AMC, Dept. of Vascular Medicine , [2] Saarland University , [3] Department of Internal Medicine II, Saarland University Medical Centre , [4] Department of Nutrition and Dietetics, School of Health and Education, Harokopio University of Athens , [5] SeLiver Group, Instituto de Biomedicina de Sevilla/CSIC/Virgen del Rocío University Hospital, University of Seville , [6] Department of Translational Medicine and Surgery, Faculty of Medicine, Università Cattolica del Sacro Cuore , [7] Department of Medical and Surgery Sciences, Fondazione Policlinico Universitario A. Gemelli IRCCS , [8] Clínica Universitária de Gastrenterologia, Faculdade de Medicina, Universidade de Lisboa , [9] Serviço de Gastrenterologia e Hepatologia, Unidade Local de Saúde de Santa Maria , [10] InflaMed Centre of Excellence, Laboratory for Experimental Medicine and Paediatrics, Translational Sciences in Inflammation and Immunology , [11] University Hospital Antwerp , [12] Department of Global Public Health & Bioethics, Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht , [13] Amsterdam University Medical Center , [14] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

14:35 uur **ALV Nederlandse Vereniging voor Hepatologie**

NVH Symposium: Non-cirrotische portale hypertensie

Woensdag 9 september | Baroniezaal
Voorzitters: Dr. M.A. Lantinga, Dr. R. Maan

Non-cirrhotische portale hypertensie: terminologie, diagnostiek en behandeling

16:30 uur **Introduction to the case**
Dr. L.J.M. Alferink, Aios MDL-arts, Erasmus MC, Rotterdam

16:35 uur **Pathologie**
Prof. dr. J. Verheij, Klinisch patholoog, Amsterdam UMC, loc. AMC, Amsterdam

16:55 uur **Follow-up on the case**
Dr. L.J.M. Alferink, Aios MDL-arts, Erasmus MC, Rotterdam

17:00 uur **PSVD Clinical**

17:30 uur **Case continued**
Dr. L.J.M. Alferink, Aios MDL-arts, Erasmus MC, Rotterdam

17:35 uur **metingen en interventies bij PSVD**
Dr. K.J. Pieterman, Radioloog, Erasmus MC, Rotterdam

MDL Fonds, informatie bijeenkomst NWO call

Woensdag 9 september | Baroniezaal

18:30 uur **Innovatieve vroegdiagnostiek van MDL-ziekten**

NWO en MDL Fonds slaan de handen ineen voor de Call for proposals “Innovatieve vroegdiagnostiek van MDL-ziekten”. Met deze Call binnen de KIC-lijn *‘Vraag voor partners’* willen NWO en MDL Fonds onderzoek mogelijk maken naar de vroege opsporing van MDL-ziekten met een hoge ziektelast of vroegsignalsering van progressie/exacerbaties van deze ziekten. Dit alles met als doel innovatieve of radicaal verbeterde vroegdiagnostiek te ontwikkelen.
Tijdens deze vooraankondiging lichten wij de aanleiding, het thema, en het tijdspad en kaders van de call toe. Daarnaast geven we uitleg over het impactplan volgens de *Theory of Change*, een essentieel onderdeel van een subsidieaanvraag binnen deze call. Uiteraard is er gelegenheid voor het stellen van vragen.

Symposium NVMDL: Preventie

Woensdag 9 september | Parkzaal

Voorzitters: Dr. M. Borkent, Dr. S.J. Aronson

09:30 uur	**Introductie van de Werkgroep Preventie** *Dr. H. van Soest, MDL-arts, Haaglanden Medisch Centrum, 's-Gravenhage*
09:35 uur	**Preventie buiten de spreekkamer: commerciële invloed op de volksgezondheid** *Dr. D.K. de Vries, Transplantatie Chirurg, Leids Universitair Medisch Centrum, Leiden*
09:55 uur	**Een transplantatiechirurg die transplantatie probeert te voorkomen** *Dr. D. de Vries, Transplantatiechirurg, Leids Universitair Medisch Centrum, Leiden*
10:15 uur	**Preventie door MDL-arts: Een logische stap op "schoenmaker hou je bij je leest?"** *Dr. R.B. Takkenberg, MDL-arts, Amsterdam University Medical Center, Amsterdam*
10:35 uur	**Interactie: Hoe kan de medisch specialist zich inzetten voor preventie binnen en buiten de spreekkamer?** *Dr. S.J. Aronson, MDL-arts, OLVG, Amsterdam*
10:45 uur	**Koffiepauze in de expositiehal**

Symposium Crohn en Colitis NL

Woensdag 9 september | Parkzaal
Voorzitters: D. van der Horst

Samen vooruit in IBD: keuzes van de patiënt voor de IBD-zorg van morgen

14:30 uur **De stem van de patiënt: van richtlijnen tot verlaging kosten van de zorg**
Prof. dr. K.H.N. de Boer, MDL-arts, Amsterdam University Medical Center, Amsterdam

15:15 uur **De onderzoeksagenda voor de toekomst: perspectief van patiënt, naaste en zorgverlener**
Dr. M. Duijvestein, MDL-arts, Radboud University Medical Center, Nijmegen
M. Scherpenzeel, Directeur, Crohn & Colitis NL, Woerden

16:00 uur **Theepauze in de expositiehal**

Seniorenprogramma

Woensdag 9 september | Zaal 80

Voorzitters: Prof. dr. C.J.J. Mulder, Prof. dr. J.F.W.M. Bartelsman

12:00 uur	**Ontvangst en lunch tot 13.00 in Restaurant Porticato (naast congresbalie)**
13:00 uur	**Endoscopische Barrett therapie van niks naar curatie** *Prof. dr. E.J. Schoon, MDL-arts, Catharina Hospital Eindhoven, Eindhoven*
13:30 uur	**Mestcel stimulatie syndroom; een vergeten probleem** *Dr. W.A. de Boer, MDL-arts, Ziekenhuis Bernhoven, Uden*
14:00 uur	**Abdominale echografie; een nieuwe uitdaging voor de MDL** *Dr. R.J. de Knegt, MDL-arts, Erasmus MC, Rotterdam*
14:30 uur	**Einde programma en evt. aansluiten bij programma in diverse zalen**

Gemodereerde postersessie

Woensdag 9 september | Meierij Foyer
Voorzitters: Dr. R.P. Voermans

12:45 uur **Interdisciplinary care for patients with harmful alcohol use: associations with openness**
J.M. Bisschop[1] , J.T. Dammers[1] , H.J.M. de Jonge[1] , H.D. van de Mheen , A.D. Rozema , J.J.P. Mathijssen , [1] Jeroen Bosch Ziekenhuis, Not applicable

12:50 uur **Preoperative exercise advice improves aerobic capacity in patients awaiting liver transplantation**
O.D.J. Zwerver[1] , A.D. Talen[2] , V.J.A. Brenninkmeijer[1] , F.J.C. Cuperus , J.M. Klaase[2] , [1] Universitair Medisch Centrum Groningen, Dept. of Gastrointestinal Surgery , [2] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

12:55 uur **Wilson's Disease: epidemiology and treatment in the Netherlands**
L.W.H. van Leeuwen[1,2] , F.H.H. Linn[1] , C.M. den Hoed[3] , S. van Meer[4] , [1] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Dept. of Gastroenterology and Hepatology , [3] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [4] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

13:00 uur **When is pancreatic cancer surveillance efficient? A microsimulation study of test characteristics and lifetime risk**
O. White[1] , I. Lansdorp-Vogelaar[1] , D. Cahen[1] , M.L.J.A. Sprij[1] , K. Overbeek[1] , G. Fuhler[1] , M.J. Bruno[1] , M. Peppelenbosch[1] , I.M.C.M. de Kok[1] , [1] Erasmus MC, Dept. of Public Health

13:05 uur **The frequency of diagnostic-only ERCP in patients with clinically suspected cholangitis due to choledocholithiasis – a retrospective cohort study**
J. Frenken[1,2] , E.H. Van Helden[3,1] , W.J. Lammers[4] , M.P.G.F. Anten[1] , J.G.P. Reijnders[2] , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Dept. of Gastroenterology and Hepatology , [3] Admiraal de Ruyter Ziekenhuis, Dept. of Gastroenterology and Hepatology , [4] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

13:10 uur **Virtual reality as a means of distraction during esophagogastroduodenoscopy: a feasibility study**
C.S. Spijkerboer[1] , P.A. Van Riet[2] , J. Honing[1] , M.C.W. Spaander[1] , [1] Erasmus MC, Dept. of Gastroenterology and Hepatology , [2] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

Ochtendprogramma V&VN MDL algemeen

Donderdag 10 september | Brabantzaal
Voorzitters: J. Peters

08:45 uur	**Welkom door voorzitter** *J. Peters, Verpleegkundig specialist, Bravis Ziekenhuis, Bergen op Zoom*
09:00 uur	**Normale slaap, wat is dat eigenlijk?** *Dr. S. Booij, Neuroloog, Canisius Wilhelmina Ziekenhuis, Nijmegen*
09:45 uur	**Chronische pijn** *M.L. Otterman, Anesthesioloog, Universitair Medisch Centrum Utrecht, Utrecht*
10:30 uur	**Koffiepauze in de expositiehal**
11:00 uur	**Eetwijzer in de zorg – van onderzoek naar implementatie** *A. Slotegraaf, Post-doc, Wageningen University & Research, Wageningen* *E. Valgaeren, Diëtist & Praktijkonderzoeker, Ziekenhuis Gelderse Vallei & Alliantie, Ziekenhuis Gelderse Vallei, Ede*
11:30 uur	**Kennisagenda Barrett** *N. Lardenoije - van der Hoorn, Verpleegkundig specialist, Antoni van Leeuwenhoek Hospital, Amsterdam*

Symposium Werkgroep Voeding

Donderdag 10 september | Brabantzaal
Voorzitters: Dr. I.A.M. Gisbertz

13:30 uur **Organisatie van voedingszorg in ziekenhuizen, wat kun je als voedingsteam en voedingscommissie betekenen voor je patient en ziekenhuis.**
Dr. I.A.M. Gisbertz, MDL-arts, Ziekenhuis Bernhoven, Uden

13:50 uur **Methodiek van onderzoek met voeding, wat zijn de uitdagingen, verschillen met geneesmiddelen onderzoek, inclusief voorbeelden.**
Dr. ir. N. de Roos, Docent Nutrition and Disease, Wageningen University & Research, Wageningen

14:10 uur **NUTRIM, een onderzoeksprogramma op het gebied van voeding en metabolisme**
Prof. dr. D.M.A.E. Jonkers, Professor, Maastricht Universitair Medisch Centrum, Maastricht

14:30 uur **Einde van deze sessie**

Symposium MDL Fonds: Gepersonaliseerde aanpak bij IBD

Donderdag 10 september | Brabantzaal
Voorzitters: M. Croon

Deze sessie belicht drie actuele ontwikkelingen op het gebied van gepersonaliseerde voeding en management van aanhoudende klachten bij IBD. Aan bod komen de effecten van een ontstekingsremmend voedingspatroon en gerichte vitamine-interventies bij de ziekte van Crohn (VitaGrAID), de potentie van digitale voedingsondersteuning in de dagelijkse IBD-zorg (DAPA-studie) en een gepersonaliseerde aanpak van persisterende buikklachten bij patiënten in remissie, waarbij digitale monitoring, identificatie van individuele triggers en gerichte interventies centraal staan (PERCEPTIVE studie).

14:30 uur **Ontstekingsremmend dieet of ontstekingsremmende vitaminen voor de ziekte van Crohn: de VitaGrAID-studie**
Prof. dr. G. Dijkstra, MDL-arts, Universitair Medisch Centrum Groningen, Groningen

14:50 uur **DAPA-studie: digitale ondersteuning van voeding bij patiënten met IBD**
Dr. M. Campmans-Kuijpers, MDL-arts, Universitair Medisch Centrum Groningen, Groningen

15:10 uur **Gepersonaliseerde aanpak van chronische buikklachten bij IBD in remissie: eerste resultaten van de PERCEPTIVE-trial**
Dr. Z. Mujagic, MDL-arts, Maastricht Universitair Medisch Centrum, Maastricht

Symposium Sectie Inflammatoire Darmziekten

Donderdag 10 september | Auditorium
Voorzitters: Dr. H.H. Fidder, Dr. D.J. de Jong

09:00 uur **Casus oncologie**
Dr. I. Molendijk, MDL-arts, Erasmus MC, Rotterdam

09:25 uur **Casus infectie**
Dr. M.M.C. Hirdes, MDL-arts, Franciscus Gasthuis & Vlietland, Rotterdam

10:00 uur **Casus medicatie geïnduceerde IBD**
Dr. M.J. Warners, MDL-arts, Meander MC, Amersfoort

10:30 uur **Koffiepauze in de expositiehal**

Symposium Sectie Inflammatoire Darmziekten: Pro en Con

Donderdag 10 september | Auditorium

Voorzitters: Dr. J.F. Brandse, Prof. dr. A.C. de Vries

11:00 uur **Inleiding Monitoring IBD. Richtlijn NVMDL**
M.E. Verweij, MDL-arts, Maasstad Ziekenhuis, Rotterdam

11:10 uur **Debat: Monitoring op afstand: zo snel mogelijk implementeren!**
Dr. S.F.G. Jeuring, MDL-arts, Maastricht Universitair Medisch Centrum, Maastricht
Dr. R.L. West, MDL-arts, Franciscus Gasthuis & Vlietland, Rotterdam

11:30 uur **Inleiding Update behandelrichtlijn IBD. Richtlijn NVMDL.**
Dr. C.P. Peters, MDL-arts, Diakonessenhuis Utrecht, Utrecht

11:40 uur **Debat: Thiopurine is eerste keuze IBD medicatie**
Prof. dr. K.H.N. de Boer, MDL-arts, Amsterdam University Medical Center, Amsterdam
Dr. M. Duijvestein, MDL-arts, Radboud University Medical Center, Nijmegen

12:30 uur **Lunchpauze in de expositiehal**

Abstractsessie HPB

Donderdag 10 september | Auditorium

13:30 uur **Early discharge with remote home monitoring: a feasible approach for mild acute pancreatitis**

N. Kant[1,2] , E.N. Brons[1] , A.C. Poen[3] , T.E.H. Römkens[4] , C.J.M. Doggen , B.M.W. Spanier , [1] Rijnstate Ziekenhuis, Dept. of Gastroenterology , [2] Universiteit Twente, Dept. of Gastroenterology , [3] Isala, Dept. of Gastroenterology , [4] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology

13:38 uur **Somatostatin analogues for prevention of severe adverse clinical course after pancreatoduodenectomy**

N.K.N. Jorritsma[1,2] , M.G. Besselink[3] , B.A. Bonsing[4] , K. Bosscha[5] , O.R. Busch[3] , F. Daams[3] , R.M. van Dam[6] , M. den Dulk[6] , C.H. van Eijck[7] , S. Festen[8] , B. Groot Koerkamp[7] , E. van der Harst[9] , I.H.J.T. de Hingh[10] , G. Kazemier[3] , M.L. Liem[11] , E.M. Manusama[12] , V.E. de Meijer[13] , J.S.D. Mieog[4] , G.A. Patijn[14] , D.S. Roos[15] , J.M. Schreinemakers[16] , M.W. Stommel[17] , F. Wit[18] , L.A. Daamen , I.Q. Molenaar , H.C. van Santvoort , F.J. Smits , [1] Universitair Medisch Centrum Utrecht, Dept. of Surgery , [2] Antonius Ziekenhuis, Dept. of Surgery , [3] Amsterdam University Medical Center, Dept. of Surgery , [4] Leids Universitair Medisch Centrum, Dept. of Surgery , [5] Jeroen Bosch Ziekenhuis, Dept. of Surgery , [6] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [7] Erasmus University Medical Center, Dept. of Surgery , [8] OLVG Hospital, Dept. of Surgery , [9] Maasstad Ziekenhuis, Dept. of Surgery , [10] Catharina Hospital Eindhoven, Dept. of Surgery , [11] Medisch Spectrum Twente, Dept. of Surgery , [12] Frisius MC, Dept. of Surgery , [13] University Medical Center Groningen, Dept. of Surgery , [14] Isala, Dept. of Surgery , [15] Reinier de Graaf Gasthuis, Dept. of Surgery , [16] Amphia Hospital, Dept. of Surgery , [17] Radboud University Medical Center, Dept. of Surgery , [18] Medisch Centrum Leeuwarden, Dept. of Surgery

13:46 uur **Current management and outcomes of mild acute pancreatitis: a Dutch multicenter cohort study**

A. Beij[1,2,3] , R.C. Verdonk[3] , M. Visch[3] , A.N. Keijzer[1] , A. Nagelhout[3,4] , L. Kager[5] , P. Honkoop[6] , W. Curvers[7] , W. Hazen[8] , P. van Duijvendijk[9] , M. Brink[10] , S. Kuiken[11] , R. Quispel[12] , F. van Delft[4] , T. Verlaan[13] , S.A.W. Bouwense[14] , T.C. Seerden[15] , R.P. Voermans[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [3] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [4] Radboud University Medical Center, Dept. of Gastrointestinal Surgery , [5] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology , [6] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [7] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [8] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [9] Gelre Ziekenhuizen, Dept. of Gastrointestinal Surgery , [10] Meander MC, Dept. of Gastroenterology and Hepatology , [11] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [12] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [13] Gelderse Vallei Hospital, Dept. of Gastroenterology and Hepatology , [14] Maastricht Universitair Medisch Centrum, Dept. of Gastrointestinal Surgery , [15] Amphia Ziekenhuis, Dept. of Gastroenterology and Hepatology

13:54 uur **A new restrictive intravenous fluid protocol leads to less fluid overload and similar outcomes in patients with acute pancreatitis.**

M. Kalimeri[1] , S. Derksen[1] , M. Emous[1] , C. Hoff[1] , M. Kaijser[1] , N. Koopmans[1] , R.C. Verdonk[2] , M. Vrooland[1] , V.K. Dik[1] , [1] Frisius MC, Dept. of Gastroenterology and Hepatology , [2] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology

14:02 uur **Early CT-derived body composition parameters and severe acute pancreatitis: a multicentre cohort study**

A. Nagelhout[1] , L.A.W.J. VanderBroeck[2] , N.D. Hildebrand[2] , D.P.J. van Dijk[2] , I.A.M. van den Bogart[3] , R.C. Verdonk[3] , H.C. van Santvoort[3,4] , T.H.E. Römkens[5] , R. Quispel[6] , T. Verlaan[7] , M.A. Brink[8] , A.C.I.T.L. Tan [9] , R.P. Voermans[10] , T. Seerden[11] , P. van Duijvendijk[12] , J.M. Jansen[13] , L.M. Kager[14] , S.S. Rensen[2] , H. Van Goor[1] , M.G. Besselink[10] , S.W.M. Olde Damink[2] , M.W.J. Stommel[1] , S.A.W. Bouwense[2] , [1] Radboud University Medical Center, Dept. of Surgery , [2] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [3] St. Antonius Ziekenhuis, Dept. of Research & Development , [4] Universitair Medisch Centrum Utrecht, Dept. of Surgery , [5] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [6] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [7] Ziekenhuis Gelderse Vallei, Dept. of Gastroenterology and Hepatology , [8] Meander MC, Dept. of Gastroenterology and Hepatology , [9] Canisius Wilhelmina Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] Amsterdam UMC, loc. AMC, Dept. of Gastroenterology and Hepatology , [11] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [12] Gelre Ziekenhuizen, Dept. of Surgery , [13] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [14] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology

14:10 uur **The road to same-day discharge after minimally invasive liver surgery: Emergence of early discharge and patient selection**

B.W. Verboeket[1,2] , B.W. Verboeket[1,2] , S.R. Moeijes[1] , J.D. van Worcum[1] , D.H.L. Lemmers[1] , M.A. Pool[1] , S. Festen[1] , T.M. Karsten[1] , M.F. Gerhards[1] , H.A. Marsman[1] , [1] OLVG Hospital, Dept. of Surgery , [2] Amsterdam University Medical Center, Dept. of Surgery

14:18 uur **Einde van deze sessie**

Videosymposium Sectie Gastrointestinale Endoscopie

Donderdag 10 september | Auditorium
Voorzitters: Dr. R. Zoutendijk, Dr. A. Inderson

14:30 uur **Programma volgt**

Een programma zal worden samengesteld adhv ingezonden video's

Collegetour NVMDL i.o.

Donderdag 10 september | Baroniezaal
Voorzitters: M.R. Struyvenberg, J.V. Veld, F.A. von Meijenfeld

09:00 uur **Gastroparese**
Prof. dr. D. Keszthelyi, MDL-arts, Maastricht Universitair Medisch Centrum, Maastricht

Daniel Keszthelyi is expert in de Neurogastroenterologie en motoriek met onder andere verstand van het op dit moment veelbesproken onderwerp gastroparese

09:30 uur **Periferie vs Academie**
Dr. V. Rijckborst, MDL-arts, Erasmus MC, Rotterdam

Na zijn opleiding heeft Vincent Rijckborst ruim 5 jaar in de periferie in een maatschap gewerkt, waarna hij de overstap naar de academie heeft gemaakt. Wat heeft deze keuze gemaakt? Wat zijn wat hem betreft de grootste verschillen?

10:00 uur **Chief Medical Information Officer (CMIO)**
J. Geesing, MDL-arts, Diakonessenhuis Utrecht, Utrecht

Naast MDL-arts is Joost Geesing tevens Chief Medical Information Officer (CMIO) van het Diakonessenhuis. Benieuwd wat dit laatste inhoudt? Sluit vooral aan!

10:30 uur **Koffiepauze in de expositiehal**

Gecombineerde abstractsessie

Donderdag 10 september | Baroniezaal

Voorzitters: Dr. J. Honing, S. van de Ven

11:00 uur **Surgical risk factors for inflammatory pouch disorders after ileoanal pouch surgery**

C.A.P. Klok[1] , M.S. Vlug[1] , T.B. Moojen[1] , E. Visser[1] , M.A. Reijntjes[1] , J.F.M. Lange[2] , G. Bislenghi[3] , M.M. Carvello , J. Warusavitarne , R. Hompes[1] , L.P.S. Stassen[4] , O.D. Faiz , A. Spinelli , A. D'Hoore[5] , W.A. Bemelman[1] , C.J. Buskens[1] , [1] Amsterdam University Medical Center, Dept. of Surgery , [2] University Medical Center Groningen, Dept. of Surgery , [3] UZ Leuven, Dept. of Surgery , [4] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [5] University Hospitals Leuven, Dept. of Surgery

11:08 uur **Prognostic significance of subclassifying clinical T3 category in rectal cancer: a Dutch nationwide cohort with standardised MRI re-assessment**

J.E.E.A. Drs. Guicherit[1] , T.C. Sluckin[2] , S.J.A. Hazen[2] , J.W.T. Dekker[3] , C.S.E.W. Schuurhuizen , M.P.W. Intven[4] , J. Nederend[5] , M. Maas[6] , M.S. Dunker , J.H.W. de Wilt[7] , M.M. Lange[2] , J.B. Tuynman[2] , P.J. Tanis[1] , [1] Erasmus MC, Dept. of Gastrointestinal Surgery , [2] Amsterdam UMC, loc. VUmc , [3] Reinier de Graaf Gasthuis , [4] Universitair Medisch Centrum Utrecht , [5] Catharina Hospital Eindhoven , [6] Antoni van Leeuwenhoek Hospital , [7] Radboud University Medical Center

11:16 uur **Fatigue-associated epigenetic and transcriptional patterns differ by disease subtype and activity state in inflammatory bowel disease patients**

F. Mol[1] , P.I. Metselaar[1] , R. Weiss[1] , M.J. van der Hoff[2] , O. Welting[1] , W.J. de Jonge[1] , A.A. te Velde[1] , M. Löwenberg[2] , A.Y.F. Li Yim[1] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research , [2] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology

11:24 uur **MFGM-enriched whey enhances intestinal epithelial maturation in a human pediatric organoid model**

J.W.M. de Kleer , S. Meisner[1] , J.L.M. Vermeulen[1] , B. Sovran[1] , T.T. Lambers[1] , V. Muncan[1] , W.J. de Jonge[1] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research

11:32 uur **Feasibility of same-day discharge after colon surgery: Interim results**

B.W. Verboeket[1,2] , M.F. Gerhards[1] , S. Festen[1] , T.M. Karsten[1] , S.M.M. de Castro[1] , G. Kazemier[2] , H.A. Marsman[1] , [1] OLVG Hospital, Dept. of Surgery , [2] Amsterdam University Medical Center, Dept. of Surgery

11:40 uur **Preoperative plasma metabolites are associated with male colorectal cancer recurrence following surgery**

A. Avramovic[1] , A.E. Petersen[2] , K. Zafeiropoulou[1] , J.L.M. Konsten[3] , N.D. Bouvy[4] , J.H.M.B. Stoot[5] , W.J. de Jonge[2] , J.P.M. Derikx[2] , M. Ghiboub[2] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research , [2] Amsterdam University Medical Center, Dept. of Pediatric Surgery , [3] VieCuri MC voor Noord Limburg, Dept. of Surgery , [4] Leids Universitair Medisch Centrum, Dept. of Surgery , [5] Zuyderland Medical Centre, Dept. of Surgery

11:48 uur **Comprehensive functional analysis of gene variants in Lynch syndrome**

A. Tsaalbi-Shtylik , S. van Hees-Stuivenberg , N. de Wind

11:56 uur **From operating room to pathology report: Delphi consensus on assessing peritoneal cytology and biopsies in gastric cancer staging**

J. Quik[1] , M.J. de Neijs[2] , N.A.D. Guchelaar[2] , J.E. Freund[3] , L.A.A. Brosens[3] , L. Oudijk[4,2] , M.L.F. van Velthuysen[2] , M. Doukas[2] , P. Snaebjornsson[1] , H. Grabsch[5] , A. Klooster , N. Doddema[2] , K. van den Burg[1] , B.P.L. Wijnhoven[2] , J.W. van Sandick[1] , S.L. Meijer[6] , L.L. Kodach[1] , [1] Antoni van Leeuwenhoek Hospital, Dept. of Surgery , [2] Erasmus MC, Dept. of Surgery , [3] Universitair Medisch Centrum Utrecht , [4] Maasstad Ziekenhuis , [5] Maastricht Universitair Medisch Centrum , [6] Amsterdam University Medical Center

12:04 uur **Einde van deze sessie**

Symposium NVMDL: cie. Kwaliteit

Donderdag 10 september | Parkzaal
Voorzitters: L.H.C. Nissen, J. Reijnders

Kwaliteitsregistraties: spiegel voor verbetering of instrument voor verantwoording?

09:00 uur **De Wet Kwaliteitsregistraties: wat verandert er voor medisch specialisten?**
D. van Veghel, Directeur-Bestuurder, Nederlandse Hart Registratie en Secretaris Samenwerkende Kwaliteitsregistraties (SKR),

09:25 uur **De Outlier Procedure van de NOV: een model voor de NVMDL?**
J. Caron, Orthopeed en voorzitter Nederlandse Orthopaedische Vereniging, ETZ Tilburg,

09:50 uur **Uitkomsten in de oncologische zorg: tussen leren en transparantie**

10:10 uur **Kwaliteitsindicatoren IBD: hoe krijg je dit in beeld en wat levert het op?**
Prof. dr. G. Dijkstra, MDL-arts, Universitair Medisch Centrum Groningen, Groningen

10:30 uur **Koffiepauze in de expositiehal**

Symposium Sectie Neurogastroenterologie en Motiliteit en Werkgroep Voeding

Donderdag 10 september | Parkzaal
Voorzitters: Dr. D. Clement, Dr. J.M. Conchillo

Functionele en motiliteitsstoornissen: oorzaak of oplossing?

11:00 uur **Tips en tricks bij enterale en parenterale voeding**
Prof. dr. P. Paine, MDL-arts, Salford Royal Hospital, Salford

11:15 uur **Feiten en fabels over non-gluten intolerantie**
Prof. dr. D.M.A.E. Jonkers, Professor, Maastricht Universitair Medisch Centrum, Maastricht

11:30 uur **ARFID onder de radar: herkenning en behandeling in de klinische praktijk**
R.M.E. Nowacki, Kinderarts, Maastricht Universitair Medisch Centrum, Maastricht

11:45 uur **Meerwaarde van dieetadviezen bij functionele buikklachten**
J. Brouns, Diëtist, Maastricht Universitair Medisch Centrum, Maastricht

Middagprogramma V&VN MDL

Donderdag 10 september | Parkzaal
Voorzitters: M. van Breugel

12:45 uur **Onderwater poliepectomie**
Dr. L.M.G. Moons, MDL-arts, University Medical Center Utrecht, Utrecht

13:15 uur **PEG problemen**
A. Baars, PEG-verpleegkundige, Catharina Hospital Eindhoven, Eindhoven
Dr. L.P.L. Gilissen, MDL-arts, Catharina Hospital Eindhoven, Eindhoven

13:45 uur **Nurse assistent propofol; NAPS project**
A.E. Bilgic, Verpleegkundige, Amsterdam University Medical Center, Amsterdam
J.C. Zandanel, Endoscopie verpleegkundige, Amsterdam University Medical Center, Amsterdam

14:15 uur **Barrett endoscopie**
Dr. Y. van Herwaarden, MDL-arts, Radboud University Medical Center, Nijmegen
Dr. J. Honing, MDL-arts, Erasmus MC, Rotterdam

14:45 uur **Borrel in de Abdijbar**

Symposium PhD netwerk

Donderdag 10 september | Zaal 80

11:00 uur **Van imposter syndrome naar inzicht in je kwaliteiten**
Dr. G. Ferone, coach bij Mennen Training & Consultancy

Herken je dat gevoel dat je elk moment door de mand kunt vallen, terwijl je het eigenlijk hartstikke goed doet? Veel zorgprofessionals en onderzoekers herkennen dit gevoel maar al te goed: het imposter syndrome.
Tijdens deze interactieve sessie laat dr. Louise Mennen, trainer en coach met jarenlange onderzoekservaring, zien wat het imposter syndrome is, waarom het zo vaak voorkomt en hoe je ermee om kunt gaan.
Daarna gaan we aan de slag met jouw kwaliteiten. Door inzicht te krijgen in je kwaliteiten én te leren hoe je signalen van het imposter syndrome kunt herkennen, krijg je praktische handvatten om deze gevoelens te relativeren en met meer vertrouwen nieuwe uitdagingen aan te gaan. Deze interactieve sessie biedt ruimte voor herkenning, uitwisseling en praktische oefeningen.
Of je nu verpleegkundige, PhD-student, A(N)IOS of medisch specialist bent: iedereen die zichzelf weleens onderschat en zijn of haar kwaliteiten beter wil leren inzetten, is van harte welkom.

12:30 uur **Lunchpauze in de expositiehal**

Gemodereerde postersessie

Donderdag 10 september | Meierij Foyer

12:45 uur **Unraveling variability in infliximab clearance in pediatric Crohn's disease: a novel approach using serum inflammatory immune proteins**
A. Camman[1] , S.A. Vuijk[1] , B. Calado[1] , Q.Z. Zhao[2] , M.M.E. Jongsma[1] , R. Colman , J.N. Samsom[1] , L. de Ridder , T. Preijers[2] , [1] Erasmus MC, Sophia Kinderziekenhuis, Dept. of Pediatric Gastroenterology Hepatology and Nutrition , [2] Erasmus MC, Dept. of Clinical Pharmacy

12:50 uur **Climate impact of intravenous versus subcutaneous infliximab administration: a life cycle assessment**
L.R. Hazeleger[1] , D. Oomkens[1] , S.L. van der Zeeuw[2] , A.C. de Vries[2] , M. Duijvestein[1] , E.M. Smale[2] , [1] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Erasmus University Medical Center, Dept. of Hospital Pharmacy

12:55 uur **Variation in clinical practice for hospitalized ulcerative colitis patients – a survey study among gastroenterologists in The Netherlands and Belgium**
M. Koningen , M.R. Naber , A. Bodelier[1] , P. Bossuyt , M. Löwenberg[2] , F.D.M. van Schaik[3] , [1] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [2] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [3] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

13:00 uur **Sex-related differences in atherosclerotic chronic mesenteric ischemia: an exploratory retrospective multicenter cohort study**
M.A.P. van Dongen[1,2] , E.K. Bocharewicz[1,2] , A.L. Iwema[1,2] , K.P. Pieterman[2] , J.L. de Bruin[2] , J.E. Roeters van Lennep[2] , M.J. Bruno[2] , P.D. Siersema[2] , R.H. Geelkerken[3] , D. van Noord[1,2] , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Dept. of Gastroenterology and Hepatology , [3] Medisch Spectrum Twente, Dept. of Surgery

13:05 uur **Lymph node assessment of the thoracic duct and surrounding compartment in esophageal cancer surgery – the TUPEC pilot-study**
H.C.G. Overtoom[1] , J.F.J.A. van Zon[1] , D.C. van der Aa[1] , W.J. Eshuis[1] , M.I. van Berge Henegouwen[1] , S.S. Gisbertz[1] , [1] Amsterdam University Medical Center, Dept. of Surgery

ABSTRACT #80

Early discharge with remote home monitoring: a feasible approach for mild acute pancreatitis

N. Kant[1,2] , E.N. Brons[1] , A.C. Poen[3] , T.E.H. Römkens[4] , C.J.M. Doggen , B.M.W. Spanier , [1] Rijnstate Ziekenhuis, Dept. of Gastroenterology , [2] Universiteit Twente, Dept. of Gastroenterology , [3] Isala, Dept. of Gastroenterology , [4] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology

Background:

Acute pancreatitis is the leading cause of acute gastroenterology-related hospital admissions in Western countries, with approximately 85% of cases following a mild clinical course. While most mild cases require only supportive care, they are typically hospitalized for four to six days. Remote home monitoring could enable early discharge, improve recovery, increase hospital bed availability, and reduce readmissions through home-based support. This study assessed the feasibility of such a care program, focusing on patient satisfaction, program implementation, and clinical outcomes.

Methods:

In this feasibility study, patients with predicted mild acute pancreatitis, determined by a predictive model based on systemic inflammatory response syndrome and C-reactive protein, were discharged early after at least 48 hours of hospitalization, supported by remote home monitoring. Remote home monitoring lasted for at least four days and included daily phone calls, symptom questionnaires via a smartphone app, and temperature, heart rate, and respiratory rate measurements using a wearable sensor. Patient satisfaction was assessed through a digital questionnaire, and clinical outcomes like readmissions and mortality were monitored for 30 days.

Results:

Fifty-two patients were included across three hospitals. The program's implementation demonstrated high feasibility. Ninety percent of patients rated the care as good or excellent. The median hospital stay was 2.3 [2.0–2.8] days, with a 13.5% readmission rate and no mortality.

Conclusion:

Early discharge of patients with mild acute pancreatitis, supported by remote home monitoring, is feasible. It reduces length of stay, maintains high patient satisfaction, and does not negatively affect clinical outcomes like readmissions or mortality.

ABSTRACT #82

Vacuum-stent therapy for colorectal transmural defects: initial experience and lessons learned

Z. Weerts[1] , D. Ramsoekh[1] , R. Hompes[1] , W. Laméris[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Surgery

Background:

Vacuum-stent therapy, which combines endoscopic vacuum therapy with a self-expanding stent, is a novel treatment for anastomotic leakage (AL) following anterior resection and rectal perforations. By providing active drainage while covering the defect, it may reduce the need for diversion or other surgical reintervention. This study describes the initial experiences with vacuum-stent therapy in a tertiary referral center.

Methods:

All patients treated with vacuum-stent therapy for colorectal transmural defects between 10/2023 and 12/2025 were included. Vacuum-stents were placed endoscopically and exchanged or removed after 5-7 days. Outcomes, including successful defect closure and adverse events, were prospectively registered.

Results:

Seventeen patients treated with vacuum-stent therapy for acute AL (n=14), chronic AL (n=1), or rectal perforation (n=2) were included. The median age was 63 years and 59% were female. Patients received a median of three stents over 15 days. Successful healing was achieved in 7/14 patients with acute AL, 0/1 with chronic AL, and 2/2 with rectal perforations. A diverting ostomy was omitted in three cases. Failure was attributed to stent luxation (n=2), severe pain (n=1), inadequate seal of the leak (n=1) or insufficient treatment response (n=4). More than half of the patients with therapeutic failure (5/8) had a pre-operative fistula. No major adverse events were observed.

Conclusion:

Vacuum-stent therapy is a promising endoscopic treatment for acute AL and rectal perforations, and can avoid a stoma in selected cases. Patient selection is essential for optimal treatment response. Larger prospective studies are needed to further assess efficacy, long-term outcomes, and cost-effectiveness.

ABSTRACT #83

Somatostatin analogues for prevention of severe adverse clinical course after pancreatoduodenectomy

N.K.N. Jorritsma[1,2] , M.G. Besselink[3] , B.A. Bonsing[4] , K. Bosscha[5] , O.R. Busch[3] , F. Daams[3] , R.M. van Dam[6] , M. den Dulk[6] , C.H. van Eijck[7] , S. Festen[8] , B. Groot Koerkamp[7] , E. van der Harst[9] , I.H.J.T. de Hingh[10] , G. Kazemier[3] , M.L. Liem[11] , E.M. Manusama[12] , V.E. de Meijer[13] , J.S.D. Mieog[4] , G.A. Patijn[14] , D.S. Roos[15] , J.M. Schreinemakers[16] , M.W. Stommel[17] , F. Wit[18] , L.A. Daamen , I.Q. Molenaar , H.C. van Santvoort , F.J. Smits , [1] Universitair Medisch Centrum Utrecht, Dept. of Surgery , [2] Antonius Ziekenhuis, Dept. of Surgery , [3] Amsterdam University Medical Center, Dept. of Surgery , [4] Leids Universitair Medisch Centrum, Dept. of Surgery , [5] Jeroen Bosch Ziekenhuis, Dept. of Surgery , [6] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [7] Erasmus University Medical Center, Dept. of Surgery , [8] OLVG Hospital, Dept. of Surgery , [9] Maasstad Ziekenhuis, Dept. of Surgery , [10] Catharina Hospital Eindhoven, Dept. of Surgery , [11] Medisch Spectrum Twente, Dept. of Surgery , [12] Frisius MC, Dept. of Surgery , [13] University Medical Center Groningen, Dept. of Surgery , [14] Isala, Dept. of Surgery , [15] Reinier de Graaf Gasthuis, Dept. of Surgery , [16] Amphia Hospital, Dept. of Surgery , [17] Radboud University Medical Center, Dept. of Surgery , [18] Medisch Centrum Leeuwarden, Dept. of Surgery

Background:

Most studies on somatostatin after pancreatoduodenectomy are single-center and individually lack power to determine its protective effect on severe consequences of postoperative pancreatic fistula. We studied the association between somatostatin and severe adverse clinical course in an unselected, prospective, nationwide cohort.

Methods:

This post-hoc analysis included all pancreatoduodenectomies in the Netherlands during the stepped-wedge cluster-randomized PORSCH trial (2018–2019), which evaluated standardization of postoperative care. Patients receiving somatostatin on or before the day of surgery were compared with those who did not. Patients starting somatostatin after the day of resection were excluded (i.e., as treatment). The composite primary outcome was 90-day mortality and/or new-onset organ failure. Treatment effects were estimated using doubly robust inverse probability treatment weighting. Adjusted odds ratios (aORs) with 95% confidence intervals (CIs) were estimated using weighted logistic regression with hospital-level cluster-robust standard errors.

Results:

Among 1,195 patients, the primary outcome occurred in 66/762 (9%) in the somatostatin group and 48/436 (11%) in the non-somatostatin group. After adjustment, standardized mean differences were <0.05. Somatostatin use was significantly associated with a lower odds of mortality and/or organ failure (aOR 0.67, 95% CI 0.47 – 0.94). Individual components of the primary outcome, and pancreatic fistula were not significantly different between groups (90-day mortality aOR 0.66, 95% CI 0.30 – 1.15; new-onset organ failure aOR 0.69, 95% CI 0.48 – 1.01; pancreatic fistula aOR 1.18, 95% CI 0.77 – 1.80).

Conclusion:

Although the incidence of clinically relevant pancreatic fistula did not differ significantly, somatostatin analogues was associated with lower odds of 90-day mortality or organ failure after pancreatoduodenectomy, suggesting that even when pancreatic fistula could not be prevented, the clinical impact of fistula could be mitigated.

ABSTRACT #84

Surgical risk factors for inflammatory pouch disorders after ileoanal pouch surgery

C.A.P. Klok[1] , M.S. Vlug[1] , T.B. Moojen[1] , E. Visser[1] , M.A. Reijntjes[1] , J.F.M. Lange[2] , G. Bislenghi[3] , M.M. Carvello , J. Warusavitarne , R. Hompes[1] , L.P.S. Stassen[4] , O.D. Faiz , A. Spinelli , A. D'Hoore[5] , W.A. Bemelman[1] , C.J. Buskens[1] , [1] Amsterdam University Medical Center, Dept. of Surgery , [2] University Medical Center Groningen, Dept. of Surgery , [3] UZ Leuven, Dept. of Surgery , [4] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [5] University Hospitals Leuven, Dept. of Surgery

Background:

Restorative proctocolectomy (RPC) with ileal pouch-anal anastomosis (IPAA) is the preferred surgical treatment for patients with refractory ulcerative colitis (UC). Inflammatory pouch disorders (IPD) like pouchitis and cuffitis are common after IPAA with an incidence up to 40% in the first year. Risk factors include primary sclerosing cholangitis (PSC), extraintestinal manifestations, extensive colitis, anti-TNF usage and admission for acute severe UC. These are all non-modifiable factors. The study aim was to identify surgery-related factors associated with the development of IPD in UC patients.

Methods:

This retrospective study included all patients >18 years with UC who underwent IPAA from 2016-2021 in 6 European centers, the MIRACLE-cohort. Primary outcomes were the incidence of pouchitis and cuffitis. Secondary outcomes included associations between the development of IPD and surgical timing (colectomy, IPAA), surgical techniques (modified 2 vs 3 stage, close rectal dissection (CRD) vs total mesorectal excision (TME), stapled vs handsewn anastomosis) and surgical complications (anastomotic leakage). Associations were tested using X^2-test or logistic regression.

Results:

411 patients were included (56.7% male, median age at IPAA 40 [IQR 29-52] years). After a median follow up of 3.6 [IQR 2.5–4.9] years, the incidence of pouchitis was 31.1% and cuffitis was 10.7%. There was no association with IPD and time from diagnosis to colectomy. However, a higher incidence of pouchitis and cuffitis was seen if the IPAA was created <6 months after colectomy vs longer intervals (45.5% vs 27.3% p<0.001; 19.6% vs 8.3% p0.002). Increased incidence of pouchitis and cuffitis was also seen after CRD vs TME (36.7% vs 19.7% p<0.001; 13.9% vs 4.9% p0.005). No relation with IPD could be found for other surgical factors or anastomotic leakage.

Conclusion:

In UC patients undergoing RPC with IPAA, IPD incidence was higher when operated <6 months after colectomy, which should be considered when planning IPAA. Increased incidence was also seen after CRD, suggesting an inflammatory role of the mesorectum warranting further study.

ABSTRACT #87

Climate impact of intravenous versus subcutaneous infliximab administration: a life cycle assessment

L.R. Hazeleger[1] , D. Oomkens[1] , S.L. van der Zeeuw[2] , A.C. de Vries[2] , M. Duijvestein[1] , E.M. Smale[2] , [1] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology, [2] Erasmus University Medical Center, Dept. of Hospital Pharmacy

Background:

Tumor necrosis factor- (TNF-) inhibitors, like infliximab, are used to treat inflammatory bowel diseases (IBD). Subcutaneous (s.c.) infliximab offers comparable efficacy and safety to intravenous (i.v.) administration and may improve patient convenience while reducing resource use. However, data on its overall climate impact are lacking. Given the growing importance of environmental sustainability in healthcare, differences in climate impact between administration of both formulations are increasingly relevant. This study aimed to quantify and compare the climate impact of infliximab i.v. versus s.c. in terms of greenhouse gas (GHG) emissions, and to identify key drivers of GHG emissions across both treatment modalities.

Methods:

A cradle-to-grave life-cycle assessment (LCA) was carried out to quantify and compare the climate impact of infliximab administered i.v. versus s.c. in real-world care pathways of two Dutch university hospitals. This preliminary analysis includes impacts of drug manufacturing (based on formulation-specific LCA provided by the manufacturer), single-use medical equipment, patient and drug transportation, and waste disposal. Climate impact in terms of GHG emissions was expressed as carbondioxide equivalents (CO_2eq) per eight-week treatment cycle, and contribution analyses identified the main GHG emission sources.

Results:

GHG emissions of infliximab i.v. were approximately twice as high in CO_2eq compared to s.c. administration. Manufacturing emerged as the primary driver of emission for both formulations, which resulted in a larger climate impact for the i.v. route. Intravenous administration also resulted in higher emissions due to patient transport, as well as increased use of single-use medical equipment and packaging, when compared to s.c. treatment.

Conclusion:

This preliminary analysis suggests that s.c. administration of infliximab is markedly more sustainable than i.v. administration, primarily due to reduced transportation emissions. These findings could inform clinical decision-making, pointing to infliximab s.c. as a potentially more sustainable and practical treatment option for IBD. Further analyses will incorporate hospital infrastructure and sensitivity testing on factors such as patient distance and dosage, guiding the development of a sustainability-based decision-support model for infliximab administration.

ABSTRACT #88

Ozanimod in patients with ulcerative colitis - Real-world evidence from the Dutch ICC Registry

L.M.M. Verleye[1,2] , D. Erven[1] , Z. Mujagić[1] , M.R. Naber[3,4] , D.G. Bouwknegt[5] , T.E.H. Römkens[6] , L.F. Wymenga[5] , R.L. Goetgebuer[4] , P.B.F. Mensink[7] , F.D.M. van Schaik[8] , B. Oldenburg[3] , M.C. Visschedijk[5] , A.A. van Bodegraven[9] , A.G.L. Bodelier[10] , M. Löwenberg[4] , M. Duijvestein[2] , M.J. Pierik , [1] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology, [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [3] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology, [4] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology, [5] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology , [6] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology, [7] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology , [8] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology, [9] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [10] Amphia Ziekenhuis, Dept. of Gastroenterology and Hepatology

Background:

Ozanimod is a sphingosine-1-phosphate receptor modulator approved for the treatment of ulcerative colitis (UC) since 2021, but yet without widespread use in daily practice. Hence, real-world evidence of its effectiveness and safety in patients with UC remains scarce.

Methods:

Effectiveness and safety of ozanimod were assessed using data from the Dutch ICC Registry. Primary outcome was drug persistence at week 24. Clinical (Simple Colitis Clinical Activity Index (SCCAI) ≤2 or normal Physician Global Assessment) and biochemical remission (faecal calprotectin (FC) ≤250 µg/g) were assessed at treatment initiation, and at week (W) 12, 24 (±4w), and 52 (±8w). Effectiveness was calculated using non-responder imputation. The occurrence of (non-)infectious adverse events was also assessed.

Results:

Thirty-four patients (≥16y) were included, 58.8% being female (20/34). Median disease duration was 6 years (Q1, Q3: 3, 13). Two patients (5.9%) were advanced therapy-naïve, 28/34 patients (82.3%) had difficult-to-treat IBD, and 3/34 patients (8.8%) initiated ozanimod as last-resort therapy before undergoing colectomy. At week 24, drug persistence was 69.1% (95%CI [54.9, 87.1], at risk = 22), declining to 49.8% (95%CI [35.0, 70.7], at risk = 16) at week 52. At week 12, 13/29 patients (44.8%) were in clinical remission. In patients with SCCAI >2 at baseline, 6/14 patients (42.9%) had SCCAI ≤2 at week 12. Seven patients (/20, 35.0%) were in biochemical remission at week 12. Twenty patients (58.8%) discontinued ozanimod, after a median treatment duration of 168 days (62, 356). Reasons for treatment discontinuation included primary non-response (6), loss of response (4), adverse events (4; lymphopenia, headache, skin and musculoskeletal complaints), colectomy (3), and patient's own decision (1). Eleven infections were reported: 7.8 infections per 100 person-years (100PY) requiring no treatment, and 18.3 infections per 100PY requiring treatment with oral antibiotics or antiviral therapy. Sixteen non-infectious adverse events were reported; 31.3 events per 100PY and 10.4 events per 100PY were deemed possibly and probably related to ozanimod, respectively. No hospitalisations or deaths were reported.

Conclusion:

In this real-world cohort, comprising a high proportion of therapy-refractory ulcerative colitis patients, up to two-thirds remained on ozanimod after 24 weeks. Clinical and biochemical remission rates and safety outcomes were comparable to those reported in clinical trials. In view of the small sample size, confirmation of our data in larger real-world cohorts is required.

ABSTRACT #90

High closure rates after Endoscopic Vacuum Therapy for upper GI transmural defects.

V. Bos[1] , L.M.D. Pattynama[1] , A.B. Van Nunen[2] , W.L. Curvers[3] , Y.J. Van Herwaarden[4] , P.J.F. De Jonge[5] , J. van Dieren[6] , A. Inderson[7] , D.B. De Koning[8] , R.J.F. Laheij[9] , P.R. Oosterwijk[10] , K. Soufidi[2] , G.A.P. Nieuwenhuijzen[3] , M. Hutteman[4] , J.W. Van Sandick[6] , K. Basiliya[7] , N. Beekmans[8] , E.H.J. Belgers[2] , W.J. Eshuis[1] , R.E. Pouw[11] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology, [2] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [3] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [4] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [5] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [6] NKI Antoni van Leeuwenhoek, Dept. of Gastroenterology and Hepatology , [7] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [8] Gelre Ziekenhuizen, Dept. of Gastroenterology and Hepatology , [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] Ziekenhuisgroep Twente, Dept. of Gastroenterology and Hepatology , [11] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

Background:

Transmural defects of the upper gastrointestinal (GI) tract are associated with high morbidity and mortality. Treatment strategies include conservative therapy, endoscopic stenting, percutaneous drainage, surgery, and endoscopic vacuum therapy (EVT). EVT involves applying negative pressure therapy within the lumen or in the cavity behind the defect, often using a vacuum-sponge or vacuum-stent. With a reported success rate of 80-100%, EVT is promising, however, prospective data are scarce and treatment strategies are not yet optimized.

Methods:

In this prospective multicenter registry in 12 hospitals in the Netherlands, we aimed to report the safety and efficacy of EVT for upper GI transmural defects. All patients (≥18 yrs) treated with EVT for transmural upper GI defects between January 2023-February 2026 were eligible. EVT was performed according to local protocols. The primary outcome was successful EVT, defined as defect closure by EVT.

Results:

221 patients (median age 66 yrs (IQR 58-73), 66% male) were included. The majority were treated for anastomotic leakage (AL) after oncologic surgery (64%) or benign indications (11%), followed by iatrogenic defects (15%), Boerhaave syndrome (5%), and other non-iatrogenic defects (4%). AL was detected after median 6 days (IQR 3-10). CT scan or contrast swallow examinations were performed in 94% of patients and showed contrast leakage in 48%, fluid collections in 37%, and pneumothorax requiring drainage in 14%. An extraluminal cavity was present in 29% of patients, which was endoscopically accessible in 42/64 (66%).

EVT was started median 1 day (IQR 0-1) after diagnosis, with a vacuum-stent in 57% or a vacuum-sponge in 43% as initial treatment. Eventually, 29% of patients underwent treatment with vacuum-sponge alone, 47% vacuum-stent alone, and 23% a combination of both devices. Defects were successfully closed in 77%, after median 16 days (IQR 8-26) and 4 EVT-related endoscopies (IQR 3-6).

Reasons for EVT failure were lack of closure progression (15%), death during treatment (5%), iatrogenic defect expansion beyond the limits of EVT resulting in death in one patient who was unfit for surgical rescue (0.5%), or other reasons (2%). EVT-related adverse events (AGREE ≥III) occurred in 7%, including the fatal adverse event after iatrogenic defect expansion described above (AGREE V). Patients in whom EVT failed were significantly older (p=.004), were more often treated for non-AL defects (p=.003), had higher perforation severity scores (p<.001), and more often required additional percutaneous drainage (p=.015).

Conclusion:

This is the largest prospective EVT cohort to date. Results show high closure rates (77%) and few adverse events (7%).

ABSTRACT #92

Who benefits from telemonitoring in Inflammatory Bowel Disease? A qualitative study of patients' ability and willingness to telemonitoring

S.W. Lathouwers[1,2] , M. van Schijndel[2] , J.P.H. Drenth[3] , C.J. van der Woude[4] , L.M.W. Nahar-van Venrooij[2] , R.L. West[1] , T.E.H. Römkens[2] , A. Sponselee , E.J.M. Wouters , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology, [2] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [3] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [4] Radboud University Medical Center, Not applicable

Background:

Telemonitoring may improve efficiency and self-management in inflammatory bowel disease (IBD). However, not all patients are willing or able to use telemonitoring. There is limited insight into which patients engage with telemonitoring and which factors influence their engagement. Understanding these factors is important for equitable, patient-centered and sustainable implementation of telemonitoring in IBD care and may help improve long-term patient engagement and adherence. This study aimed to explore factors influencing patients' ability and willingness to use telemonitoring in routine IBD care.

Methods:

A multicenter qualitative study was conducted with adult IBD patients in stable remission, who were eligible for telemonitoring. Purposeful sampling was used to include patients with varying levels of interest in telemonitoring and differing responses to the program information thereby capturing a broad range of barriers and facilitators to telemonitoring adoption. Semi-structured interviews were conducted and analyzed using thematic analysis.

Results:

Eighteen patients were included. Patients' acceptance of telemonitoring was primarily determined by a balance between their perceived clinical value and perceived burden. Five main themes were identified: (1) perceived clinical value, (2) fitting into daily life and perceived burden, (3) preference for hybrid care and personal contact, (4) skills and support, and (5) trust, autonomy, and attitudes towards digital care.

In addition, differences in motivation and capability appeared to influence patients' engagement with telemonitoring. Patients willing to use telemonitoring valued rapid feedback, reassurance, efficiency, and increased autonomy. Patients unwilling to use telemonitoring more often reported stable disease, limited added value, and barriers related to digital skills or negative attitudes towards digital healthcare. Most patients did not want telemonitoring to replace personal contact with healthcare professionals, but preferred hybrid care in which telemonitoring was added to standard care.

Conclusion:

The findings suggest that telemonitoring may not suit all patients with IBD equally and that implementation should be tailored to individual needs and preferences. Engagement with telemonitoring in patients with IBD appears to be shaped by an interaction between perceived value, burden, capability, and patient attitudes. Patients generally preferred telemonitoring as part of a hybrid care model rather than as a fully digital replacement of standard care. Successful implementation requires further research into patient selection, expectation management, and tailored support for patients who experience modifiable barriers

ABSTRACT #95

Current management and outcomes of mild acute pancreatitis: a Dutch multicenter cohort study

A. Beij[1,2,3] , R.C. Verdonk[3] , M. Visch[3] , A.N. Keijzer[1] , A. Nagelhout[3,4] , L. Kager[5] , P. Honkoop[6] , W. Curvers[7] , W. Hazen[8] , P. van Duijvendijk[9] , M. Brink[10] , S. Kuiken[11] , R. Quispel[12] , F. van Delft[4] , T. Verlaan[13] , S.A.W. Bouwense[14] , T.C. Seerden[15] , R.P. Voermans[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology, [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology, [3] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology, [4] Radboud University Medical Center, Dept. of Gastrointestinal Surgery, [5] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology, [6] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [7] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology, [8] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology, [9] Gelre Ziekenhuizen, Dept. of Gastrointestinal Surgery, [10] Meander MC, Dept. of Gastroenterology and Hepatology , [11] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [12] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [13] Gelderse Vallei Hospital, Dept. of Gastroenterology and Hepatology, [14] Maastricht Universitair Medisch Centrum, Dept. of Gastrointestinal Surgery, [15] Amphia Ziekenhuis, Dept. of Gastroenterology and Hepatology

Background:

Approximately 80% of acute pancreatitis cases follow a mild course. Although evidence suggests that early discharge after 24–48 hours is safe and feasible, current clinical practice in the Netherlands is expected to vary considerably, often resulting in prolonged hospitalization. Current treatment practices and the factors driving this variation remain poorly described.

Aim: To describe current treatment practices and clinical outcomes of mild acute pancreatitis, and to identify which patient- and treatment-related factors contribute to length of hospital stay.

Methods:

This was a multicenter observational study in 14 hospitals in the Netherlands between 2015-2026. Follow-up time comprised 3 months from day of acute pancreatitis diagnosis. Included were patients admitted with acute pancreatitis classified as mild according to the Revised Atlanta Classification (no organ failure, no local complications). Excluded were patients with chronic pancreatitis. Study outcomes were length of stay, imaging, pain management, antibiotic use, in-hospital complications, and readmission rates.

Results:

A total of 518 patients with mild acute pancreatitis were included from 14 hospitals. Biliary etiology was the most common (57%). The median length of stay (LOS) for the index admission was 6 (4–8) calendar days, with interhospital variation in median length of stay ranging from 4 to 7 days. Within the 3 month follow up period, 40% of patients underwent CT imaging, 70% received opioids, 18% received antibiotics, and 6% received enteral nutrition. The nonelective readmission rate was 15%, with a median LOS of 5 (3–7) days. Of all readmissions, 56% were due to ongoing or recurrent acute pancreatitis. Cholecystectomy was performed in 39% of patients, of whom 45% underwent (delayed) cholecystectomy after discharge, with a median interval of 27 (8–51) days from discharge. Development of local complications occurred in 2% of cases after the index admission.

Conclusion:

In this multicenter cohort, clinical outcomes of mild acute pancreatitis were favorable, with low progression in disease severity and moderate readmission rates. Nevertheless, median length of stay substantially exceeded 48 hours, with considerable inter-hospital variation. Nearly half of cholecystectomies were still delayed until after discharge, and antibiotic use appeared higher than clinically warranted. These findings suggest that the current management may be more resource intensive than the generally favorable course warrants, indicating opportunities to improve care efficiency and patient satisfaction. Standardized protocols and careful patient selection are needed to identify candidates for early and safe discharge.

ABSTRACT #96

Interdisciplinary care for patients with harmful alcohol use: associations with openness

J.M. Bisschop[1] , J.T. Dammers[1] , H.J.M. de Jonge[1] , H.D. van de Mheen , A.D. Rozema , J.J.P. Mathijssen , [1] Jeroen Bosch Ziekenhuis, Not applicable

Background:

Patients with higher levels of harmful alcohol use often have a complexity of physical, psychological, withdrawal, and social problems. Interdisciplinary hospital care is provided to these patients, including, among others, offering (post)care interventions. However, associations between patients' characteristics and openness to (post) care interventions offered during this interdisciplinary care remain unknown.

Methods:

In this retrospective cohort study, all adult patients admitted to a general hospital between June 2019 and March 2023 with harmful alcohol use, who received interdisciplinary care, were included (N= 202). Multivariable logistic regression was used to examine patients' openness to post-care interventions for alcohol use and which factors are associated. The factors included gender, age at the time of the event, living situation, having children, smoking, drug use, a history of psychiatric disorders, and a history of harmful alcohol use.

Results:

Most patients scored high on openness to (post-care) interventions (66.4%), while 33.7% did not. In the multivariable model, higher age was associated with less openness, and having a history of harmful alcohol use was associated with more openness to post-care interventions.

Conclusion:

This study highlights that two-thirds of patients who received interdisciplinary care for harmful alcohol use were open to post-care interventions. Hospitals are a critical resource for addressing harmful alcohol use; screening and interdisciplinary interventions during and after admission should be offered and modified to the patient's needs. More research is necessary to explore the patient's perspective about the interdisciplinary care and changes within patients over time after the admission period.

ABSTRACT #99

A new restrictive intravenous fluid protocol leads to less fluid overload and similar outcomes in patients with acute pancreatitis.

M. Kalimeri[1] , S. Derksen[1] , M. Emous[1] , C. Hoff[1] , M. Kaijser[1] , N. Koopmans[1] , R.C. Verdonk[2] , M. Vrooland[1] , V.K. Dik[1] , [1] Frisius MC, Dept. of Gastroenterology and Hepatology , [2] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology

Background:

Intravenous (IV) fluid therapy is a key component of early acute pancreatitis management, yet both inadequate resuscitation and fluid overload may worsen outcomes. In September 2022, a protocol switch to a restrictive, urine-output and hemodynamics-guided IV fluid strategy was implemented in our hospital. We evaluated whether this protocol switch reduced early fluid overload without worsening clinical outcomes in patients admitted with acute pancreatitis.

Methods:

This single-center, retrospective cohort study compared admissions for acute pancreatitis during a standard, European guideline-concordant, IV fluid protocol period (Sept 2019 to Aug 2022) with admissions during a restrictive-protocol period (Oct 2022 to Aug 2025), excluding a one-month washout period. The primary outcome was any sign of fluid overload within 72h, defined as clinical signs, radiological signs and/or new diuretic initiation. Secondary outcomes included 72h IV volume, Modified Marshall organ failure within 24-96h, supportive interventions, length of stay and in-hospital mortality. Logistic regression adjusted for age, cardiac comorbidity and chronic kidney disease; GEE analysis accounted for repeated admissions.

Results:

The cohort included 624 admissions in 522 patients: 315 during the standard-protocol period and 309 during the restrictive-protocol period. Baseline severity was comparable, with no significant differences in baseline CRP, SIRS within 0-24h or IMRIE scores 0-48h. Total IV fluid administration within 72h was lower with the restrictive protocol than with the standard protocol (median 3.7 vs 5.4 L, p<0.001). The primary outcome of any sign of fluid overload occurred in 90/309 (29.1%) of the admissions in the restrictive cohort versus 123/315 (39.0%) standard cohort (p=0.009). This association remained after adjustment for age, cardiac comorbidity and chronic kidney disease (OR 0.64, 95% CI 0.46-0.90; p=0.011), and in GEE analysis accounting for repeated admissions (OR 0.60, 95% CI 0.42-0.87; p=0.007). New diuretic initiation within 72h occurred less frequently with the restrictive protocol (9.7% vs 15.2%, p=0.037), as was non-invasive ventilation (including nasal oxygen therapy) (21.0% vs 30.5%, p=0.007). Total hospital stay, organ failure within 24-96 h, ICU admission, invasive ventilation, hemodialysis, drainage of peripancreatic fluid collections/WON and in-hospital mortality did not differ significantly.

Conclusion:

A more restrictive IV fluid strategy was associated with a lower risk of fluid overload, less new diuretic initiation and less need for non-invasive ventilation, without adversely affecting important pancreatitis-related clinical outcomes.

ABSTRACT #101

Wilson's Disease: epidemiology and treatment in the Netherlands

L.W.H. van Leeuwen[1,2] , F.H.H. Linn[1] , C.M. den Hoed[3] , S. van Meer[4] , [1] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Dept. of Gastroenterology and Hepatology , [3] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [4] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

Background:

Recent developments in the diagnosis and treatment of Wilson's Disease (WD) may improve patient outcomes. To determine whether Dutch patients could benefit from these developments, insight into the Dutch population is needed. Currently, the prevalence of WD patients in the Netherlands is unknown. This study aims to identify all WD patients followed up in the Netherlands and collects data on treatment patterns and patient characteristics.

Methods:

This multicenter observational study includes all adults and children with a diagnosis of WD currently in follow-up in the Netherlands. Inclusion started in July 2025, and patients are eligible to participate with a Leipzig score of ≥ 3 and provided informed consent. The study is conducted at all university hospitals in the Netherlands. Additional patients in general hospitals were identified through direct inquiries to treating hepatologists and neurologists. Data on presenting symptoms, initial treatment, current clinical status and treatment were collected.

Results:

In total 232 WD patients were identified in the Netherlands. To date, 153 patients have been included (median age 37 years (IQR 25-49), 81 (54%) men, 18 children). The median age at diagnosis was 15 years (IQR 10-22). Clinical presentation was in 46% hepatic, 13% neurologic, 8% combined, 26% identified by screening, 4% coincidence finding or other presentation, and 3% with missing data. Acute liver failure was observed in 15 patients with hepatic presentation. Most patients were initially treated with D-penicillamine (50%), followed by zinc (33%), no medication (8%), trientine (4%), D-penicillamine and zinc (3%) , and 2% missing data. Currently patients are treated with zinc (31%), D-penicillamine (20%), no medication (21%), trientine (15%), chelator and zinc (12%) or 1% missing. 25 patients underwent a liver transplantation. The common European mutation p.His1069Gln was reported in 39% (n=59) of patients.

Conclusion:

An estimated prevalence of clinically relevant WD patients in the Netherlands (1:78.200) reflects the rarity of WD. Hepatic presentation was the most frequent phenotype, with 21% of these patients presenting with acute liver failure. Treatment has changed over the years, with increased use of trientine and a third of Dutch patients being treated with zinc. More data on the Dutch population are awaited.

ABSTRACT #102

Preoperative exercise advice improves aerobic capacity in patients awaiting liver transplantation

O.D.J. Zwerver[1] , A.D. Talen[2] , V.J.A. Brenninkmeijer[1] , F.J.C. Cuperus , J.M. Klaase[2] , [1] Universitair Medisch Centrum Groningen, Dept. of Gastrointestinal Surgery , [2] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

Background:

Patients awaiting orthotopic liver transplantation (OLT) are often frail due to malnutrition, sarcopenia, and reduced aerobic capacity. A decreased ventilatory anaerobic threshold (VAT) is a marker of poor aerobic capacity and is associated with increased pre- and post-transplant mortality. We aimed to use the waiting list period before transplantation to improve preoperative aerobic capacity in patients awaiting OLT.

Methods:

Patients awaiting OLT underwent cardiopulmonary exercise testing (CPET) as part of standard care. Based on CPET results, patients were classified as *unfit* (VAT ≤13 mL/kg/min and/or VO2peak ≤18 mL/kg/min) or *fit* (VAT >13 mL/kg/min and VO2peak >18 mL/kg/min). Individualized exercise advice was provided, consisting of endurance training (≥300 minutes per week) and twice-weekly high-intensity interval training (HIIT). Absolute changes in VAT and VO2peak between pre-training (T0) and post-training (T1) were evaluated.

Results:

Sixty-four patients (50% female; mean age 52.2 ± 12.7 years) completed baseline CPET. Aerobic capacity was generally reduced (median VAT 13.55 mL/kg/min; median VO_2peak 19.55 mL/kg/min). Thirty-two patients underwent repeat CPET after ~13 weeks, of whom 19 were classified as unfit and 13 as fit. In the overall cohort with 2 CPETs, VAT increased significantly (median 12.50 to 13.16 mL/kg/min, p<0.001), whereas the increase in VO_2peak (18.47 to 18.67 mL/kg/min) was not statistically significant. In unfit patients, both VAT (10.44 to 12.29 mL/kg/min; p < 0.001) and VO2peak (15.91 to 16.55 mL/kg/min; p = 0.033) improved significantly. No significant changes were observed in fit patients.

Conclusion:

Preoperative exercise advice incorporating endurance training and HIIT significantly improves aerobic capacity in patients awaiting OLT, with the greatest beneficial effect observed in those with low baseline aerobic capacity. These findings highlight the potential of the transplant waiting period as a window for prehabilitation.

ABSTRACT #103

Sex-related differences in atherosclerotic chronic mesenteric ischemia: an exploratory retrospective multicenter cohort study

M.A.P. van Dongen[1,2] , E.K. Bocharewicz[1,2] , A.L. Iwema[1,2] , K.P. Pieterman[2] , J.L. de Bruin[2] , J.E. Roeters van Lennep[2] , M.J. Bruno[2] , P.D. Siersema[2] , R.H. Geelkerken[3] , D. van Noord[1,2] , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology, [2] Erasmus MC, Dept. of Gastroenterology and Hepatology, [3] Medisch Spectrum Twente, Dept. of Surgery

Background:

Chronic mesenteric ischemia (CMI) is a rare but serious condition typically caused by atherosclerotic stenosis of one or more mesenteric arteries. Although cardiovascular disease is generally more prevalent in men, CMI shows a marked female predominance, with approximately 70% of cases occurring in women. The reasons for this disparity remain poorly understood and may reflect differences in symptom presentation, cardiovascular risk profiles, or diagnostic pathways. Similar sex-related differences in clinical presentation, associated with diagnostic delay, have been described in other cardiovascular diseases, such as coronary artery disease. Therefore, this study aimed to evaluate sex-related differences in clinical presentation, cardiovascular risk factors, treatment, and outcomes in atherosclerotic CMI.

Methods:

This retrospective, multicenter cohort study included 269 patients diagnosed with atherosclerotic CMI, treated between January 1, 2007, and April 1, 2025, at two mesenteric ischemia expert referral centers. Demographic data, clinical symptoms, cardiovascular risk factors, treatment, and outcomes were compared by sex using descriptive statistics.

Results:

Women comprised 71.7% of the cohort. Nausea ($p = 0.005$) and altered eating patterns ($p = 0.008$) were more frequently reported in women. In contrast, a history of cardiovascular disease, including ischemic heart disease ($p < 0.001$) and heart failure ($p = 0.003$), as well as diabetes ($p = 0.017$) and pre-existing use of antithrombotic therapy ($p = 0.009$) were more prevalent in men. Symptom duration prior to presentation was similar between sexes (median 9 months in women vs. 10 months in men; $p = 0.935$). No significant sex differences were observed in stenosis severity, treatment approaches, reinterventions, and mortality. General intervention-related complications, such as hematoma or pseudoaneurysm, occurred more frequently in women ($p = 0.042$).

Conclusion:

Although cardiovascular disease is generally more prevalent in men, atherosclerotic CMI predominantly affects women. Atypical symptoms, such as nausea and altered eating patterns, were more often reported in women, which may contribute to underrecognition of CMI in clinical practice. These findings raise important questions regarding the mechanisms underlying the marked female predominance in CMI, including the potential role of hormonal influences, anatomical variation, and sex-related differences in cardiovascular risk profiles. Further prospective research to gain a deeper understanding of the disease is warranted to improve recognition, promote awareness, and optimize care for patients with CMI.

ABSTRACT #104

Percutaneous Endoscopic Colostomy; a retrospective analysis on success, complications and patient experiences.

G.J.L. van Neerven[1] , Y. van Dillen[1] , A. Baars[1] , T. van Bommel[1] , J. van Liempd[1] , H. Flink[1] , L.P.L. Gilissen[1] , [1] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology

Background:

Percutaneous endoscopic colostomy (PEC) is a variant of percutaneous endoscopic gastrostomy, placed in the colon. It is indicated for antegrade colonic lavage in case of therapy-refractory constipation (TRC) or fixation of the colon to the abdominal wall and decompression in cases of recurring sigmoid volvulus (RSV). PEC is only discussed when surgical intervention is considered, which is more invasive. PEC is less invasive, but relatively unknown. Current literature shows some case series only. This study aims to evaluate clinical and patients experiences in a larger series.

Methods:

This retrospective study was conducted in a referral hospital. Technical success, PEC success, adverse events (AE) and patient experiences were evaluated.

Results:

Eighty-eight patients received a PEC between October 1. 2007 to June 1. 2024. Procedural success rate was 100%. Eighty-one patients (92.0%) received a PEC for TRC and seven (8.0%) for RSV. Seven patients (8.0%) experienced at least one major AE: peritonitis (8.0%) and perforation (2.3%), of which one patient (1.1%) died, despite surgical intervention. Minor AE were common (90.9%): pain (78.4%), wound infection (52.3%), leakage (35.2%) and bleeding (9.1%). At six months follow-up, 53 patients (60.2%) still used the PEC. Sixty-three patients (71.67%) completed the questionnaire. Mean patient experience was 7.67 (SD 2.17; range 0-10), and 65.1% reported an improvement in quality of life.

Conclusion:

PEC is successful in patients and is associated with improved quality of life. PEC should be considered in patient with TRC or RSV, when the next therapeutic step would be surgical intervention.

ABSTRACT #105

Azathioprine versus mycophenolate mofetil in combination with prednisolone in patients with treatment-naïve autoimmune hepatitis: 3-year follow-up of the CAMARO-trial.

C.D. Slooter[1] , R.J.A.M. Snijders[2] , A.E.C. Stoelinga[3] , K.M.A. Gerrits[1] , T.J.G. Gevers[4] , S. Pape[2] , M. Biewenga[5] , M.E. Tushuizen[3] , R.C. Verdonk[6] , H.J.M. De Jonge[7] , J.M. Vrolijk[8] , S.F. Bakker[9] , T. Vanwolleghem , M.A.M.C. Baven-Pronk[10] , U. Beuers[1] , A.J. van der Meer[5] , N.M.F. van Gerven[11] , M.G.M. Sijtsma[12] , B.C. van Eijck[13] , M.C. van Ijzendoorn[14] , M. van Herwaarden[15] , F.F. van den Brand[1] , K. Sebib Korkmaz[16] , A.P. dan ven Berg[17] , M.M.J. Guichelaar[18] , M. Kramer[4] , F. Govaert[19] , S. Jansen[20] , S.K. van der Wiel[20] , L.H. Oterdoom[21] , I.M. Kerkhof[12] , M. Bartelink[15] , D.M. Hotho[22] , A.D. Levens[3] , B. van Hoek[3] , Y.S. de Boer[1] , J.P.H. Drenth[1] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology, [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology, [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology, [4] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology, [5] Erasmus MC, Dept. of Microbiology and Immunology, [6] Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology, [7] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology, [8] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology, [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology, [10] Groene Hart Ziekenhuis, Dept. of Gastroenterology and Hepatology, [11] Rode Kruis Ziekenhuis, Dept. of Gastroenterology and Hepatology, [12] St. Jans Gasthuis, Dept. of Gastroenterology and Hepatology, [13] Spaarne Gasthuis, Dept. of Gastroenterology and Hepatology, [14] Bernhoven Hospital, Dept. of Gastroenterology and Hepatology, [15] Deventer Ziekenhuis, Dept. of Gastroenterology and Hepatology, [16] IJsselland Ziekenhuis, Dept. of Gastroenterology and Hepatology, [17] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology, [18] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology, [19] Slingeland Ziekenhuis, Dept. of Gastroenterology and Hepatology, [20] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology, [21] HagaZiekenhuis, Dept. of Gastroenterology and Hepatology, [22] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

Background:

The CAMARO trial demonstrated superior short-term tolerability and response rates at 24 weeks of mycophenolate mofetil (MMF) compared with azathioprine (AZA), both in combination with prednisolone, in treatment-naïve autoimmune hepatitis (AIH). However, before broader implementation of MMF as first-line therapy, its long-term efficacy and tolerability in a chronic disease requiring prolonged immunosuppression remain important clinical questions. We therefore evaluated the long-term outcomes of both treatment strategies.

Methods:

Patients enrolled in the multicenter randomized CAMARO trial were retrospectively followed for up to 3 years after treatment initiation. Co-primary endpoints were continued trial-assigned treatment with normalized alanine aminotransferase (ALT) at 3 years and time to biochemical remission (BR), defined as normalization of ALT and immunoglobulin G, analyzed according to a treatment-policy estimand. Secondary outcomes included treatment discontinuation, steroid-free remission, and adverse events.

Results:

Three-year follow-up was available for 67 patients (96%; 30 AZA, 37 MMF). At 3 years, 57% of AZA-treated patients versus 76% of MMF-treated patients remained on trial-assigned treatment with normalized ALT after exclusion of one patient with primary biliary cholangitis variant syndrome (p=0.067). Median time to biochemical remission (BR) was shorter with MMF than AZA (16 vs 64 weeks; p=0.002) and remained significant after adjustment for baseline ALT and cirrhosis (HR 2.74, 95% CI 1.49–5.06; p=0.001). Among patients without ALT normalization at 24 weeks who remained on therapy, subsequent normalization rates were similar between groups (AZA 6/12 vs MMF 6/11). Treatment discontinuation occurred more frequently with AZA than MMF (39% vs 23%), with intolerance contributing to discontinuation in 67% and 44% of cases, respectively. Three-year steroid-free remission probability (64%, 95% CI 40–78 vs 66%, 95% CI 47–79), loss of response (20% vs 26%), and adverse event rates were comparable between AZA- and MMF-treated patients throughout follow-up.

Conclusion:

MMF was associated with faster biochemical remission and numerically higher rates of continued trial-assigned treatment with normalized ALT at 3 years compared with AZA, without a clear safety disadvantage. Among patients who remained on therapy after the trial phase, long-term efficacy and safety were comparable between treatments. These findings suggest that the early advantages of MMF are maintained over time and support MMF as a first-line treatment strategy in treatment-naïve AIH.

ABSTRACT #106

Prognostic significance of subclassifying clinical T3 category in rectal cancer: a Dutch nationwide cohort with standardised MRI re-assessment

J.E.E.A. Drs. Guicherit[1] , T.C. Sluckin[2] , S.J.A. Hazen[2] , J.W.T. Dekker[3] , C.S.E.W. Schuurhuizen , M.P.W. Intven[4] , J. Nederend[5] , M. Maas[6] , M.S. Dunker , J.H.W. de Wilt[7] , M.M. Lange[2] , J.B. Tuynman[2] , P.J. Tanis[1] , [1] Erasmus MC, Dept. of Gastrointestinal Surgery , [2] Amsterdam UMC, loc. VUmc , [3] Reinier de Graaf Gasthuis , [4] Universitair Medisch Centrum Utrecht , [5] Catharina Hospital Eindhoven , [6] Antoni van Leeuwenhoek Hospital , [7] Radboud University Medical Center

Background:

The independent prognostic value of cT3 subclassification, besides MRI-based features including mesorectal fascia involvement, extramural venous invasion and tumour deposits, remains controversial in primary rectal cancer staging. This population-based study aimed to evaluate the prognostic impact of cT3 subcategories.

Methods:

Patients undergoing rectal cancer resection in 2016 were identified from the Dutch ColoRectal Audit. Additional clinical data were retrospectively collected from 67 Dutch hospitals and MRIs were re-evaluated. Patients with cT3 rectal cancer were stratified by subcategory (cT3ab versus cT3cd) and neoadjuvant therapy (5x5Gy with short interval or upfront resection versus downstaging (chemo)radiotherapy). The primary outcome was 4-year cumulative locoregional recurrence.

Results:

Among 925 patients, 318 cT3ab and 73 cT3cd tumours were analysed in the no-downstaging group, and 307 cT3ab and 227 cT3cd tumours in the downstaging group. Four-year locoregional recurrence rate was 4.6% versus 9.7% without downstaging (p=0.126), and 8.4% versus 12.5% with downstaging (p=0.202). Patients with cT3cd tumours had higher rates of distant metastases and lower disease-free survival. cT3 subcategory was not an independent prognostic factor after adjustment for other MRI features, age and ASA, except for disease-free survival in the no-downstaging group.

Conclusion:

cT3 subclassification appears to have no independent prognostic value in rectal cancer.

ABSTRACT #108

One day of antibiotic treatment is non-inferior to 4-7 days in patients with acute cholangitis after adequate biliary drainage: a multi-centre randomised controlled trial (COBRA)

A.G. Overdevest[1] , E. Sieswerda , S. Haal[2] , M.G.W. Dijkgraaf[2] , K.S. Boparai , F. Ter Borg[3] , M.A. Brink[4] , F. van Delft[5] , V.K. Dik[6] , L.P.L. Gilissen[7] , M. Hadithi[8] , W.L. Hazen[9] , F. van der Heide[10] , W.J. den Hollander[11] , A. Inderson[12] , P.J. de Jonge[13] , S.D. Kuiken[14] , J.M. Munneke[15] , B. Opsteeg[16] , L. Perk[17] , E.J.G. Peters[1] , A.C. Poen[18] , J.W. Poley[19] , R. Quispel[20] , W.O.A. Rohof[14] , R.C.H. Scheffer[21] , D.W. Schölvinck[22] , E.J. van Soest[23] , A. Tan[24] , W.J. Thijs[25] , N.G. Venneman[26] , R.C. Verdonk[27] , F.P. Vleggaar[28] , W. van de Vrie[29] , J.M. Vrolijk[30] , R.L.J. van Wanrooij[1] , P.W. Weijenborg[31] , M.C.B. Wielenga[2] , R. Zoutendijk[27] , J.A. Bogaards[1] , J.M. Prins[2] , R.P. Voermans[2] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Amsterdam UMC, loc. AMC, Dept. of Gastroenterology and Hepatology, [3] Deventer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [4] Meander MC, Dept. of Gastroenterology and Hepatology, [5] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [6] Frisius MC, Dept. of Gastroenterology and Hepatology , [7] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [8] Maasstad Ziekenhuis, Dept. of Gastroenterology and Hepatology, [9] Elisabeth TweeSteden Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology, [11] Alrijne Ziekenhuis, Dept. of Gastroenterology and Hepatology, [12] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology, [13] Erasmus MC, Dept. of Gastroenterology and Hepatology , [14] OLVG Hospital, Dept. of Gastroenterology and Hepatology, [15] Flevoziekenhuis, Dept. of Gastroenterology and Hepatology , [16] Groene Hart Ziekenhuis, Dept. of Gastroenterology and Hepatology, [17] Haaglanden Medisch Centrum, Dept. of Gastroenterology and Hepatology, [18] Isala, Dept. of Gastroenterology and Hepatology, [19] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [20] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [21] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [22] Zaans Medisch Centrum, Dept. of Gastroenterology and Hepatology , [23] Spaarne Gasthuis, Dept. of Gastroenterology and Hepatology , [24] Canisius Wilhelmina Ziekenhuis, Dept. of Gastroenterology and Hepatology , [25] Martini Ziekenhuis, Dept. of Gastroenterology and Hepatology, [26] Medisch Spectrum Twente, Dept. of Gastroenterology and Hepatology, [27] Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [28] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology , [29] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology, [30] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology , [31] Dijklander Ziekenhuis, Dept. of Gastroenterology and Hepatology

Background:

International guidelines recommend 4-7 days of antibiotic treatment after adequate biliary drainage for acute cholangitis. Observational data suggest shorter treatment may be sufficient. We assessed non-inferiority of 1 versus 4-7 day(s) of antibiotics after adequate endoscopic biliary drainage in adults with acute cholangitis.

Methods:

This multicentre, open-label, randomised controlled non-inferiority trial was conducted across 31 hospitals in the Netherlands. We enrolled adults with acute cholangitis (Tokyo Guidelines 2018 criteria) due to distal biliary obstruction after adequate endoscopic biliary drainage and fever resolution within 24 hours after ERCP. Patients were randomly assigned 1:1 to receive antibiotics for 1 or 4-7 day(s) after ERCP, stratified by blood culture status and cholangitis aetiology (benign or malignant) at time of randomisation. We excluded patients with concomitant infections or immunosuppressants. The primary outcome was clinical cure, defined as the patient being symptom-free by day 14, without relapse or death occurring by day 30. Secondary outcomes included (all-cause) mortality, and antibiotic-related adverse events. Total follow-up was 90 days. Key outcomes were adjudicated by an independent blinded committee. Primary analysis followed intention-to-treat principal and we concluded non-inferiority if the one-sided 95% confidence limit for the absolute risk difference in clinical cure exceeded -7.5%. Additionally, we performed exploratory subgroup analyses.

Results:

Between 2023 and 2025, we randomized 413 patients (1-day group: n=205; 4-7-day group: n=208). Three patients (all in the 4-7-day group) were lost to follow-up and were excluded from all analyses. Median age was 74 years, 43.4% were women, 10.0% had malignant obstruction, 57.6% had moderate/severe cholangitis, and 35.6% had gram-negative bacteraemia at the time of randomisation. Protocol adherence was 93.0%. In the intention-to-treat analysis, clinical cure occurred in 195/205 patients (95.1%) in the 1-day group vs. 192/205 (93.7%) in the 4-7-day group, with an absolute risk difference of 1.5% (one-sided 95% confidence limit: -2.4%), demonstrating non-inferiority. All-cause 90-day mortality was 6/205 (2.9%) in the 1-day group vs. 3/205 (1.5%) in the 4-7-day group; cholangitis-related mortality was 2/205 (1.0%) vs. 0/205 (0%). Antibiotic-related adverse events were reported in 8.3% in the 1-day group vs. 16.6% in the 4-7-day group. Non-inferiority was maintained in the prespecified subgroup analyses for malignant obstruction and gram-negative bacteraemia.

Conclusion:

One day of antibiotics after adequate endoscopic biliary drainage is non-inferior to 4-7 days in adults with acute cholangitis.

ABSTRACT #110

Long-term outcomes after appendectomy for maintenance of remission in ulcerative colitis: Five-year results from the ACCURE randomized controlled trial.

I.D. van Dijk[1] , E. Visser[2] , G.R.A.M. D'Haens[2] , T.D. Pinkney , C.J. Buskens[2] , [1] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Surgery

Background:

The ACCURE randomized controlled trial previously demonstrated that appendectomy significantly reduced 1-year clinical relapses ulcerative colitis (UC) patients in remission not receiving advanced therapy (biologicals or small molecules), compared with standard medical therapy alone. The long-term clinical effectiveness of therapeutic appendectomy, however, remains unknown. We therefore evaluated the long-term clinical effectiveness of laparoscopic appendectomy.

Methods:

This analysis included UK and Dutch participants from the ACCURE trial, using a modified intention-to-treat approach, excluding patients with missing follow-up or Crohn's reclassification. Patients were prospectively followed for five years, with 6-monthly assessments. The primary outcome was initiation of advanced medical therapy (biologicals or small molecules). Secondary outcomes were colectomy, colorectal neoplasia and endoscopic remission at 3 years. Time-to-event outcomes were analyzed using Cox proportional hazard regression adjusted for prespecified confounders.

Results:

The follow-up cohort consisted of 184 patients. 7 patients were excluded (5 loss of follow-up; 2 reclassified to Crohn's disease). 177 were included in this long term analysis (85 appendectomy; 92 control). Baseline characteristics were similar. The appendectomy group included 55.3% females, with a mean age of 42.4 years (SD 12.3), and a median disease duration of 5.0 years (IQR 1.8-11.8). Corresponding values in the control group were 55.4% females, a mean age of 43.4 years (SD 12.9) and a median disease duration of 5.2 years (IQR 1.6-11.1). Over a median follow-up of 5 years (IQR 5-5), initiation of advanced medical therapy occurred significantly less often after appendectomy than with medical therapy alone (8.2% [7/85] vs 22.8% [21/92]; RR 0.30 [95% CI 0.12-0.76]; p=0.008). In time-to-event analyses (n=163), appendectomy was associated with a lower hazard of initiation of advanced medical therapy (HR 0.33; 95% CI, 0.14-0.79; p=0.012, adjusted HR 0.30; 95% CI, 0.13-0.73; p=0.003). No appendectomy patients required colectomy, compared with three patients (3.3%) in the control group due to therapy-refractory disease (p=0.09). Only one case of neoplasia (dysplasia) was identified, incidentally in a colectomy specimen from a patient operated for therapy-refractory disease.

Conclusion:

In this 5-year follow-up of the ACCURE-trial, appendectomy remained superior to medical therapy alone, with significantly fewer patients requiring escalation to advanced medical therapy and without increased risk of developing colorectal neoplasia. These findings support appendectomy as a durable strategy for selected patients with UC in remission.

ABSTRACT #111

High sensitivity of Next-Generation Sequencing on bile-derived cell-free DNA for mutation-based diagnosis of perihilar cholangiocarcinoma: first results from the prospective BAMBI study

E. Smit[1] , J.A. Fritzsche[1] , J.B.G. Halfwerk , R.L.J. van Wanrooij[1] , M.C.B. Wielenga[1] , Y.S. de Boer[1] , G. Kazemier[1] , T. le Large[1] , R. Lameris[1] , S.A.G.M. Cillessen[1] , M.P.M. Noë[1] , J. Verheij[1] , C.Y. Ponsioen[1] , F. Dijk[1] , R.P. Voermans[1] , [1] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology

Background:

Pathological confirmation in case of suspected perihilar cholangiocarcinoma (pCCA) is challenging. Endoscopic retrograde cholangiopancreatography (ERCP) with brush cytology has high specificity (95-100%) but limited sensitivity (41-67%), often delaying diagnosis. Liquid biopsy approaches, particularly plasma cell free DNA (cfDNA), have shown promise in oncology, but are limited in early-stage disease. Bile, in contrast, can contain up to 20-fold higher cfDNA concentrations than plasma, providing a potentially richer source of tumor-derived DNA for biliary tumors. Since bile can be collected during routine ERCP, analysis of bile-derived cfDNA may enhance diagnostic sensitivity without additional procedural burden. The primary aim of this study was to evaluate the feasibility and accuracy of Next-Generation Sequencing (NGS) on bile-derived cfDNA for mutation-based diagnosis of pCCA.

Methods:

In this prospective cohort study (2023-2025), bile samples were collected during ERCP from patients with suspected pCCA. Cell-free DNA was extracted using the QIAamp MinElute circulating cfDNA Mini Kit, and NGS was performed using the Ion Torrent (Oncomine Pan-Cancer Cell-Free assay). Final diagnosis was established by histology and/or compatible clinical follow-up. The primary endpoint was the diagnostic sensitivity of cfDNA sequencing; the secondary endpoint was the combined sensitivity of cfDNA and brush cytology.

Results:

Bile samples were obtained from 60 patients with suspected pCCA. High-quality cfDNA was successfully extracted from all samples, and NGS mutation analysis has thus far been completed in 46 patients. Among these, one or more (likely) pathogenic mutations were detected in 41 patients, yielding a sensitivity of 89%. Brush cytology was performed in 44 patients and was positive for malignancy in 34 cases (77%). Combining brush cytology with bile cfDNA, a definitive diagnosis was established in 44 patients, yielding a sensitivity of 96%.

Conclusion:

In the first results of this prospective proof-of-concept study, mutational analysis on bile-derived cfDNA was shown possible and substantially improved the detection of pCCA at the initial diagnostic stage. NGS on cfDNA in bile achieved a sensitivity of 89%. When combined with brush cytology the sensitivity even increased to 96%. Beyond improving diagnosis, identifying actionable mutations through cfDNA analysis may not only enhance detection but could also play an important role in guiding future targeted therapeutic strategies. Our next steps involve validating these findings in a dedicated benign cohort to establish diagnostic specificity and developing an optimized, pCCA-specific gene panel to further optimize diagnostic yield.

ABSTRACT #113

Peg-IFN add-on versus nucleos(t)ide analogue withdrawal in patients with chronic hepatitis B – a pooled analysis of two global cohorts (RETRACT-B and PROSPER)

E.J. Dongelmans[1] , L.A. Patmore[1] , B.E. Hansen[1] , R.A.J. Post[1] , H.L.A. Janssen[1] , M.J. Sonneveld[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

Background:
Both nucleos(t)ide analogue (NA) withdrawal and pegylated-interferon (peg-IFN) add-on are strategies to increase HBsAg loss rates in NA-treated patients. It remains unclear which strategy is superior.

Methods:
We compared HBsAg loss rates in HBeAg negative patients who stopped NA therapy with patients who received peg-IFN add-on using individual participant data from two global cohorts: (1) RETRACT-B, including patients who withdrew NA therapy and, (2) PROSPER, which studied NA-treated patients allocated to 48 weeks of peg-IFN add-on.

The primary outcome was the cumulative HBsAg loss rate at 2-years after NA-stop or start of peg-IFN add-on (Kaplan-Meier method).

Secondary outcome included ALT-flares (5≥xULN). Analyses were performed in the overall population and stratified by ethnicity. All analyses were repeated after Inverse Probability of Treatment Weighting (IPTW), adjusted for age, sex, ethnicity, type and duration of NA therapy, cirrhosis and ALT and HBsAg at baseline.

Results:
In total, 2,095 patients were included (NA-stop: n=1,772; peg-IFN add-on: n=323). Compared to NA-stop patients, peg-IFN add-on patients were younger (48 vs. 52 years, p<0.001), more often non-Asian (38 vs. 19%, p<0.001), and had higher baseline ALT (26 vs. 23, p=0.002). Baseline HBsAg (2.8 vs. 2.7 log10 IU/mL, p=0.30), and cirrhosis (8 vs. 11%, p=0.09) were similar.

At 2 years, peg-IFN add-on resulted in higher HBsAg loss rates compared to NA-stop (16 vs. 5%, p<0.001; IPTW: 13 vs. 5%, p<0.001). The superiority of peg-IFN add-on was apparent in Asians (20 vs. 3%, p<0.001; IPTW: 13 vs. 3%, p<0.001), but not in non-Asians (9 vs. 13%, p=0.37; IPTW: 8 vs. 12%, p=0.54); being consistent across HBsAg strata. Among patients with HBsAg levels <1,000 IU/mL, HBsAg loss rates were higher in peg-IFN add-on patients compared to those who stopped NA therapy in Asian (30% vs. 4.7%, p<0.001; IPTW: 20% vs. 4.8%, p<0.001), but not in non-Asian patients (19% vs. 33%, p=0.13; IPTW: 27% vs. 35%, p=0.68).

ALT-flares were more common after NA-stop (24 vs. 6%, p<0.001; IPTW: 23 vs. 5%, p<0.001), being consistent in Asian (24 vs. 7%, p<0.001; IPTW: 24 vs. 5%, p<0.001) and non-Asian patients (22 vs. 7%, p<0.001, IPTW: 21 vs. 3%, p=0.016). ALT-flares following NA withdrawal occurred later than those after peg-IFN add-on (median time: 25 [12-47] vs. 12 [8-24] weeks, p=0.008; IPTW: 25 [12-47] vs. 12 [8-33] weeks, p=0.061).

Conclusion:
Peg-IFN add-on resulted in higher HBsAg loss rates compared to NA withdrawal in Asians, while responses were similar in non-Asians. These findings may inform personalised decision-making on the optimal strategy to increase HBsAg loss rates in NA-treated patients.

ABSTRACT #114

Unraveling variability in infliximab clearance in pediatric Crohn's disease: a novel approach using serum inflammatory immune proteins

A. Camman[1] , S.A. Vuijk[1] , B. Calado[1] , Q.Z. Zhao[2] , M.M.E. Jongsma[1] , R. Colman , J.N. Samsom[1] , L. de Ridder , T. Preijers[2] , [1] Erasmus MC, Sophia Kinderziekenhuis, Dept. of Pediatric Gastroenterology Hepatology and Nutrition, [2] Erasmus MC, Dept. of Clinical Pharmacy

Background:

Adequate infliximab trough levels are associated with improved clinical outcomes in paediatric Crohn's disease (CD), an immune-driven condition. However, achieving optimal anti-TNF trough levels can be challenging. Although clinical parameters explain part of the variability in infliximab clearance, treatment failure remains common and is most often associated with low trough levels. We investigated whether serum inflammatory immune protein concentrations contribute to the inter-individual variability in infliximab clearance in pediatric CD.

Methods:

In this ancillary study of the multicentre, open-label randomised controlled TISKids trial, children with newly diagnosed, untreated moderate-to-severe CD who received first-line infliximab were included. Serum protein concentrations were determined using Proximity Extension Assay at week 0, 10/14, and week 22, and infliximab trough levels were determined at week 6, 14, and 22. The published population PK model by Colman et al. was adapted to conduct a stepwise covariate analysis evaluating the effect of 73 serum inflammatory immune protein concentrations on inter-individual infliximab clearance in longitudinal analyses.

Results:

Forty-eight patients (120 infliximab trough levels and 133 serum inflammatory immune protein measurements) were included. Concentrations of 31/73 immune proteins were significantly reduced at week 22 versus baseline in patients with adequate infliximab trough at week 22, compared to only 19/73 in patients with inadequate trough. Tumour Necrosis Factor Receptor Superfamily Member 9 (TNFRSF9/CD137) was the only protein significantly associated with infliximab clearance, with lower concentrations (5.861 NPX) linked to a 30.5% reduction in clearance (relative to the calculated reference subject, 7.776 NPX). After accounting for clinical parameters, TNFRSF9 explained 4.7% of the remaining interindividual variability (26.4%).

Conclusion:

Serum TNFRSF9 concentrations, in addition to clinical characteristics, explain part of the variability in infliximab clearance in moderate-to-severe paediatric CD.

ABSTRACT #118

When is pancreatic cancer surveillance efficient? A microsimulation study of test characteristics and lifetime risk

O. White[1] , I. Lansdorp-Vogelaar[1] , D. Cahen[1] , M.L.J.A. Sprij[1] , K. Overbeek[1] , G. Fuhler[1] , M.J. Bruno[1] , M. Peppelenbosch[1] , I.M.C.M. de Kok[1] , [1] Erasmus MC, Dept. of Public Health

Background:

Pancreatic Cancer (PC) is frequently detected in advanced stages and as a result has a dismal survival rate. Surveillance of high-risk individuals (HRIs) offers the opportunity to detect high-grade dysplasia (HGD) or early-stage cancers that remain surgically curable. New surveillance tests (e.g. biomarkers and AI) are under development since current test characteristics still lack satisfactory accuracy to identify PC at early stages. However, the test characteristics required for effective surveillance are unclear. We aimed to quantify the impact of sensitivity and specificity for various lifetime PC risk (LR) cohorts on surveillance yield.

Methods:

We used an established microsimulation model (MISCAN-pancreas) to simulate cohorts undergoing annual imaging from ages 40–75, with LRs ranging from 1.5% to 20.3%. Sensitivity and specificity for HGD were varied from 0–100%. Outcomes included life-years gained (LYG) per 1,000 individuals and the number of surgeries needed to treat (NNT) to prevent one PC death. We developed interactive contour plots that show the outcomes in the sensitivity-specificity parameter space.

Results:

Across nearly 8,000 simulations, specificity was the dominant determinant of both LYG and NNT. For LRs <10%, positive LYG required specificity >90%; below this threshold, false-positive resections produced up to 700 life-years lost and a NNT >230. Sensitivity influenced outcomes only once LR exceeded 12.2% and specificity >90%. In high-risk cohorts (LR ≥ 12.2%), even tests with 0% sensitivity and specificity improved LYG, with perfect-test scenarios yielding up to 2,030 LYG in the highest LR cohort, and NNT <5 across wide regions of the parameter space. Additional tests required very high specificity (≥95%) to maintain favourable LYG and NNT in low-risk cohorts, whereas high-risk groups also benefited from sensitivity-driven improvements. Sensitivity analyses showed that surgical mortality was the most influential factor in determining surveillance benefit.

Conclusion:

In conclusion, pancreatic surveillance efficiency is strongly dependent on test specificity in all cohorts, while high-risk groups additionally require improved sensitivity to optimize benefit and efficiency. Current tests are not sufficiently accurate to offer benefit in cohorts with a lifetime risk ≤10%.

ABSTRACT #119

Anti-HDV reflex testing among HBsAg positive individuals in the Netherlands

E. Fath el Bab[1] , A.A. van der Eijk[1] , L.A. Patmore[1] , J.J.C. Voermans[1] , T.J.W. van der Laar[2] , H.L. Zaaijer , A. Riezebos-Brilman , H.L.A. Janssen[1] , K.T.D. Thai , M.J. Sonneveld[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] OLVG Hospital, Dept. of Medical Microbiology

Background:

Hepatitis delta virus (HDV) is the most severe form of viral hepatitis and carries a high risk of liver-related complications. Universal anti-HDV reflex testing in all HBsAg positive individuals is recommended according to the EASL guidelines. Nevertheless, HDV remains underdiagnosed, primarily due to limited awareness. This study aims to access the diagnostic yield of reflex anti-HDV testing in HBsAg positive samples obtained from blood donor screening, general practice and a tertiary hospital in the Netherlands.

Methods:

Anti-HDV reflex testing was conducted in HBsAg positive samples collected in 2024-2025 from laboratories serving general practice (general practitioners and maternity care (n=249)), the laboratory responsible for Dutch blood donor screening (n=218) and a virology laboratory of a tertiary hospital in the Netherlands (n=283). Anti-HDV positive samples were subsequently tested for HDV RNA. Positive results were communicated to the primary caregiver and appropriate linkage to care was established.

Results:

Reflex testing was successfully conducted in 99.3% (n=745) of 750 HBsAg positive individuals in the study period. Among these, 244 (32.8%) originated from general practice, 218 (29.3%) from blood donor screening and 283 (38.0%) from the hospital. The overall prevalence of anti-HDV was 6.7% (n=50), with a prevalence of 4.1% in general practice (n=10), 2.3% in blood donor screening (n=5) and 12.4% in the hospital (n=35). HDV RNA testing was performed in all anti-HDV positive samples. HDV RNA was detectable in 54.0% (n=27), including 6 cases (60%) from general practice, 1 (20%) through blood donor screening and 20 (57.1%) from the hospital. The median qHDV RNA among hospital patients was 2.42E6 IU/mL (IQR 1.94E4 - 2.75E7 IU/mL), with 13 patients (72.2%) showing ALT>40 U/L. HDV RNA was detectable in 2.5% of HBsAg positive samples obtained from general practitioners, in 0.5% of samples obtained from blood donors and in 7.1% of hospital samples.

Conclusion:

Reflex anti-HDV testing in both primary and secondary care settings in the Netherlands proved feasible and effective. The high prevalence in samples obtained from general practitioners suggests that universal screening for HDV is warranted in HBsAg positive individuals.

ABSTRACT #122

Variation in clinical practice for hospitalized ulcerative colitis patients – a survey study among gastroenterologists in The Netherlands and Belgium

M. Koningen , M.R. Naber , A. Bodelier[1] , P. Bossuyt , M. Löwenberg[2] , F.D.M. van Schaik[3] , [1] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [2] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology , [3] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology

Background:

Acute severe ulcerative colitis (ASUC) is a well-defined condition traditionally guided by the Truelove and Witts criteria. The expansion of therapeutic options for ulcerative colitis (UC) has improved outpatient management of moderately to severely active UC. If hospitalization is required, these patients often present without systemic symptoms, in contrast to ASUC. This subgroup of patients with non-acute severe UC (NSUC) is poorly defined and lacks a clear management strategy. This study aimed to assess variability in treatment strategies for ASUC and NSUC patients among gastroenterologists.

Methods:

A survey was developed to assess variability in diagnostic and therapeutic management of hospitalized UC patients. The survey was pilot tested among four IBD specialists before distribution via email to gastroenterologists in the Netherlands and Belgium. Questions addressed diagnostics and general management, and two case vignettes representing a typical ASUC patient and an NSUC patient with prior exposure to several treatment modalities and steroid non-response. The primary outcome was the variation in treatment sequences between the ASUC and NSUC case.

Results:

In total, 78 gastroenterologists responded to the survey (response rate: 22.3%, 51/128 Dutch, 27/221 Belgian), self-identified as IBD-specialists (46%) or gastroenterologists with IBD interest (47%), and most worked in non-academic hospitals (71%). In total, 58 gastroenterologists (74%) reported managing ASUC and NSUC patients differently. In the ASUC case vignette, two in-hospital treatment strategies were observed. Twothirds of gastroenterologists (65%) opted for intravenous (IV) corticosteroids (59/74) as first-line treatment, followed by infliximab (55/59), and a second rescue therapy with a JAK inhibitor (29/55) or referral for colectomy (18/55). A smaller group (11%) preferred to start upfront with infliximab (14/74), then opted for a JAK inhibitor (9/14), after which patients were referred for colectomy (8/9). In the NSUC case vignette, treatment strategies were more heterogenous (IV corticosteroids 38%, JAK inhibitor 26%, ustekinumab intensification 14%, vedolizumab and IV corticosteroids 11%). Rescue therapy most frequently consisted of a JAK inhibitor (34/49), while 15% (11/75) of gastroenterologists opted for colectomy.

Conclusion:

This survey study among Dutch and Belgian gastroenterologists demonstrates that medical treatment sequences of typical ASUC patients are relatively consistent. In contrast, NSUC patients are managed with considerable variability. These findings highlight an unmet need for clearer definitions of NSUC patients and structured treatment strategies for this emerging patient population.

ABSTRACT #123

Early CT-derived body composition parameters and severe acute pancreatitis: a multicentre cohort study

A. Nagelhout[1] , L.A.W.J. VanderBroeck[2] , N.D. Hildebrand[2] , D.P.J. van Dijk[2] , I.A.M. van den Bogart[3] , R.C. Verdonk[3] , H.C. van Santvoort[3,4] , T.H.E. Römkens[5] , R. Quispel[6] , T. Verlaan[7] , M.A. Brink[8] , A.C.I.T.L. Tan[9] , R.P. Voermans[10] , T. Seerden[11] , P. van Duijvendijk[12] , J.M. Jansen[13] , L.M. Kager[14] , S.S. Rensen[2] , H. Van Goor[1] , M.G. Besselink[10] , S.W.M. Olde Damink[2] , M.W.J. Stommel[1] , S.A.W. Bouwense[2] , [1] Radboud University Medical Center, Dept. of Surgery , [2] Maastricht Universitair Medisch Centrum, Dept. of Surgery , [3] St. Antonius Ziekenhuis, Dept. of Research & Development , [4] Universitair Medisch Centrum Utrecht, Dept. of Surgery , [5] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [6] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [7] Ziekenhuis Gelderse Vallei, Dept. of Gastroenterology and Hepatology , [8] Meander MC, Dept. of Gastroenterology and Hepatology , [9] Canisius Wilhelmina Ziekenhuis, Dept. of Gastroenterology and Hepatology , [10] Amsterdam UMC, loc. AMC, Dept. of Gastroenterology and Hepatology , [11] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [12] Gelre Ziekenhuizen, Dept. of Surgery , [13] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [14] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology

Background:

Acute pancreatitis is a common gastrointestinal disorder, with approximately 20% of patients developing severe acute pancreatitis (SAP), characterized by persistent organ failure and substantial mortality. Early risk stratification remains challenging, as conventional clinical and biochemical scores mainly reflect acute physiological derangements rather than underlying patient vulnerability. Body composition derived from routine CT scans, including skeletal muscle mass, radiodensity, and adipose tissue distribution, may influence disease severity through their interaction with systemic inflammation. However, previous studies in AP have rarely focused on early imaging or standardized body composition measurements. We therefore aimed to evaluate the association between early CT-derived body composition parameters and the development of SAP.

Methods:

We performed a retrospective analysis of adult patients with a first episode of acute pancreatitis from a nationwide Dutch cohort (2006–2024) who presented within 72 hours of symptom onset and had an early abdominal CT scan. Skeletal muscle and adipose tissue quantity and density were measured at the level of the third lumbar vertebra (L3) and converted into sex-specific Z-scores. SAP was defined according to the Revised Atlanta Classification. Associations between body composition parameters and SAP were analysed using multivariable logistic regression adjusted for age, sex, and relevant clinical covariates.

Results:

In total, 262 patients with early CT imaging were included, of whom 17% developed SAP. Compared with patients with mild or moderately severe AP, patients with SAP had lower skeletal muscle index, lower subcutaneous adipose tissue density, and more frequently had pre-existing renal comorbidity. In multivariable analysis, higher skeletal muscle index, higher visceral adipose tissue attenuation, and lower skeletal muscle density were independently associated with SAP, along with renal comorbidity. Secondary analysis of skeletal muscle phenotypes showed that patients with high muscle mass but low density had the highest risk of SAP.

Conclusion:

Higher skeletal muscle index, higher visceral adipose tissue attenuation, and lower skeletal muscle density were independently associated with severe acute pancreatitis. These CT-derived alterations may identify a vulnerable patient subgroup with an enhanced systemic inflammatory response, although inflammatory edema may also contribute. Early CT-based body composition assessment may support identification of patients at increased risk of severe disease and aid early clinical decision-making.

ABSTRACT #124

From operating room to pathology report: Delphi consensus on assessing peritoneal cytology and biopsies in gastric cancer staging

J. Quik[1] , M.J. de Neijs[2] , N.A.D. Guchelaar[2] , J.E. Freund[3] , L.A.A. Brosens[3] , L. Oudijk[4,2] , M.L.F. van Velthuysen[2] , M. Doukas[2] , P. Snaebjornsson[1] , H. Grabsch[5] , A. Klooster , N. Doddema[2] , K. van den Burg[1] , B.P.L. Wijnhoven[2] , J.W. van Sandick[1] , S.L. Meijer[6] , L.L. Kodach[1] , [1] Antoni van Leeuwenhoek Hospital, Dept. of Surgery, [2] Erasmus MC, Dept. of Surgery, [3] Universitair Medisch Centrum Utrecht, [4] Maasstad Ziekenhuis, [5] Maastricht Universitair Medisch Centrum, [6] Amsterdam University Medical Center

Background:

Staging laparoscopy with peritoneal cytology and biopsies is recommended in the diagnostic work-up of patients with potentially resectable gastric cancer. However, (cyto)pathology workflows remain poorly standardised. We aimed to develop consensus-based recommendations for the cytological and histological assessment of peritoneal fluid and biopsies obtained during staging laparoscopy.

Methods:

A modified Delphi study was conducted among Dutch experts in gastric cancer (cyto)pathology. In Round 1, 62 statements on specimen handling, microscopic assessment, biomarker testing and reporting were rated (agree/neutral/disagree); consensus was predefined as ≥80% agreement. Statements not reaching consensus were discussed during an online meeting and revised. In Round 2, all statements were re-rated (agree/disagree) with a ≥70% agreement threshold. Descriptive analyses informed the development of structured reporting templates.

Results:

Thirty-one experts from university, general, and independent pathology practices participated. In Round 1, 39/62 statements (63%) reached consensus; this increased to 58/62 (94%) in Round 2. Consensus was achieved on required clinical information, specimen submission, lavage volumes and storage/fixation conditions. Experts agreed on standard initial cytological and histological techniques, indications and panels for ancillary immunohistochemistry, criteria for PD-L1 testing and pragmatic guidance for mismatch repair (MMR) and HER2 assessment on peritoneal biopsies, and structured diagnostic categories for reporting.

Conclusion:

This Delphi study achieved broad expert consensus on (cyto)pathology workflows for staging laparoscopy in gastric cancer patients. The resulting recommendations and reporting templates provide a structured framework for the specimen handling, assessment of peritoneal fluid and biopsies, supporting greater standardisation and consistency in gastric cancer staging.

ABSTRACT #125

The frequency of diagnostic-only ERCP in patients with clinically suspected cholangitis due to choledocholithiasis – a retrospective cohort study

J. Frenken[1,2] , E.H. Van Helden[3,1] , W.J. Lammers[4] , M.P.G.F. Anten[1] , J.G.P. Reijnders[2] , [1] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Dept. of Gastroenterology and Hepatology , [3] Admiraal de Ruyter Ziekenhuis, Dept. of Gastroenterology and Hepatology , [4] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

Background:

ERCP is the primary therapeutic intervention for cholangitis due to choledocholithiasis. In some cases, no stones are identified during the procedure. These diagnostic-only ERCPs unnecessarily expose patients to procedural risks. Variation in diagnostic criteria for cholangitis and pre-procedural imaging may contribute to this. This study aimed to determine the frequency of negative ERCPs in patients with clinically suspected cholangitis due to choledocholithiasis and to evaluate the performance of clinical scores of acute cholangitis such as Tokyo Guidelines 2018 to predict presence of choledocholithiasis.

Methods:

A single-centre, retrospective observational cohort study was conducted, including patients who were clinically diagnosed with cholangitis due to suspected choledocholithiasis and underwent ERCP between 2017 and 2025. Patients with prior ERCP with sphincterotomy or hepatopancreatobiliary malignancies were excluded. Patient characteristics, laboratory values, imaging findings and procedural ERCP results were extracted from electronic medical records.

Results:

Of 219 included patients, 210 (96%) underwent ERCP with successful CBD cannulation. In 45 (21%) of 210 patients no choledocholithiasis was detected. ERCP-related adverse events occurred in 50 (23%) of 219 patients, including 15 (33%) of 45 patients with a diagnostic-only ERCP. TG18 criteria demonstrated a sensitivity and specificity for the presence of choledocholithiasis of 97% and 12%, respectively. 38 (20%) of 190 patients diagnosed with acute cholangitis according to TG18, underwent a diagnostic-only ERCP. Charcot's triad and BILE criteria did nog perform better. In case of stone visualization prior to ERCP, the rate of diagnostic-only ERCP decreased to 0-8%, depending on the imaging modality.

Conclusion:

A substantial proportion of patients with suspected cholangitis undergo unnecessary ERCP, exposing them to procedural risks without providing any therapeutic benefit. In contrast to current guidelines, use of pre-procedural imaging in patients with suspected cholangitis to confirm the presence of choledocholithiasis will likely reduce the rate of diagnostic-only ERCPs.

ABSTRACT #126

Effectiveness and safety of Ustekinumab and Filgotinib in ulcerative colitis: Comparative analysis from the Dutch ICC Registry

M.R. Naber , Z. Mujagic[1] , M. Pierik[1] , L.M.M. Verleye[1] , D.G. Bouwknegt[2] , M.C. Visschedijk[2] , A.E. van der Meulen[3] , R.L. West[4] , M. Duijvestein[5] , A.A. van Bodegraven[6] , A. Bodelier[7] , S. van der Marel[8] , A.C. de Vries[9] , B. Oldenburg[10] , M. Löwenberg[11] , F.D.M. van Schaik[10] , [1] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [2] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [4] Franciscus Gasthuis & Vlietland, Dept. of Gastroenterology and Hepatology , [5] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [6] Zuyderland Medical Centre, Dept. of Gastroenterology and Hepatology , [7] Amphia Hospital, Dept. of Gastroenterology and Hepatology , [8] Haaglanden Medisch Centrum, Dept. of Gastroenterology and Hepatology , [9] Erasmus MC, Dept. of Gastroenterology and Hepatology , [10] University Medical Center Utrecht, Dept. of Gastroenterology and Hepatology , [11] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology

Background:

Ustekinumab (UST) and Filgotinib (FIL) are approved for the treatment of ulcerative colitis (UC). These agents are generally prescribed following failure of conventional immunomodulators and/or tumour necrosis factor (TNF) antagonists. Positioning of these agents is hampered by the lack of head-to-head trials. Therefore, comparative data derived from real-world cohorts are needed to guide treatment selection. The aim of this study was to compare effectiveness and safety of UST and FIL in a prospective cohort.

Methods:

Adult (≥18 years) UC patients initiating UST or FIL treatment in routine care were enrolled in the Initiative on Crohn and Colitis (ICC) registry. Patients with prior surgery or previous exposure to interleukin 12/23 or Janus kinase inhibitors were excluded. The primary outcome was corticosteroid-free clinical remission (CSFCR; Simple Clinical Colitis Activity Index [SCCAI] ≤2 without corticosteroid use) at week 52. Secondary outcomes included biochemical remission (C-reactive protein [CRP] ≤5 mg/L and/or faecal calprotectin [FC] ≤250 g/g) at 52 weeks, treatment persistence and frequency of adverse events (incidence rate ratio's [IRR]). Inverse probability of treatment weighting (IPTW) was applied to account for baseline differences.

Results:

In total, 155 patients (UST n=85; FIL n=70) were included. Baseline characteristics regarding age, disease duration, disease extent, SCCAI score and corticosteroid use were comparable between the two groups. UST-treated patients were exposed to more previous therapies with different mechanisms of action (p=0.031) and were more often aTNF exposed (92% vs 79%, p=0.019). A total of 144 patients (UST n=77; FIL n=67) had baseline disease activity and were included in effectiveness analyses. CSFCR rates at week 52 were 43.3% (95%CI 31.6-55.9) and 50.0% (95%CI 37.3-62.7) for UST and FIL, respectively. Corresponding biochemical remission rates were 34.7% (95%CI 22.9-48.7) and 41.5% (95%CI 29.3-54.9). No significant differences in clinical and biochemical remission rates were observed in unadjusted and IPTW-adjusted analyses. Treatment persistence at 52 weeks was 76.3% (95%CI 0.67-0.86) and 57.1% (95%CI 0.58-0.81) for UST and FIL, respectively, with no difference after weighting (p=0.127). FIL was associated with a higher rate of non-infectious events (IRR 1.64, p=0.048).

Conclusion:

In this real-world prospective cohort study, we observed similar clinical and biochemical effectiveness up to 52 weeks after treatment initiation with UST or FIL in UC patients. This effect was observed despite greater prior treatment exposure in the UST group. FIL treatment was associated with a higher rate of non-infectious adverse events compared with UST.

ABSTRACT #127

Virtual reality as a means of distraction during esophagogastroduodenoscopy: a feasibility study

C.S. Spijkerboer[1] , P.A. Van Riet[2] , J. Honing[1] , M.C.W. Spaander[1] , [1] Erasmus MC, Dept. of Gastroenterology and Hepatology , [2] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology

Background:

Virtual reality (VR) is increasingly used to reduce anxiety and pain in medical settings. Its use during esophagogastroduodenoscopy (EGD) may reduce sedative administration (SA) and resource use. Evidence for VR during EGD is limited. This pilot study assesses the feasibility of VR (audio-visual) in unsedated patients undergoing EGD.

Methods:

Patients ≥18 years undergoing unsedated diagnostic or surveillance EGD were approached. EGDs were performed by gastroenterologists and last-year residents in specialist training. Feasibility was evaluated using patient and staff satisfaction (Net Promoter Score (NPS), 1-10 scale), willingness to participate, procedure time, and technical success of EGD and VR. SA use (dose and indication) and discomfort (modified Gloucester Comfort Scale (mGCS), 1-5 scale) were recorded. Patients selected VR content pre-procedural with a local researcher, which started shortly before scope insertion.

Results:

Of 49 approached patients, 24 agreed to participate (49%). Main reasons for participation were interest in research (46%) and VR (29%), and interest in alternatives for SA (13%) or the wish to use less medication (8%). Non-participants mainly declined because they experienced too much anxiety requiring sedation (54%), followed by no need for distraction (15%). Median age was 60 years (IQR 50–77), 63% was male, and the majority of patients had had a prior EGD (58%). In total,16 diagnostic and 8 surveillance procedures were performed with a median procedure time of 9 minutes (6–10), and a mean discomfort score of 2.0 (SD 0.9). Technical success was 100% for EGD and 88% for VR (3 failures occurred due to connectivity issues). No SA as rescue medication was used. Satisfaction was high, with median (IQR) NPS scores of 8 (7–9) among patients and nurses, and 9 (8–9) among endoscopists. Patients reported effective distraction, and staff reported no workflow disruption.

Conclusion:

VR use during unsedated EGD is feasible, with high satisfaction across staff and patients, and without the need for rescue SA. Further research is necessary to evaluate barriers and facilitators for implementation.

ABSTRACT #128

Risk of relapse after cessation of anti-TNF therapy in ulcerative colitis in corticosteroid-free clinical remission: an individual participant data meta-analysis (IPD-MA) on 654 patients from 8 studies

M.J.C. Devillers[1] , J.S. Staal[2] , T. Hackmann[3] , S. Ten Bokkel-Huinink[4] , K. Farkas , P. Molander , G. Fiorino , M.J. Casanova , S.N. Hong , B. Oldenburg[5] , R. Mahmoud[5] , N. Dussias , J.P. Gisbert , M. Chaparro , E.W. Steyerberg[3] , A.C. de Vries[4] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Erasmus MC, Sophia Kinderziekenhuis, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum , [4] Erasmus MC , [5] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology

Background:

Side effects, patient preference, and high costs may prompt cessation of anti-TNF in ulcerative colitis (UC) patients in sustained remission. Given the risk of relapse, careful patient selection is essential. This study aimed to assess relapse rates and identify predictors of relapse following anti-TNF cessation in UC patients in remission.

Methods:

A systematic search on cohort studies reporting relapse rates after cessation of anti-TNF in ≥30 UC patients in clinical remission was performed 6 September 2024. We excluded patients with steroid use, ≤6 months anti-TNF therapy, ≤16 years, previous colectomy, golimumab as anti-TNF or without follow-up. Continuation of treatment with immunomodulators or mesalamine was allowed. A relapse was defined as the need to (re)start treatment with steroids, advanced therapies, or the need for surgical treatment, as applied by the original author. Pooled relapse rates were computed using a random-effects model. A prediction model was built with a Cox proportional hazards model, performance assessed by iteratively leaving one study out (internal-external cross-validation). Missing covariate data was multiply imputed 100 times using the MICE algorithm. Variable selection was guided by three criteria: ≤20% missing data, a univariate p-value ≤ 0.2, and input from clinical experts.

Results:

In total, 654 patients from 8 studies were included in the individual patient data meta-analysis. At anti-TNF cessation, median age was 40 years (IQR 31-51) with a median anti-TNF treatment of 18 months (IQR 18-36). Most patients were treated with infliximab (n = 610, 93%). 42 patients (9%) received a second-line anti-TNF therapy. The pooled relapse rate were 24% [95% CI 19-29%, I^2 = 44%] and 34% [95% CI 29-40%, I^2 = 39] at 1 and 2 years after cessation. In our model, thiopurine therapy and older age at cessation were associated with a reduced risk of relapse, whereas immunomodulator refractoriness as indication for starting anti-TNF was associated with an increased risk. Other factors included in the model were disease extent, type of anti-TNF, history of anti-TNF, fecal calprotectin level and endoscopic activity, leading to a c statistic of 0.55 [95% CI 0.51-0.59].

Conclusion:

Approximately 1 in 4 patients experience a relapse of UC within 1 year after anti-TNF cessation, increasing to 1 in 3 within 2 years. A prediction model for relapse was built in this large IPD meta-analysis cohort and may aid in shared decision-making on anti-TNF cessation. However, its limited discriminative ability underscores the need for refinement, incorporating data on microscopic remission and emerging molecular and immunological markers to better capture deeper disease control.

ABSTRACT #130

Fatigue-associated epigenetic and transcriptional patterns differ by disease subtype and activity state in inflammatory bowel disease patients

F. Mol[1] , P.I. Metselaar[1] , R. Weiss[1] , M.J. van der Hoff[2] , O. Welting[1] , W.J. de Jonge[1] , A.A. te Velde[1] , M. Löwenberg[2] , A.Y.F. Li Yim[1] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research, [2] Amsterdam UMC, loc. VUmc, Dept. of Gastroenterology and Hepatology

Background:

Fatigue is a prevalent and disabling symptom inflammatory bowel disease (IBD), yet its underlying biological mechanisms remain poorly understood. We aimed to characterize fatigue-associated molecular signatures in IBD patients and healthy controls by integrating DNA methylation and mRNA expression analyses.

Methods:

In this exploratory multi-omics study, peripheral blood was collected from 40 patients with Crohn's disease (CD), 29 with ulcerative colitis (UC), and 10 healthy controls. Fatigue severity was assessed using the Multidimensional Fatigue Inventory and analyzed as a continuous variable. Epigenome-wide DNA methylation profiling and mRNA sequencing were performed. Differentially methylated regions (DMRs) and differentially expressed genes (DEGs) were identified for healthy controls, active and quiescent CD and UC, adjusting for age, sex, and smoking status. Pathway enrichment was performed using KEGG-based gene set enrichment analysis for DEGs and overrepresentation analysis for DMRs. Genes with both differential methylation and expression were used to identify relevant pathways.

Results:

Fatigue severity in active CD was associated with transcriptional suppression of immune and metabolic pathways, whereas in quiescent CD fatigue was characterized by transcriptional upregulation of mitochondrial and metabolic processes. In active UC, fatigue was linked to transcriptional activation of anabolic pathways alongside epigenetic silencing of neuroactive ligand-receptor pathways, while quiescent UC showed limited epigenetic alterations. In healthy controls, higher fatigue was associated with transcriptional suppression of metabolic pathways, including oxidative phosphorylation and ribosome biogenesis, alongside epigenetic silencing of neuroactive ligand-receptor loci. Fatigue-associated DMRs and DEGs were largely distinct across disease type and activity state, with minimal overlap across the five comparison groups, though neuroactive ligand-receptor silencing emerged as a recurrent epigenetic theme.

Conclusion:

Fatigue-associated DNA methylation and mRNA expression profiles differed substantially by disease subtype and activity state, manifesting in a context-dependent manner that involved immune, metabolic, and neuroimmune pathways. Partial convergence in epigenetic patterning, particularly silencing of neuromodulatory pathways, was observed across disease contexts, suggesting shared upstream mechanisms alongside group-specific transcriptional programs. These findings highlight the biological heterogeneity of fatigue and support multi-omics approaches to identify potential biomarkers and therapeutic targets.

ABSTRACT #131

The utility of biochemical non-invasive tests for fibrosis as compared to liver stiffness measurements in the population with Primary Biliary Cholangitis

E. Werner[1] , T.D. Blom[1] , G.H.X. Weijsters[1] , M.M.F. Vos[1] , M.C.B. van Hooff[1] , R.C. de Veer[1] , U.H.W. Beuers[2] , J.P.H. Drenth[2] , F.J.C. Cuperus[3] , R. van Dijk[4] , B.J. Veldt[5] , M. Klemt-Kropp[6] , S. van Meer[7] , R.C. Verdonk[8] , H.J. Flink[9] , J.M. Vrolijk[10] , C.Y. Ponsioen[2] , M. Kramer[11] , J. van Kemenade[12] , E.M.M. Kuiper[13] , M. Beukema[14] , K. Boonstra[15] , F. Boersma[16] , E.S. de Vries[17] , H.J.M. de Jonge[18] , F.H.J. Wolfhagen[19] , L.C. Baak[20] , S.L. Onderwater[21] , H.L.A. Janssen[1] , B.E. Hansen[1] , A.J. van der Meer[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology , [4] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [5] Reinier de Graaf Gasthuis, Dept. of Gastroenterology and Hepatology , [6] Noordwest Ziekenhuisgroep, Dept. of Gastroenterology and Hepatology , [7] Universitair Medisch Centrum Utrecht, Dept. of Gastroenterology and Hepatology , [8] St. Antonius Ziekenhuis, Dept. of Gastroenterology and Hepatology , [9] Catharina Hospital Eindhoven, Dept. of Gastroenterology and Hepatology , [10] Rijnstate Ziekenhuis, Dept. of Gastroenterology and Hepatology , [11] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [12] Van Weel Bethesda Dirksland, Dept. of Gastroenterology and Hepatology , [13] Maasstad Ziekenhuis, Dept. of Gastroenterology and Hepatology , [14] Streekziekenhuis Koningin Beatrix, Dept. of Gastroenterology and Hepatology , [15] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology , [16] Gelre Ziekenhuizen, Dept. of Gastroenterology and Hepatology , [17] Isala, Dept. of Gastroenterology and Hepatology , [18] Jeroen Bosch Ziekenhuis, Dept. of Gastroenterology and Hepatology , [19] Albert Schweitzer Ziekenhuis, Dept. of Gastroenterology and Hepatology , [20] OLVG Hospital, Dept. of Gastroenterology and Hepatology , [21] Diakonessenhuis Utrecht, Dept. of Gastroenterology and Hepatology

Background:

Biochemistry is used to evaluate therapeutic management in people with primary biliary cholangitis (PBC). While liver stiffness measurement (LSM) is considered a non-invasive staging parameter with added prognostic value, its availability varies. We aimed to assess the biochemical non-invasive tests (NITs) for fibrosis as compared to LSM, also for their relation to clinical outcome.

Methods:

The retrospective Dutch PBC Cohort includes every identifiable individual with PBC in the Netherlands from 1990 up to last data collection (2019-2023) in all 71 Dutch hospitals. These analyses include UDCA-treated individuals with ≥1 LSM during follow-up (FU) and available FIB-4 (based on age, AST, ALT and platelets) and APRI (based on AST and platelets) within three months. In survival analyses on liver transplantation (LT)-free survival or liver disease progression (LDP; decompensated cirrhosis, LT or liver-related death) the first LSM was defined as index date. LSM, FIB4 and APRI were log transformed. A LSM ≥10kPa was considered advanced disease.

Results:

In total, 728 people were included; 648 (89%) were female and median age was 59 years (IQR 51–67). First LSM was available after a median FU of 5.2 years (IQR 1.1-10.5). Median LSM was 6.9 kPa (IQR 5.3–10.0), with 184 (25.3%) having a LSM≥10 kPa. Median FIB-4 was 1.3 (IQR 0.97–1.8) and median APRI was 0.4 (IQR 0.3–0.7). The LSM correlated weakly with APRI (r=0.4, p<0.01) and FIB-4 (r=0.4, p<0.01). At a FIB-4 cutoff of 3.25, specificity for LSM≥10 was 97.9% and the sensitivity was 23.4%. At an APRI cutoff of 0.54, specificity was 77.8% and the sensitivity was 38.6%. Median FU after the index LSM was 2.7 years (IQR 1.1–4.5). Univariately, LSM (HR 3.0, 95%CI 2.1–4.3), FIB-4 (HR 3.7, 95%CI 2.6–5.2) and APRI (HR 2.2, 95%CI 1.6-2.9) were associated with LT/death, all p<0.01. The corresponding C-statistics were 0.72 for LSM, 0.77 for FIB-4 (p=0.352 vs LSM), and 0.69 for APRI (p=0.474 vs LSM). When combined, the FIB-4 (aHR 2.9, 95%CI 1.9–4.3) and LSM (aHR 1.9, 95%CI 1.2–2.9) remained associated with LT/death, as was the case for APRI (aHR 1.6, 95%CI 1.2–2.3) and LSM (aHR 2.5, 95%CI 1.7–3.7), all p<0.01. Addition of LSM to each NIT improved the C-statistic (0.78 for LSM and FIB-4 and 0.73 for LSM and APRI, p <0.01). Results were consistent in people aged 35-65 years and when looking to LDP, though effect sizes were more pronounced (all C-stat >0.80).

Conclusion:

Both FIB4 and APRI showed good prognostic discrimination among patients with PBC and may be considered as readily available alternatives for LSM. However, combining LSM with the biochemical staging parameters improved the prognostic performance.

ABSTRACT #133

Recapitulating cirrhosis in vitro using a primary liver microphysiological system and patient plasma profiling

L.M. de Jong[1] , L. de Haan , V. van Duinen , I. Schildt , S. de Ruiter , L. Cuzi , L. van den Broek , M.J. Coenraad[1] , [1] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

Background:
Liver cirrhosis is the end stage of chronic liver disease and a major cause of liver-related mortality. Progress in understanding its pathophysiology and developing therapies is hampered by the lack of preclinical models that recapitulate the multicellular architecture and complexity of the cirrhotic liver.

This study aims to develop a human liver microphysiological system (MPS) that mimics key features of cirrhosis and to investigate how well-characterized patient plasma from different stages of cirrhosis affects liver phenotype in the MPS.

Methods:
Plasma from patients with compensated cirrhosis, decompensated cirrhosis, and acute-on-chronic liver failure (ACLF) was profiled using targeted lipidomics and Olink® Reveal proteomics. In parallel, we developed a primary human liver model using OrganoPlate® Graft uniflow technology by embedding primary hepatocytes, liver-derived endothelial cells, stellate cells, and Kupffer cells in hydrogel under unidirectional flow. Cirrhosis-like features were induced through prolonged exposure to combined LPS/TGF- with controlled lipid loading.

Results:
Lipidomics on plasma showed widespread lipid suppression with selective accumulation of free fatty acids, lactosylceramides, and phosphatidic acids in decompensated and ACLF patients, while plasma of compensated patients remained largely unchanged. Proteomic profiling revealed stage-specific remodeling, with clear separation by PCA (PC1 45%, PC2 12%) and 519, 717, and 758 proteins altered in compensated cirrhosis, decompensated cirrhosis, and ACLF patients, respectively. IL-6, HAVCR, CA9 and MUC13 were consistently among the top altered hits across all disease stage comparisons.

To evaluate the impact of disease-stage specific plasma on liver phenotype, we developed a human liver MPS containing all four cell types, which maintained core hepatic functions, including stable albumin production (>5µg/mL/day) and CYP activity for 19 days. The model was immune competent, with a 4-fold IL-6 increase after LPS stimulation, and displayed a perfusable vascular network. The 10-day cirrhosis trigger induced lipid accumulation and secretion of inflammatory and pro-fibrotic mediators (eg. 2.27-fold fibronectin and 2.3-fold pro-collagen I increase), recapitulating steatosis and fibrosis. Plasma exposure experiments on the MPS model are ongoing.

Conclusion:
Plasma profiling revealed disease stage-specific lipid and proteomic alterations. To explore the functional impact of these changes, we developed a human liver MPS that maintained hepatic function and recapitulated cirrhosis-like steatosis and fibrosis, establishing a platform with the potential to link patient plasma profiles to liver phenotype.

ABSTRACT #135

MFGM-enriched whey enhances intestinal epithelial maturation in a human pediatric organoid model

J.W.M. de Kleer , S. Meisner[1] , J.L.M. Vermeulen[1] , B. Sovran[1] , T.T. Lambers[1] , V. Muncan[1] , W.J. de Jonge[1] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research

Background:

At birth, the anatomical structure of the human intestine is largely established. However, the neonatal intestine is not yet functionally mature and must adapt to the challenges of the extrauterine environment. Intestinal maturation is a genetically programmed process influenced by external factors such as microbial signals, maternal hormones, and early-life nutrition. Human milk is the golden standard for feeding newborns providing complete nutrition for the first six months of life and promoting intestinal epithelial maturation by enhancing tight junction expression, decreasing barrier permeability, and stimulating epithelial cell differentiation.

Lactating mammary cells secrete milk fats as vesicles enveloped by a trilayered milk fat globule membrane (MFGM), which is mostly absent in infant formula. Recently, MFGM-enriched whey was developed enabling the addition of bovine milk-derived MFGM to formula. Bioactive components within the MFGM, including sphingolipids, phospholipids, glycosylated proteins, and polyunsaturated fatty acids, possibly affect epithelial maturation. To elucidate the role of bovine milk-derived MFGM in epithelial maturation, we investigated the effects of MFGM-enriched whey using a pediatric intestinal organoid model.

Methods:

Human ileal tissue was obtained during stoma reversal surgeries of five infants aged 5 weeks to 5 months. Three-dimensional organoids were stimulated for seven days with either MFGM-enriched whey or whey protein isolate (WPI) control. Differences between MFGM-stimulated organoids and control were analysed through bulk RNA-sequencing, RT-qPCR, immunohistochemistry, and electron microscopy.

Results:

MFGM exposure induced distinct morphological changes in organoid growth. Bulk RNA sequencing revealed 742 significantly altered genes compared to control medium, and 758 compared to WPI, with enrichment of metabolic and membrane-associated pathways. Brush border protein expression and activity were significantly upregulated following MFGM stimulation. Transmission electron microscopy and immunohistochemistry confirmed glycogen and lipid accumulation. Increased expression of genes involved in nutrient transport and absorption was validated by RT-qPCR.

Conclusion:

We conclude that MFGM stimulation promotes functional maturation of human pediatric intestinal organoids, characterized by enhanced digestive enzyme activity, metabolic reprogramming, and increased nutrient storage.

ABSTRACT #136

Endoscopic drainage of potentially resectable perihilar cholangiocarcinoma using a suprapapillary plastic stent with retrieval string (CHORDA-plastic); a prospective pilot study

E. Smit[1] , J.A. Fritzsche[1] , M.C.B. Wielenga[1] , Y.S. de Boer[1] , P. Fockens[1] , G. Kazemier[1] , J.I. Erdmann[1] , O.M. van Delden[1] , I.J.A.J. Zijlstra[1] , R. Lameris[1] , C.Y. Ponsioen[1] , R.L.J. van Wanrooij[1] , R.P. Voermans[1] , [1] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology

Background:

In patients with potentially resectable perihilar cholangiocarcinoma (pCCA), drainage of the future liver remnant (FLR) is essential. Conventional plastic stents bridge the papilla, causing reflux and biliary bacterial colonization, potentially increasing bacterial cholangitis risk. We evaluated the safety and feasibility of preoperative drainage using a suprapapillary plastic stent with a retrieval string.

Methods:

This prospective pilot study enrolled patients with pCCA (potentially) eligible for resection. Modified plastic stents (7–10 Fr) with retrieval strings were placed. The primary outcome was safety (severe drainage-related AEs). Secondary outcomes included technical and clinical success.

Results:

Forty patients with potentially resectable pCCA were enrolled (2023-2025). Bismuth classification was as follows: type I (n=1, 3%), type II (n=4, 10%), type IIIa (n=19, 48%), type IIIb (n=3, 8%), and type IV (n=13, 33%). Suprapapillary stent placement was technically successful in all patients (100%). Severe drainage-related AEs occurred in 13 patients (33%). Bacterial cholangitis occurred in five patients (13%), post-ERCP pancreatitis in four (10%), and stent dysfunction without bacterial cholangitis in six (15%). Clinical success was achieved in 34/39 (87%) patients. Half of the patients did undergo resection (n=18) or a liver transplantation (n=2). Overall, 29 patients reached surgery or scheduled stent exchange without the need for an unplanned re-intervention (72%).

Conclusion:

This prospective pilot study shows that endoscopic biliary drainage using a suprapapillary plastic stent with a retrieval string is both technically feasible and appears safe in patients with potentially resectable pCCA. Most patients required no unplanned re-intervention and the cholangitis rate was lower than reported in previous studies. Larger comparative trials are warranted to further evaluate its efficacy, and define its role within the preoperative management strategy for pCCA.

ABSTRACT #137

Factors influencing patient acceptance of less intensive surveillance strategies for low-risk pancreatic cysts: a cross-sectional questionnaire study

B. van Hooijdonk[1] , M.L.J.A. Sprij[1] , B. Nix[1] , J. Meziani[1] , F. van Delft[2] , P. Appelhof[2] , M.C.B. Wielenga[3] , R.P. Voermans[3] , C. Hoge[4] , P. Honkoop , K.V. Grooteman , W.L. Curvers , I.C.A.W. Konings , L.A. van der Waaij , M.P. Schwartz , J.F. Bergmann , N.G. Venneman , R. Quispel , A.M. van Berkel , F.G.I. van Vilsteren , R.C. Verdonk , A.C. Tan , E. Kouw , I.M.C.M. de Kok , M.J. Bruno , I.J. Korfage , D.L. Cahen , [1] Erasmus MC, Not applicable , [2] Radboud University Medical Center, Dept. of Gastroenterology and Hepatology, [3] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology, [4] Maastricht Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

Background:

Patient preferences and patient' knowledge of their cancer risks are key factors in decisions on less rigorous pancreatic cyst surveillance strategies. We examined factors influencing acceptance of reducing or stopping surveillance, assessed patients' perceived pancreatic cancer (PC) risk and information delivery preferences.

Methods:

A cross-sectional online questionnaire study nested within the PACYFIC registry was conducted. Dutch participants undergoing active surveillance for low-risk pancreatic cysts (i.e., without worrisome features and high-risk stigmata according to the Kyoto guideline) were eligible. Views on reducing or stopping surveillance were assessed using a 5-point Likert scale. We assessed how perceived PC risk and self-reported risk knowledge affected these outlooks and evaluated patient-reported acceptable reasons and circumstances for reduced surveillance. Reasons and acceptable circumstances were compared between respondents with positive vs. negative views. Statical analysis included Kruskal-Wallis tests, chi-square tests and Spearman's Rank correlation coefficient.

Results:

With a response rate of 48.8%, 257 respondents were included. Median age was 67.0 years (IQR 60.7-73.8), median cyst size 14 mm (IQR 10-19) and time since first cyst detection 4.2 years (IQR 2.2-7.0). Perceived PC risk exceeded the actual risk (median 22.0%, IQR 9.0-50.0) and was not associated with self-reported risk knowledge (r_s=0.06, p=.376). Positive views were reported by 36.2% for less frequent surveillance and 32.0% for surveillance cessation; these were associated with lower perceived PC risk (r_s = -.27, p<.001, r_s = -.34, p<.001, respectively). Fear of PC and need for reassurance were dominant reasons for those with negative views, whereas follow-up-related stress and time and cost savings were more common among those with positive views. A evidence-based low PC risk was the most important circumstance for accepting less or no surveillance, even among respondents with negative views, with patient-reported acceptable risk thresholds ranging from 6-10%. Cyst stability was more frequently reported by respondents with positive views for accepting reduced surveillance, while absence of surgical treatment was more often cited by those with negative views.

Conclusion:

Most patients expressed reluctance toward reduced surveillance, driven by fear of PC and reassurance needs. Importantly, low-risk pancreatic cyst patients markedly overestimate their PC risk; yet, many would accept reduced surveillance at risk thresholds that far exceed their actual risk. Bridging the gap between perceived and actual risk through explicit patient education is key to implement less intensive surveillance.

ABSTRACT #138

The road to same-day discharge after minimally invasive liver surgery: Emergence of early discharge and patient selection

B.W. Verboeket[1,2] , B.W. Verboeket[1,2] , S.R. Moeijes[1] , J.D. van Worcum[1] , D.H.L. Lemmers[1] , M.A. Pool[1] , S. Festen[1] , T.M. Karsten[1] , M.F. Gerhards[1] , H.A. Marsman[1] , [1] OLVG Hospital, Dept. of Surgery , [2] Amsterdam University Medical Center, Dept. of Surgery

Background:

Minimally invasive liver surgery (MILS) has gained traction over recent decades. This study assesses the implementation and outcomes of robotic liver surgery (RLS) in a medium-volume centre and identifies characteristics associated with a postoperative hospital stay of one night or less.

Methods:

This single-centre retrospective cohort study included 417 liver resections (2011–2023), of which 252 were minimally invasive. Perioperative outcomes and length of stay (LOS) were assessed. Implementation progress was evaluated by stratifying cases into Initial (IP) and Later Phase (LP). Multivariable logistic regression identified independent predictors of short stay.

Results:

MILS was associated with reduced operative time, blood loss, LOS, and morbidity compared to open surgery. RLS showed a lower conversion rate than laparoscopic liver surgery (LLS) (0.9% vs. 7.4%, p=0.025) and shorter median LOS (1 day [IQR 1–3] vs. 4 days [IQR 3–6], p<0.001), even during early adoption. Major complications (Clavien-Dindo grade 3–4) were lower in the robotic IP group versus LLS (3.7% vs. 14.7%, p=0.046).

Among 252 minimally invasive resections, 90 patients (35.7%) were discharged within one night. Multivariable logistic regression identified six independent predictors of a hospital stay of one night or less. Robot-assisted surgery (OR 6.53, 95% CI 2.72–15.66), ERAS protocol use (OR 3.46, 95% CI 1.26–9.51), and surgery performed in 2018 or later (OR 24.14, 95% CI 2.93–198.62) were all associated with a significantly higher likelihood of early discharge. Conversely, anatomically major resection (OR 0.21, 95% CI 0.05–0.86), simultaneous colorectal surgery (OR 0.033, 95% CI 0.004–0.31), and intraoperative blood loss ≥500 cc (OR 0.081, 95% CI 0.026–0.25) were each associated with a significantly lower likelihood. The model explained approximately 65% of the variance in postoperative LOS (Nagelkerke R^2 = 0.646). Readmission rates did not differ significantly between short- and longer-stay patients (4.4% vs. 9.9%, p=0.150).

Conclusion:

RLS can be safely implemented in medium-volume centres and combined with ERAS, enables same-day or next-day discharge in over one-third of patients. Patient selection should favour robot-assisted approaches, minor resections, no simultaneous colorectal surgery, and anticipated blood loss below 500 cc.

ABSTRACT #139

Clinical significance of early rises in aspartate- and alanine aminotransferase on hepatic encephalopathy post-transjugular intrahepatic portosystemic shunt

S. de Reus[1] , E. Werner[1] , D.J. van Doorn[2] , M. Spaan[2] , D. Bijdevaate[1] , K. Pieterman[1] , F. Piecha[3] , P. Hübener[3] , R.B. Takkenberg[2] , A.J. van der Meer[1] , H.L.A. Janssen[1] , B.E. Hansen[1] , R. Maan[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology , [2] Amsterdam University Medical Center , [3] University Medical Center Hamburg-Eppendorf

Background:

Transjugular intrahepatic portosystemic shunt (TIPS) is an established treatment for portal hypertensive complications. Aspartate- and alanine aminotransferase (AST, ALT) rises occur in up to 95% of patients post-TIPS, but their clinical significance remains unclear. We hypothesized that early AST/ALT elevations reflect shunt-related hepatic changes and are associated with increased ammonia exposure, increasing the risk of hepatic encephalopathy (HE).

Methods:

This retrospective study included consecutive cirrhotic patients undergoing TIPS between January 2007 and December 2023 at tertiary centers in the Netherlands and Germany. TIPS indications were set by treating hepatologists. AST/ALT was recorded at baseline, day one and seven post-TIPS, when available by using predefined windows. The primary endpoint was early HE (eHE), defined as any HE-grade within 30 days post-TIPS.

Results:

We included 547 patients; 368 male (67%), with a median age of 58 (IQR 52 – 65). The most common etiology of cirrhosis was alcohol-related in 296 (54%) patients, and refractory ascites was the main TIPS-indication (n=285, 52%).

Median baseline AST and ALT were 44 (IQR 33 – 78) and 26 U/L (IQR 19 – 45). On day one, AST and ALT increased in 257 (85%) and 234 (75%) patients. Median AST and ALT were 32 (IQR 8 – 75) and 12 U/L (IQR 1 – 33) on day one. Among patients with all available labs that had an AST increase on day one, 65% (106/164) had a subsequent decline on day seven, compared with 42% (72/170) for ALT.

Within 30 days post-TIPS, 125 patients experienced eHE (23%). Each 50 U/L increase in AST on day one was associated with a borderline increase in eHE risk (OR 1.01 , 95% CI 1.00 – 1.02, p = 0.06), but this was weakened when adjusting for MELD, age and prior HE (OR 1.01, 95% CI 0.99 – 1.02). ALT on day one was not related to eHE (OR 1.03, 95% CI 0.99 – 1.07). Given the rise-fall pattern of AST post-TIPS, we evaluated patients who retained high AST (≥ 100 U/L) on day seven, despite a decline from peak level. Using Firth's penalization to account for small sample size (n = 164), this was associated with eHE (OR 3.69, 95% CI 1.45 - 10.09, p = 0.01).

Conclusion:

Early post TIPS rises in AST and ALT are common, typically mild, and not independently associated with eHE. Persistent AST elevation on day seven, in contrast, could be linked to increased risk of eHE. Given that this observation is limited by small sample size, this finding must be confirmed. While early transaminase rises likely overlap with other risk factors for eHE, they may still signal an adverse clinical phenotype and support consideration of preventive HE strategies.

ABSTRACT #140

Lymph node assessment of the thoracic duct and surrounding compartment in esophageal cancer surgery – the TUPEC pilot-study

H.C.G. Overtoom[1] , J.F.J.A. van Zon[1] , D.C. van der Aa[1] , W.J. Eshuis[1] , M.I. van Berge Henegouwen[1] , S.S. Gisbertz[1] , [1] Amsterdam University Medical Center, Dept. of Surgery

Background:

Standardization of thoracic duct (TD) management during esophageal cancer surgery remains controversial. TD resection has been hypothesized to enhance oncologic radicality, since it may increase the total lymph node yield. This study aims to quantify the lymph node yield of the TD and surrounding compartment in esophageal cancer surgery.

Methods:

This ongoing single-center, prospective pilot study evaluates the lymph node yield of indocyanine green (ICG)-guided TD resection during minimally invasive esophagectomy for esophageal carcinoma (cT1–4aN0–3M0), following neoadjuvant chemo(radio)therapy. The ICG is injected (2ml of 2.5mg/ml) in the small bowel mesenteric root or inguinal lymph node based on the surgical approach – either Ivor-Lewis or McKeown, respectively – before the thoracic phase. Standardized two-field lymphadenectomy is performed according to the TIGER study protocol. The TD and lymph node station 112aoa are processed separately for histopathological evaluation. The primary endpoint is the total lymph node yield in the thoracic duct and surrounding lymphatic compartment. Secondary endpoints include successful ICG-enhanced visualization of the thoracic duct, completeness of resection, procedural safety, and postoperative morbidity.

Results:

Twenty-two of the sixty planned patients were enrolled up to April 2026. No ICG related adverse events occurred. The cohort consisted predominantly of male patients (64%), with a median age of 68 years, and diagnosed with cT3 (64%) and cN0-1 (68%) staged adenocarcinoma (82%). The TD was successfully visually enhanced by ICG-fluorescence in 20/22 patients (91%) and successfully resected in all patients. No viable tumor cells were identified within the resected thoracic ducts. The median resected lymph node yield was 34 [IQR: 24 - 43]. Lymph node station 112aoa contained median 2 lymph nodes [range 0-8], none of which containing tumor cells. The TD contained 0 lymph nodes. Chyle leakage occurred in 4/22 patients (18%) and was managed conservatively in 3 out of 4 cases.

Conclusion:

This study demonstrated a median of two lymph nodes within station 112aoa, whereas no lymph nodes were identified in the thoracic duct itself. Final analyses are anticipated in September 2026. The clinical and oncologic implications of thoracic duct management will be further investigated in the subsequent phase II and phase III TUPEC trial.

ABSTRACT #141

Location and activity of inflammatory bowel disease are associated with colectomy, but not with liver transplant-free survival in patients with primary sclerosing cholangitis

D. Sneek[1] , B. Mol[2] , M. de Jong[1] , A.J. van der Meer[1] , P. Miranda-Afonso[1] , A. Inderson[3] , R.K. Weersma[4] , C.Y. Ponsioen[2] , B.E. Hansen[1] , A.C. de Vries[1] , [1] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology, [2] Amsterdam University Medical Center, Dept. of Gastroenterology and Hepatology , [3] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology , [4] Universitair Medisch Centrum Groningen, Dept. of Gastroenterology and Hepatology

Background:

Primary sclerosing cholangitis (PSC) is a rare liver disease characterized by chronic inflammation of the biliary tree. Up to 80% of patients with PSC are also diagnosed with inflammatory bowel disease (IBD). PSC-IBD is reported to present predominantly in the proximal colon and to follow a mild yet persistent course. We studied whether IBD type, location, and activity in patients with PSC are associated with colectomy and liver transplant (LT)-free survival.

Methods:

Patients diagnosed with PSC and IBD with at least one colonoscopy were selected from the EpiPSC2 cohort, a dynamic population-based PSC registry in the Netherlands. Cox regression with time-dependent covariates for IBD activity and location was applied. IBD activity was defined as the cumulative inflammatory burden (CIB) over follow-up, using the Mayo endoscopic subscore from 0 (none) to 3 (severe). IBD location was classified as right-sided colitis, left-sided colitis, or pancolitis. The index date was set to the second diagnosis, and the first colonoscopy was the entry time to account for left truncation.

Results:

The analyses included 580 patients who had 3394 colonoscopies (median 5, interquartile range [IQR] 2–9). During follow-up, 221 patients had right-sided colitis at any time, 226 had left-sided colitis, and 277 had pancolitis. Among colonoscopies with active inflammation, the median severity of colitis was mild (Mayo 1, IQR 1–2). In 5509 patient-years of follow-up, 81 colectomies and 125 LTs were performed; 44 patients died of PSC-related causes.

Left-sided colitis and pancolitis were associated with a 4-fold higher hazard of colectomy (hazard ratio [HR] 4.1, 95% confidence interval [CI] 2.3–7.5, p<0.001; and HR 4.4, CI 2.6–7.6, p<0.001, respectively) than no inflammation, whereas right-sided colitis was not associated (HR 0.7, CI 0.3–2.1, p=0.54). No differences were observed for the liver-related outcome. The CIB was associated with a 4.7-fold higher hazard of colectomy (CI 3.4–6.6, p<0.001) and showed the strongest association in the left-sided colon (HR 5.2, CI 3.7–7.3, p<0.001). The CIB was not associated with LT-free survival (HR 0.8, CI 0.6–1.2, p=0.30). The IBD type at diagnosis was not associated with either outcome.

Conclusion:

In this study, right-sided colitis, left-sided colitis, and pancolitis occurred with similar frequency in patients with PSC-IBD. Left-sided colitis and pancolitis were associated with a 4-fold higher hazard of colectomy, with a higher risk as CIB increased. Right-sided colitis was not associated with a higher risk of colectomy as compared to no inflammation, suggesting this may be considered a separate IBD type. Location and severity of IBD were not related to LT-free survival.

ABSTRACT #143

Feasibility of same-day discharge after colon surgery: Interim results

B.W. Verboeket[1,2] , M.F. Gerhards[1] , S. Festen[1] , T.M. Karsten[1] , S.M.M. de Castro[1] , G. Kazemier[2] , H.A. Marsman[1] , [1] OLVG Hospital, Dept. of Surgery , [2] Amsterdam University Medical Center, Dept. of Surgery

Background:

Enhanced Recovery After Surgery (ERAS) protocols and the widespread adoption of minimally invasive techniques have progressively shortened postoperative hospital stays following colon resection. At our centre, nearly half of all patients undergoing colon resection are currently discharged within one postoperative day. Drawing on institutional expertise, including being the first Dutch centre to pioneer same-day discharge (SDD) in bariatric surgery, this study investigates whether discharge on the day of surgery itself is feasible after robotic colon resection in a selected population.

Methods:

A prospective single-centre feasibility study enrolled adults with ASA classification I–II scheduled for elective robotic colon resection for malignant indication, with a target of 30 patients and a interim analysis at 10 inclusions (January–September 2026). Discharge criteria included haemodynamic stability, absence of early complications, and stable haemoglobin levels. Patients were monitored using remote postoperative monitoring using pulse oximetry and temperature measurement. The primary endpoint was successful SDD without readmission within 48 hours; secondary endpoints comprised patient satisfaction, quality of recovery, and 30-day rates of morbidity, mortality, reoperation, readmission, and emergency department visits.

Results:

Among patients discussed at the multidisciplinary team meeting for colon surgery, 58% met eligibility criteria, with ASA classification above II being the predominant reason for exclusion. Of those eligible, 82% provided informed consent. Ten patients (age range 54–75 years) were enrolled for intended SDD, undergoing right hemicolectomy (n=6), sigmoid resection (n=2), left hemicolectomy (n=1), and two intraoperative conversions from sigmoid resection to partial mesorectal excision. SDD was successfully achieved in 9 of 10 patients (90%); one patient required overnight admission following an intraoperative complication. No emergency department visits or readmissions occurred within the 48-hour primary endpoint window. All nine successfully discharged patients reported satisfaction with the SDD pathway and adequate functional recovery on postoperative day one. Two subsequent readmissions occurred beyond 48 hours for reasons unrelated to SDD; both patients nonetheless expressed satisfaction with their discharge experience.

Conclusion:

These interim findings suggest that SDD following elective robotic colon resection appears to be feasible and safe in selected patients. Final results are expected in September 2026.

ABSTRACT #145

Trends in and determinants of hcc surveillance adherence: A nationwide cohort study

M. Moussa[1] , D. Sprengers[1] , W.P. Brouwer[1] , R. Maan[1] , H.L.A. Janssen[1] , A.J. van der Meer[1] , M.J. Sonneveld[1] , [1] Erasmus MC, Dept. of Gastroenterology and Hepatology

Background:

Current guidelines recommend bi-annual liver imaging in patients with cirrhosis as it facilitates early HCC diagnosis and potentially curative treatment. Previous studies in highly selected patient populations suggest suboptimal adherence to surveillance. We aimed to study time-trends in and determinants of adherence to HCC surveillance in a nationwide sample.

Methods:

We identified patients receiving hospital-based care for cirrhosis in the Netherlands from 2015–2023 through a search of the Dutch Central Bureau of Statistics (CBS) database. Information on diagnostic procedures was obtained through cross-referencing with insurance claims databases. Adherence was assessed in 14-month intervals, with optimal adherence defined as ≥ 2 imaging studies within this timeframe. Longitudinal trends in adherence were analyzed using Generalized Estimating Equations (GEE), while a multivariable logistic regression model was fit to identify contemporary determinants of non-adherence in the most recent year (2023-2024).

Results:

We identified 23,467 individuals with cirrhosis (63% compensated), the majority of whom were male (60%). Median age was 62.1 years (SD± 12.4) and non-viral etiology predominated (85%). During the study period, the number of patients increased by 65% from 5,521in 2015 to 9,133 in 2023. The rate of optimal adherence increased from 17% to 40% (Annual percentage change [APC]: 11.3% [95% CI: 10.6–12.1]; p < 0.001), while the proportion of patients who underwent no surveillance at all declined from 24% to 14%. Multivariable GEE models showed that management in an academic hospital (aOR: 1.44 [95% CI: 1.37–1.52]; p<0.001) and having decompensated cirrhosis (aOR: 1.08 [95% CI: 1.04–1.13]; p<0.001) were independent predictors of optimal adherence. In the patients in care in 2023 (n = 9,133), treatment in an academic hospital was associated with a higher likelihood of optimal adherence (aOR: 1.40 [95% CI: 1.23–1.58]; p<0.001), while lower socioeconomic status was associated with a reduced likelihood of optimal surveillance (aOR: 0.90 [95% CI: 0.82–1.00]; p = 0.04).

Conclusion:

Although HCC surveillance adherence appears to be improving over time, biannual imaging rates remain suboptimal. As we observed important disparities across hospitals and socioeconomical status, our findings call for initiatives to ensure equal participation to potentially life-saving care.

ABSTRACT #146

Preoperative plasma metabolites are associated with male colorectal cancer recurrence following surgery

A. Avramovic[1] , A.E. Petersen[2] , K. Zafeiropoulou[1] , J.L.M. Konsten[3] , N.D. Bouvy[4] , J.H.M.B. Stoot[5] , W.J. de Jonge[2] , J.P.M. Derikx[2] , M. Ghiboub[2] , [1] Amsterdam UMC, loc. AMC, Tytgat Institute for Liver and Intestinal Research, [2] Amsterdam University Medical Center, Dept. of Pediatric Surgery , [3] VieCuri MC voor Noord Limburg, Dept. of Surgery, [4] Leids Universitair Medisch Centrum, Dept. of Surgery, [5] Zuyderland Medical Centre, Dept. of Surgery

Background:

Disease recurrence remains a major cause of mortality in non-metastatic colorectal cancer (CRC), yet reliable biomarkers for preoperative recurrence risk stratification are lacking. Increasing evidence suggests that systemic metabolic alterations and host–microbiome are closely interconnected in CRC progression. In this study, we aimed to identify preoperative plasma metabolites and corresponding gut microbiome features associated with postoperative CRC recurrence.

Methods:

Sixty-four patients with non-metastatic CRC from the multicenter REVEAL cohort (NCT02347735) were included (32 recurrence, 32 matched non-recurrence controls). Preoperative plasma and fecal samples were collected prior to surgery. Recurrence status was prospectively tracked for at least three years post-surgery. Plasma metabolites were quantified using ultra-high-pressure liquid chromatography, while fecal microbial profiles were assessed by 16S rRNA sequencing. Sex-stratified analyses, pathway enrichment, microbiome–metabolite integration analyses, receiver operating characteristic (ROC) analyses, and random forest modeling were performed to identify recurrence-associated signatures and evaluate their predictive performance.

Results:

Across the full cohort, metabolomic differences between recurrence and non-recurrence groups were limited. In contrast, sex-stratified analyses revealed pronounced metabolic alterations in males. Male patients who developed recurrence exhibited significantly lower preoperative plasma levels of multiple amino acids, including histidine, alanine, lysine and proline compared with non-recurrent males, whereas female patients showed minimal recurrence-metabolomic differences. ROC analyses revealed strong predictive performance for these amino acids in males (e.g., histidine (AUC=0.86) and alanine (AUC=0.84)), confirmed by RF modeling. Pathway analysis suggested reduced amino acid metabolism with lower input into the tricarboxylic acid (TCA) cycle. Microbiome–metabolite integration analyses in males showed that lower amino acid levels were associated with changes in gut bacterial composition, with recurrence linked to taxa involved in amino acid metabolism.

Conclusion:

Preoperative plasma amino acid depletion is associated with postoperative CRC recurrence in male patients and is accompanied by distinct gut microbial alterations, supporting a role for host–microbiome metabolic interactions in recurrence risk. These findings highlight the potential of integrated metabolomic and microbiome profiling for recurrence risk stratification and underscore the importance of considering sex as a biological variable in biomarker development.

ABSTRACT #147

Comparison of four meld-based scores and assessment of sex equity in waiting listoutcomes in patients awaiting liver transplantation in the netherlands

D. van der Helm[1] , R.F. van Golen[2] , W. Polak[2] , I.P.J. Alwayn[1] , H. Lam[1] , B. Goudsmit[1] , H.A.N.S. Blokziji[3] , V.E. de Meijer[3] , M. Fiocco , C.M. den Hoed[2] , M.J. Coenraad[1] , [1] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology, [2] Erasmus University Medical Center, Dept. of Gastroenterology and Hepatology, [3] University Medical Center Groningen, Dept. of Gastroenterology and Hepatology

Background:

Background and aims: The Model for End-Stage Liver Disease (MELD) score estimates the 3-month mortality risk on the waitlist and has been the cornerstone of organ allocation for liver transplantation in many organ sharing societies worldwide. Over time, several refinements have been implemented to enhance equity and predictive accuracy, leading from the original MELD to MELD-Na, refitted MELD-Na (reMELD-Na), and MELD 3.0. This study aims to (1) compare the predictive performance of MELD, MELD-Na, reMELD-Na, and MELD 3.0 in adult patients actively listed for liver transplantation in two transplant centers in the Netherlands, and (2) to evaluate potential sex disparities in waiting list mortality and transplantation rates.

Methods:

Method: Consecutive adult patients who were assigned an active transplantable status ("T-status") on the liver transplantation waitlist between 2007 and 2024 in two Dutch transplant centers were included. Patients listed for acute liver failure, waiting list registration for retransplantation, and patients in whom one of the scores could not be calculated due to missing data were excluded. Cause-specific hazard ratio (HRcs) models for death were estimated using competing risk analysis. Competing events were transplantation, waitlist removal for other reasons than transplantation, transition to nontransplantable status, assignment of exception points and death. Each model had two risk factors: MELD-based score and sex.

Results:

Results: 1867 unique patients were included. The 3-month predictive ability for death on the waitlist of the four scoring systems was comparable for all MELD-based scores: MELD HRCS 1.17 (95%CI 1.15-1.19) and sex HRCS 1.18 (95%CI 0.80-1.74); MELD-Na HRCS 1.19 (95%CI 1.17-1.21) and sex HRCS 1.29 (95%CI 0.87-1.91); reMELD-Na HRCS 1.27 (95%CI 1.23-1.30) and sex HRCS 1.26 (95%CI 0.85-1.86); MELD 3.0 HRCS 1.18 (95%CI 1.16-1.21) and sex HRCS 1.48 (95%CI 1.00-2.18). No significant sex differences were observed in the cumulative incidence of death on the waitlist ($p = 0.20$) or transplantation ($p = 0.49$).

Conclusion:

Conclusion: In this multicenter Dutch cohort, the predictive performance for waitlist mortality of MELD, MELD-Na, reMELD-Na, and MELD 3.0 was comparable. Moreover, the absence of significant sex-related differences in mortality and transplantation rates supports the fairness of currently used MELD-based scores for organ prioritization and allocation between men and women in the Netherlands.

ABSTRACT #151

An individual participant data meta-analysis assessing the performance of clinical care pathways for detecting significant fibrosis in Metabolic dysfunction-Associated Steatotic Liver Disease (MASLD)

K.M.A. van Eekhout[1] , L.N.D. Broekman , L.A.M. Konings , A.N. Saidi , S. Driessen , K.C. van Son , A.M. van Dijk , A.L. Mak , M.C. Cabezas , M. Michel[2,3] , E. Mentsiou-Nikolaou[4] , J.P. Kalafati[4] , R. Gallego-Durán[5] , A. Liguori[6,7] , A.M. Tudor[7,6] , M. do Mar d'Orey[8,9] , S. Carvalhana[8,9] , H. Cortez-Pinto[8,9] , M. Romero-Gómez[5] , L. Miele[6,7] , G.V. Dedoussis[4] , J.M. Schattenberg[3,2] , L. Vonghia[10,11] , S.M. Francque[10,11] , O.H. Franco[12] , Y. Vali[13] , D. Maya-Miles[5] , M.E. Tushuizen[14] , A.G. Holleboom[13] , [1] Amsterdam UMC, loc. AMC, Dept. of Vascular Medicine , [2] Saarland University , [3] Department of Internal Medicine II, Saarland University Medical Centre , [4] Department of Nutrition and Dietetics, School of Health and Education, Harokopio University of Athens , [5] SeLiver Group, Instituto de Biomedicina de Sevilla/CSIC/Virgen del Rocío University Hospital, University of Seville , [6] Department of Translational Medicine and Surgery, Faculty of Medicine, Università Cattolica del Sacro Cuore , [7] Department of Medical and Surgery Sciences, Fondazione Policlinico Universitario A. Gemelli IRCCS , [8] Clínica Universitária de Gastrenterologia, Faculdade de Medicina, Universidade de Lisboa , [9] Serviço de Gastrenterologia e Hepatologia, Unidade Local de Saúde de Santa Maria , [10] InflaMed Centre of Excellence, Laboratory for Experimental Medicine and Paediatrics, Translational Sciences in Inflammation and Immunology , [11] University Hospital Antwerp , [12] Department of Global Public Health & Bioethics, Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht , [13] Amsterdam University Medical Center , [14] Leids Universitair Medisch Centrum, Dept. of Gastroenterology and Hepatology

Background:

Care pathways using sequential non-invasive tests (NITs) for Metabolic dysfunction-Associated Steatotic Liver Diseases (MASLD) with fibrosis aim to improve early detection of significant fibrosis while reducing unnecessary referrals of mild cases, but comparative large-scale evidence is limited. We aimed to provide a standardized evaluation of care pathways using an individual participant data meta-analysis (IPDMA).

Methods:

We pooled individual data from European cohorts of adults aged 18–80 years at cardiometabolic risk, excluding excessive alcohol use and other liver diseases. We evaluated 93 care pathways combining blood-based NITs (FIB-4, MAF-5, NFS, APRI, BARD) with liver stiffness measurement (LSM)-based NITs (FibroScan, FAST, AGILE-3+). Performance was assessed using pathway's test characteristics and patient flow metrics.

Results:

A total of 4,168 participants from 10 cohorts were included, 3,850 had data available to assess significant fibrosis. Significant fibrosis was present in 19.5% (n = 752), based on: 1. histology (n = 507), 2. MRE (n = 15), 3. MRI-cT1 (n = 14) or, 4. VCTE-LSM (n = 216). Two-tier pathways consistently outperformed one-tier strategies. The best-performing pathways combined MAF-5 with FibroScan (≥8 kPa) or FAST (>0.35), achieving sensitivities of 72.7% and 74.8%, and specificities of 93.4% and 86.1%, respectively. Findings were consistent across sensitivity analyses, including stratification by diabetes status and level of care.

Conclusion:

Two-tier diagnostic pathways, particularly those combining MAF-5 with LSM-based tests, provide the most accurate identification of clinically significant fibrosis while maintaining acceptable referral rates. While awaiting prospective validation in large-scale, multinational cohorts, this IPDMA supports implementation of clinical pathways for liver fibrosis detection in participants at cardiometabolic risk for MASLD.

ABSTRACT #152

Comprehensive functional analysis of gene variants in Lynch syndrome

A. Tsaalbi-Shtylik , S. van Hees-Stuivenberg , N. de Wind

Background:

Lynch syndrome (LS) is a prevalent, dominantly inherited, predisposition to colorectal cancer caused by a deleterious variant in one of four genes involved in DNA mismatch repair (MMR). Affected individuals greatly benefit from periodic surveillance. Unfortunately, in individuals suspected of LS, a Variant of Uncertain Significance (VUS) in one of the MMR genes is frequently identified. In case the functional consequence of such a VUS cannot be determined, targeted preventive and healthcare for these individuals and their relatives is impossible. Here we describe two complementary assays that determine the functional consequences of a MMR gene VUS, which greatly improves their classification.

Methods:

The first assay, called Complete *In vitro* Mismatch Repair Activity (CIMRA) assay, that was developed with support from the MDL fonds, measures the activity of a MMR gene VUS in a test tube. The assay only requires information on the VUS and outputs an Odds of Pathogenicity with high sensitivity and specificity. The assay is now routinely used for classification.

Also with the support from the MDL fonds we currently are developing a complementary, *in cellulo*, functional assay, called Prospective Classification Catalogs (PCC). To this aim we are performing genetic screens in cultured cells to identify variants that disrupt MMR gene function at a large scale and list these variants in PCC. We envisage that a simple lookup in the PCC of a VUS, identified in an individual suspected of LS, will reveal whether that VUS is deleterious and, therefore causative of LS.

Results:

We have developed and carefully optimized the conditions and tailored cell lines required for the genetic screen. Currently we are performing and analyzing the screen itself. Then, we will validate the identified deleterious mutations and compile them in PCC, followed by their dissemination.

Conclusion:

We anticipate that the combination CIMRA+PCC will enable to rapidly and reliably classify the large majority of MMR gene VUSs, identified in individuals suspected of LS.