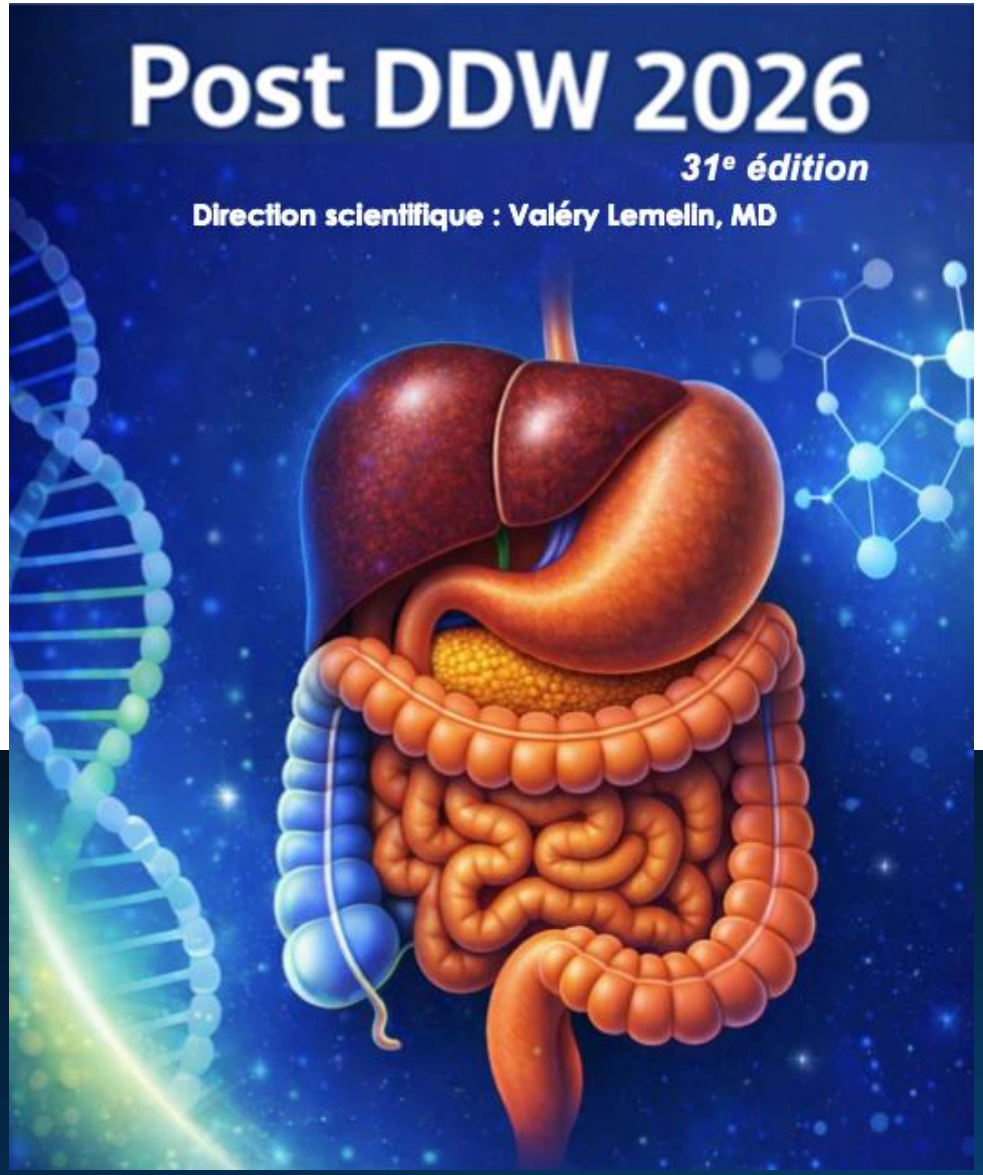
Données saillantes en pédiatrie

Guillermo Costaguta, MD

CHU de Québec-Université Laval



Conflits d'intérêts potentiels

Nature des relations	Nom de l'organisation à but lucratif ou sans but lucratif
Les paiements directs incluant les honoraires	
La participation à des comités consultatifs ou des bureaux de conférenciers	Mirum Pharmaceuticals Medison Pharma
Le financement de subventions ou d'essais cliniques	Pfizer
Les brevets sur un médicament, un produit ou un appareil	
Tout autre investissement ou toute autre relation qu'un participant raisonnable et bien informé pourrait considérer comme un facteur d'influence sur le contenu de l'activité éducative	

Compétences CanMEDS

X	**Expert médical** (En tant qu'experts médicaux, les médecins assument tous les rôles CanMEDS et s'appuient sur leur savoir médical, leurs compétences cliniques et leurs attitudes professionnelles pour dispenser des soins de grande qualité et sécuritaires centrés sur les besoins du patient. Pivot du référentiel CanMEDS, le rôle d'expert médical définit le champ de pratique clinique des médecins .)
	Communicateur (En tant que communicateurs, les médecins développent des relations professionnelles avec le patient et ses proches ce qui permet l'échange d'informations essentielles à la prestation de soins de qualité.)
	Collaborateur (En tant que collaborateurs, les médecins travaillent efficacement avec d'autres professionnels de la santé pour prodiguer des soins sécuritaires et de grande qualité centrés sur les besoins du patient.)
X	**Leader** (En tant que leaders, les médecins veillent à assurer l'excellence des soins, à titre de cliniciens, d'administrateurs, d'érudits ou d'enseignants et contribuent ainsi, avec d'autres intervenants, à l'évolution d'un système de santé de grande qualité.)
	Promoteur de santé (En tant que promoteurs de la santé, les médecins mettent à profit leur expertise et leur influence en oeuvrant avec des collectivités ou des populations de patients en vue d'améliorer la santé. Ils collaborent avec ceux qu'ils servent afin d'établir et de comprendre leurs besoins, d'être si nécessaire leur porte-parole, et de soutenir l'allocation des ressources permettant de procéder à un changement.)
X	**Érudit** (En tant qu'érudits, les médecins font preuve d'un engagement constant envers l'excellence dans la pratique médicale par un processus de formation continue, en enseignant à des tiers, en évaluant les données probantes et en contribuant à l'avancement de la science.)
X	**Professionnel** (En tant que professionnels, les médecins ont le devoir de promouvoir et de protéger la santé et le bien-être d'autrui, tant sur le plan individuel que collectif. Ils doivent exercer leur profession selon les normes médicales actuelles, en respectant les codes de conduite quant aux comportements qui sont exigés d'eux, tout en étant responsables envers la profession et la société. De plus, les médecins contribuent à l'autoréglementation de la profession et voient au maintien de leur santé.)

Maladies inflammatoires de l’intestin chez l’enfant

SHORT ILEAL MICROVILLUS LENGTH AT DIAGNOSIS OF PEDIATRIC CROHN'S DISEASE IS AN INDEPENDENT PREDICTOR OF AGGRESSIVE DISEASE – A STUDY OF 690 CHILDREN

Authors: Kelli L. VanDussen[1,2], Ruiwen Zhou[3], Courtney A. Bartel[1,2], Rachel Cooke[4], Kathleen Lake[1], Laura Linneman[3], Thomas Aviles[1], Charles Samson[3], Ajay S. Gulati[4], Ta-Chiang Liu[3]

[1]Cincinnati Children's Hospital Medical Center, Cincinnati, OH
[2]University of Cincinnati College of Medicine, Cincinnati, OH
[3]Washington University School of Medicine, St. Louis, MO
[4]University of North Carolina, Chapel Hill, NC

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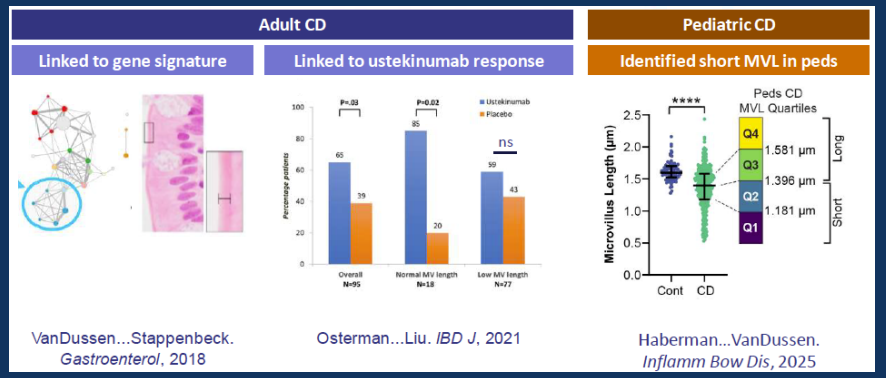


VanDussen...Stappenbeck. *Gastroenterol*, 2018

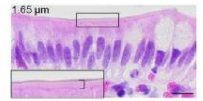
Osterman...Liu. *IBD J*, 2021

Haberman...VanDussen. *Inflamm Bow Dis*, 2025

Pediatric CD cohorts

- Site 1 WUSTL
- Site 2 CCHMC
- Site 3 UNC

Obtained ileal pathology samples from newly diagnosed CD patients



Measured MVL

n = 807 patients

Collect demographic and clinical metadata

- Age at diagnosis, sex, race
- Disease location
- Perianal disease
- Body mass index (BMI)
- weighted PCDAI (wPCDAI)
- Physician global assessment (PGA)
- C-reactive protein (CRP)
- Fecal calprotectin
- Aggressive disease course outcomes

n = 690 patients

Ileal MVL phenotype	Long (n=335)	Short (n=324)	P value
PGA ≥3	190 (40.6%) n=320	206 (65.6%) n=314	0.119
sPCDAI score	30.0 (20.0-45.0) n=237	35.0 (25.0-45.0) n=238	0.121
Normalized CRP	2.8 (0.2-8.1) n=269	4.2 (1.5-9.4) n=228	**0.002**
Normalized fecal calprotectin	16.0 (7.0-102.1) n=121	17.6 (8.2-96.6) n=104	0.724
Ileal location (L1 or L3)	221 (66.0%)	261 (80.6%)	**>0.0001**
Any USB location (L4)	192 (57.3%)	185 (57.1%)	>0.999
Perianal disease	83/313 (26.5%)	61/301 (20.3%)	0.071

Ileal MVL phenotype	Long (n=335)	Short (n=324)	P value
Follow-up (months)	59.4 (40.5-87.2)	52.0 (36.3-80.8)	0.063
B2 and/or B3 (%)	9 (2.7%)	22 (6.8%)	**0.016**
Surgery	8 (2.4%)	12 (3.7%)	0.369

Predictor	OR	95% CI	*P*-value
sPCDAI	1.04	1.01–1.06	**0.0047**
MVL	0.24	0.09–0.67	**0.0058**
Calprotectin	1.00	1.00–1.00	0.052
CRP	1.00	0.998–1.01	0.119
Female	1.46	0.75–2.84	0.266
Ileal	0.99	0.48–2.19	0.981

5.6% avait développé une maladie aggressive dans les premiers 5 ans après Dx

Infliximab Pharmacokinetics Reveal Sonographic Transmural Healing in Children with Inflammatory Bowel Disease

Ertug Toroslu, Perseus V. Patel, Ruben J. Colman

Presenter: **Ruben J. Colman, MD, PhD**
Endowed Faculty Scholar for Pediatric IBD and Celiac Disease
Assistant Professor of Pediatrics
Director of Intestinal Ultrasound

Stanford MEDICINE Children's Health — Center for IBD and Celiac Disease

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@ColmanMD.bsky.social

Stanford | Colman Lab Precision Therapeutics for IBD

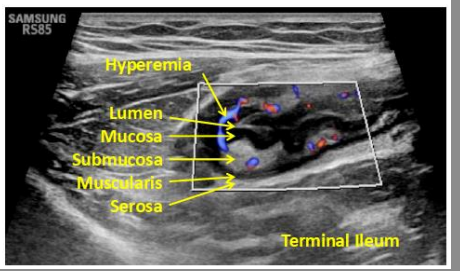
The Adult Framework

- **Adult bowel wall thickness Cutoffs**: Adult healing targets < 3.0 mm
- **PK Limitations**: Analysis restricted primarily to static trough levels
- **Static Timing**: Associations at Week-14 and maintenance

The Pediatric Challenge

- **Early Evidence**: IFX exposure linked to endoscopic and MRE healing
- **Dynamic Need**: Lack of validated IUS-specific PK targets during induction

- International Bowel UltraSound (IBUS) acquisition consensus.[1]
- **Transmural healing** – Bowel wall thickness <2.5mm in all segments. +/- normal color doppler [pediatric consensus].[2]

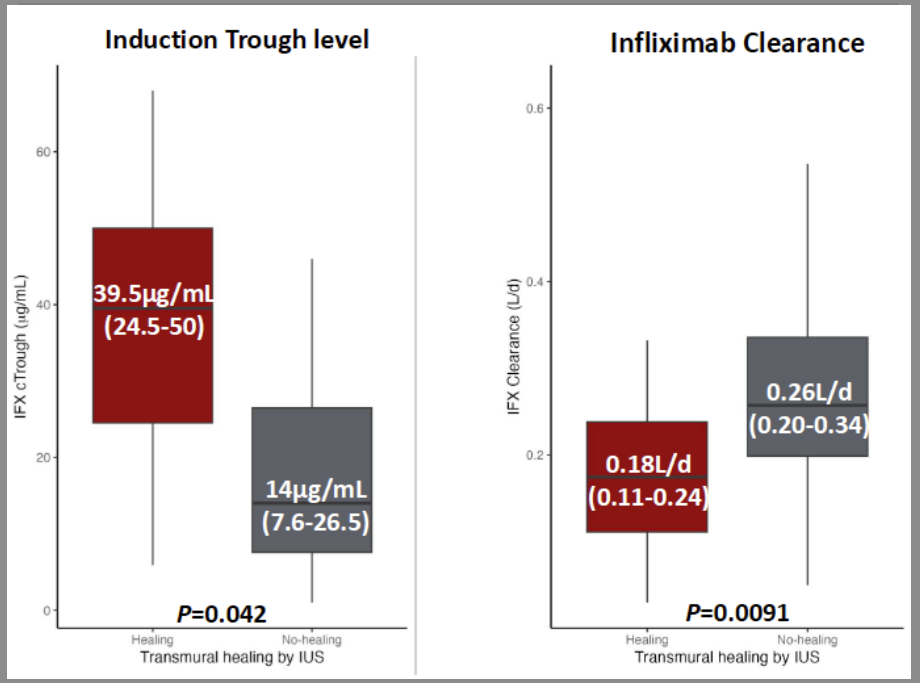


Results – Demographics

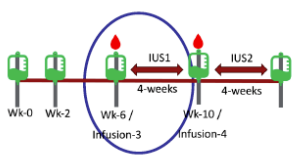
Baseline	n=45
Diagnosis Age, yrs (sd) (1-17)	10 (4.2)
IFX induction age, yrs (sd) (1-17)	11.6 (4.0)
Sex, F	58% (26)
Diagnosis	
Crohn's disease	53% (24)
Ulcerative colitis/IBD-unclassified	47% (21)
Paris CD location:	
L1	21% (5)
L2	8% (2)
L3	71% (17)
Paris UC location:	
E2	20% (4)
E3	5% (1)
E4	75% (15)
Severe UC (S1)	75% (15)

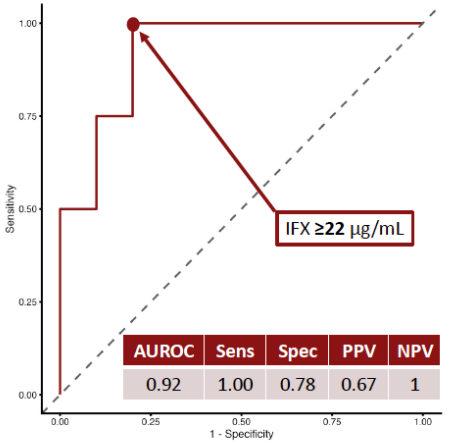
Baseline	n=45
Prior biologics (vedolizumab)	4% (2)
Albumin (g/dL) median, IQR ESR (mm/hr), IQR Calprotectin (µg/g)	3.6 (3.3-4.1) 20 (7.5-41) 916 (366-1753)
Weight, kg (IQR)	29.9 (23-44)
Baseline Clearance (L/d), IQR	0.24 (0.15-0.32)
Baseline weight-based IFX dose (mg/kg)	10.8 (10-11.6)

- 45 patients (67 IFX cTrough-IUS pairs)
- median of 17 (8-31) infusions per patient.



Infusion-3 level that Predicts Transmural Healing





AUROC	Sens	Spec	PPV	NPV
0.92	1.00	0.78	0.67	1

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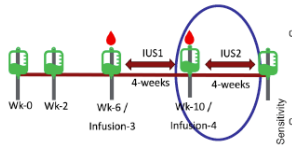
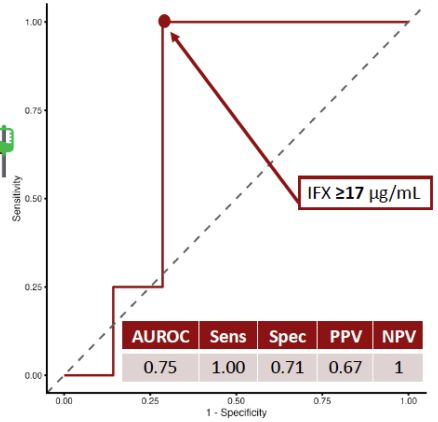
*Compared to ≥18µg/mL literature recommended to predict infusion-4 ≥5 and clinical response

Infusion-4 level that Predicts Transmural Healing





AUROC	Sens	Spec	PPV	NPV
0.75	1.00	0.71	0.67	1

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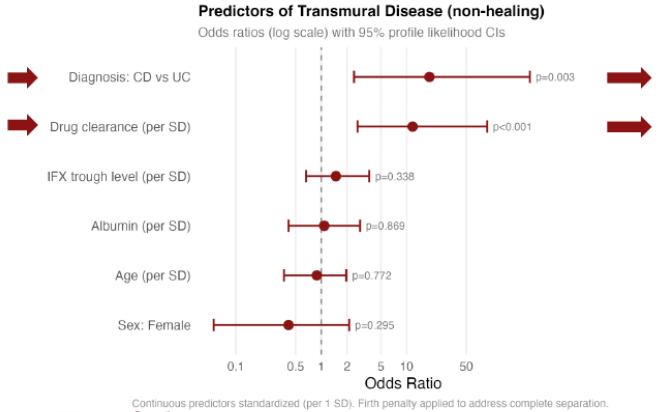
Predictors of Transmural Disease (Non-healing)



	aOR	95% CI	*P*-value
Diagnosis (CD)	18.47	2.42 - 276.42	0.003
Clearance	11.74	2.66 - 87.74	0.0003
Trough level	1.49	0.66 - 3.65	0.338
albumin	1.08	0.41 - 2.84	0.869
age	0.89	0.37 - 1.96	0.772
Sex (Female)	0.41	0.06 - 2.12	0.295

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Firth penalized multivariable logistic regression
Continuous variables normalized (z-scores)

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Center for IBD
and Celiac Disease

Upadacitinib is Safe and Effective for Induction and Maintenance of Remission in Pediatric IBD: A Pragmatic Multi-center Study

Perseus V. Patel, Javier A. Lopez-Rivera, Paula Prieto, Evan Greenhall, Brad Pasternak, Keren Appel, Emily Wilks, Sabina Ali, Brad Constant, Michael J. Rosen, Ruben J. Colman

May 3, 2026

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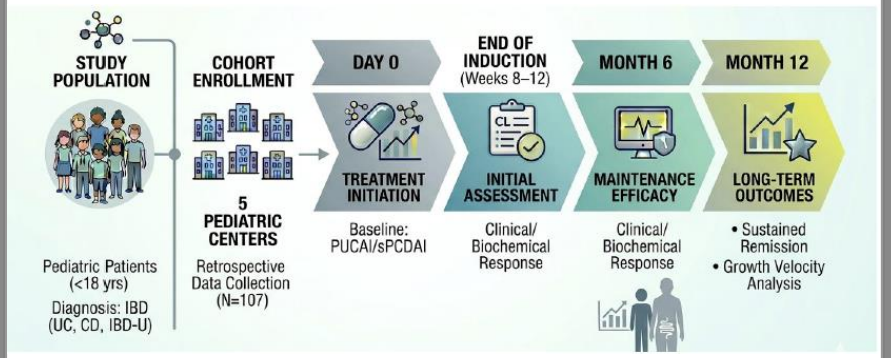
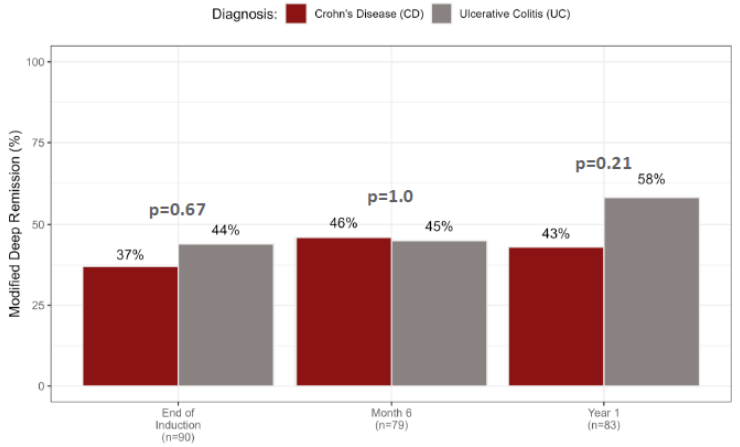
- 107 patients: 67 UC; 37 CD; 4 IBD-U
- Age: 15 [13.8-16] years-old
- All anti-TNF exposed
  - 54% failed ≥2 advanced therapies

Baseline Disease Activity	
PUCAI (n=60)	47.5 [25-65]
Short PCDAI (n=32)	27.5 [10, 40]
C-reactive protein (n=91)	1.1 [0.5-3.1] mg/dL
Albumin (n=95)	3.9 [3.4-4.2] g/dL
Hemoglobin (n=97)	12 [10.2-13.9] g/dL
Fecal calprotectin (n=55)	1940 [1228-3000] µg/g



Secondary Outcome: Modified Deep Remission (MDR)



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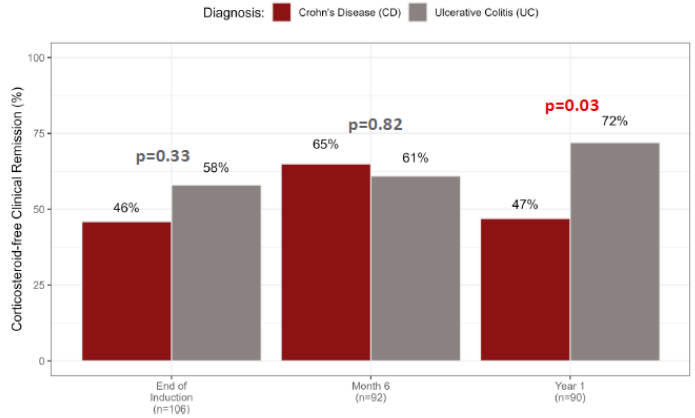
MDR: Endoscopic remission, CRP ≤ 0.5 mg/dL, or calprotectin < 250 µg/g

Primary Outcome: Corticosteroid-free Clinical Remission



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- **Effective in a biologic-exposed cohort, with tolerable safety.**
  - Including dual advanced therapy
- **Predictors of response**
  - Milder disease
  - Younger patients
- **Limitations reflective of retrospective, real-world data.**
  - Data heterogeneity
  - Composite biochemical endpoint
- **Future work**
  - Prospective, endoscopic & transmural endpoints
  - Phenotype-specific responses in CD
  - Therapy positioning

REAL-WORLD EFFECTIVENESS & SAFETY OF RISANKIZUMAB INDUCTION AND MAINTENANCE THERAPY IN PEDIATRIC PATIENTS WITH CROHN'S DISEASE: A MULTICENTER RETROSPECTIVE ANALYSIS

Elizabeth A. Spencer, Quentin Buck, Lauren V. Collen, Ronen Stein, Tyler Babinski, Dror S. Shouval, Firas Rinawi, Richard K. Russell, Eyal Zifman, Chani Topf-Olivestone, Christos Tzvinikos, Mordechai Slae, Raffi Lev-Tzion, Dan Turner, Marla C. Dubinsky, Amit Assa

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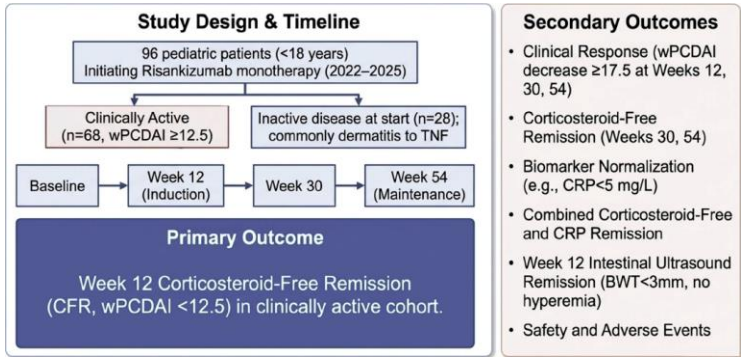

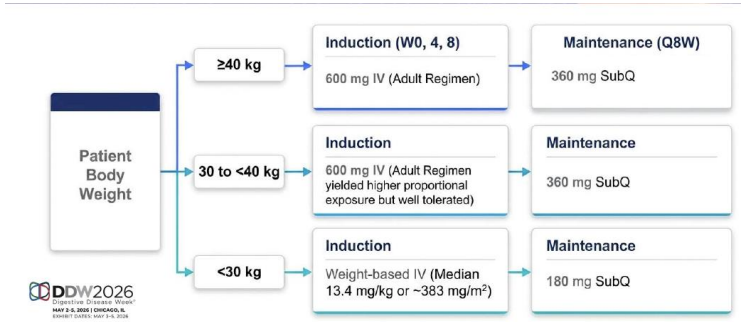

A Heavily Pre-Treated, Refractory Pediatric Cohort

Demographics
Median age 15 [IQR 13-16]
Age Range: 7-17 years
51% Male

Phenotype
78% Ileocolonic (L3)
31% with growth impairment history

Treatment History
49% failed ≥2 advanced therapies
47% prior Infliximab exposure
38% prior Ustekinumab exposure
Only 10% advanced-therapy naïve

Clinical Status
71% initiated with active disease (wPCDAI ≥12.5)
Median baseline wPCDAI: 35

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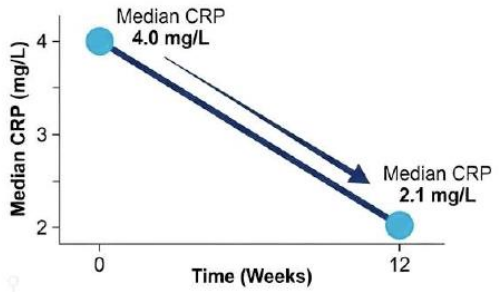
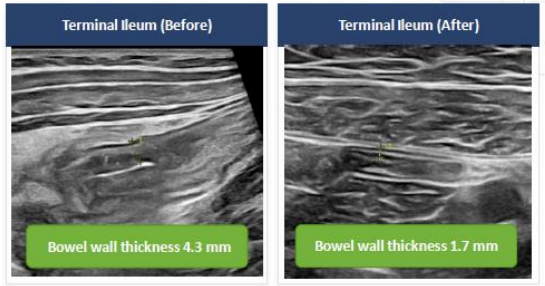
C-Reactive Protein (n=68)



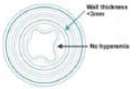
66% of the cohort achieved total CRP remission by Week 12.

CRP Remission = C-reactive protein (<5 mg/L)

Intestinal Ultrasound (n=20)



40% attained IUS Remission at Week 12.



Advanced Therapy Naïve

100% attained CFR (7/7)

High effectiveness

Prior Ustekinumab

OR 1.08 (p=0.88)

Effectiveness is preserved; statistically identical to Uste-naïve patients

Prior Infliximab

OR 0.34 (p=0.06)

Effectiveness is attenuated by prior anti-TNF exposure

Rapid Clinical Improvement by Week 12

Outcomes for the clinically active cohort (n=68)

Outcome Funnel

54% (37/68)
Clinical Response
≥17.5-point decrease in wPCDAI

Primary Outcome
41% (28/68)
Corticosteroid-Free Remission
wPCDAI <12.5 at Week 12

32% (22/68)
Deep Remission
CFR + CRP Remission concurrently

Median wPCDAI dropped from 35 at baseline down to **16 at Week 12 (p<0.001)**.

Pregnancy and Infant Outcomes Following *In Utero* Exposure to JAK Inhibitors in IBD

An ECCO Global Multicenter Cohort Study

Mette Julsgaard, Cynthia H Seow, Dana Duricova, Sunanda Kane, Neha Zacharias, Kristyna Zdychyncova, Rupert W Leong, Anneline Cremer, Klaartje B. Kok, Anna Kagramanova, Barbora Pipek, Kristina Candido, Irit A Biron, Rachel Cooney, Rafal Filip, Vytautas Kiudelis, Michal Konecny, Sudarshan Paramsothy, Daniela Pugliese, Genoile Santana, Edoardo V Savarino, Brigita Smolovic, Sophie Vieujean, Shu-Chen Wei, Simon MD Baunwall, Uma Mahadevan

Uma Mahadevan MD

Lynne and Marc Benioff Professor of Gastroenterology

Director, Colitis and Crohn's Disease Center

University of California, San Francisco

JAKi treatment in pregnancy (n=58)

Tofacitinib, n=38
- *5 mg BID or 10 mg BID*
- 26 (68%) received treatment throughout pregnancy
- 12 discontinued in pregnancy at median GW 7 (Range 5-31)

Upadaticinib, n=18
- *30 mg daily or 45 mg daily*
- 12 (80%) received treatment throughout pregnancy
- 3 discontinued in pregnancy at median GW 6 (Range 3-6)

Filgotinib, n=2
- *200 mg daily*
- 1 received treatment throughout pregnancy
- 1 discontinued in pregnancy at GW 11

Study Objective & Methods

Objective: Retrospective case series of *in utero* exposure to JAKi

METHODS
International (25 centres, 17 countries) multicentre, retrospective, observational study
Open Call (ECCO Newsletter)
Endorsed by **ECCO Confer**

RedCap:
- Disease activity,
- Maternal & infant outcomes
- Congenital abnormalities
- Vaccine response
- Childhood development

European Crohn's and Colitis Organisation

Key Results: Pregnancy Outcomes

Spontaneous abortions, *n (%)*	5	(8.6)
Induced abortions, *n (%)*	6	(10.3)
Live born infants, *n (%)*	47	(81.1)
Median (IQR) gestational week for delivery	40	(38-41)
Cesarean section	24	(41.4)
• Elective CS	16	(66.6)
• Emergency CS	8	(33.3)
Median (IQR) birth weight	3050	(2870-3410)
Congenital abnormalities	0	-
Preterm	2	(3.4)
APGAR < 7 at 5 minutes, *n (%)*	2	(3.4)
Small for Gestational Age (SGA)	4	(6.9)
Low Birth Weight (≤ 2500 gram)	6	(10.3)

Conclusion

European Crohn's and Colitis Organisation

- Ongoing disease remission in pregnancy results in optimal pregnancy outcomes
- JAKi: Use only if no other viable option for maternal health
- Shared decision making is key
- **No adverse signals:**
  - Maternal complications
  - Pregnancy outcomes
  - Infant development
  - Infection risk
  - Vaccine response

Use JAKi with caution:

Safety data in pregnancy remain very limited

ECCO Confer JAKi study recruiting: contact **mjn@clin.au.dk**

piano

Mette Julsgaard. mjn@clin.au.dk; **LinkedIn**, **X**@JulsgaardMette

Hépatologie pédiatrique

The Plasma Proteome Reveals Prognostically Important Molecular Endotypes in Pediatric Cholestasis

Rupa S Kanchi, Kathleen Loomes, Keith Hazleton, Juliet Emamaullee, Kasper Wang, Pamela Valentino, Ronald J Sokol, Phillip Rosenthal, Jean P Molleston, Alexander Miethke, John Magee, M. Kyle Jensen, Alyssa Kriegermeier, Saul J. Karpen, Simon Horslen, Arianna Barbetta, Cristian Coarfa, Benjamin Shneider

Research supported by
NIH National Institute of Diabetes and Digestive and Kidney Diseases
ChiLDReN Childhood Liver Disease Research Network

DDW2026 Digestive Disease Week®
MAY 2–5, 2026 | CHICAGO, IL
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1. To identify molecular endotypes across pediatric cholestatic liver diseases using plasma proteomics
2. To assess the association of these endotypes with clinical outcomes

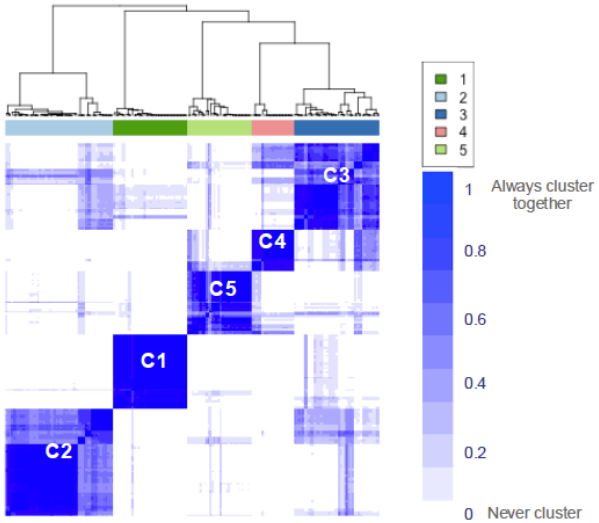
Pediatric liver disease patients (ChiLDReN)

- FORCE (NIH/NIDDK): FibroScan in Pediatric Cholestatic Liver Disease
- Fibroscan-based measurements of liver stiffness, Shneider et al., *Hep Comm,* 2020, 4(11)
- Collection of serum and plasma as an associated biorepository
- FORCE baseline: 170 samples; BA (n = 93), A1AT (n = 31), ALGS (n = 46)

Healthy controls

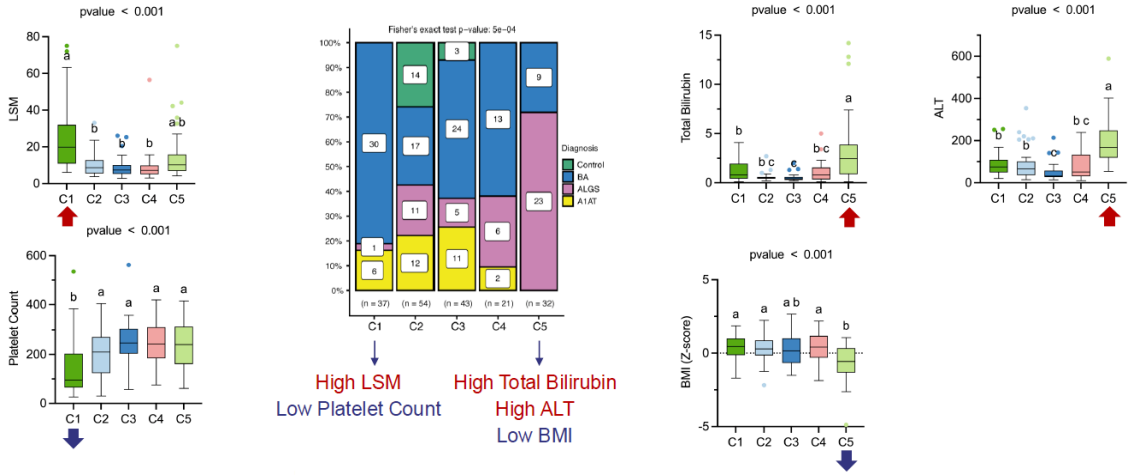
- From general pediatric gastroenterology clinic (n = 17)
- Patients being evaluated for constipation, with no known liver diagnoses

	A1AT (n = 31)	ALGS (n = 46)	BA (n = 93)
Age (years)	13.1 (9.7, 16.2)	11.5 (8.3, 16.0)	8.1 (4.5, 11.8)
Total bilirubin (mg/dL)	0.50 (0.30, 0.80)	1.15 (0.50, 3.00)	0.50 (0.40, 1.00)
ALT (mg/dL)	43 (29, 61)	137 (75, 198)	59 (36, 94)
Albumin (g/dL)	4.40 (4.00, 4.60)	4.30 (3.90, 4.60)	4.30 (3.90, 4.50)
INR	1.10 (1.00, 1.14)	1.04 (1.00, 1.10)	1.10 (1.00, 1.14)
PELD score	-12 (-15, -8)	-6 (-10, 1)	-11 (-14, -5)
Platelet count	226 (167, 257)	251 (180, 305)	198 (98, 279)
n (%) < 150	7 (22.6%)	9 (19.6%)	33 (35.5%)



Consensus matrix of samples , K = 5

Heatmap shows consistency/stability in clustering of pairs of samples

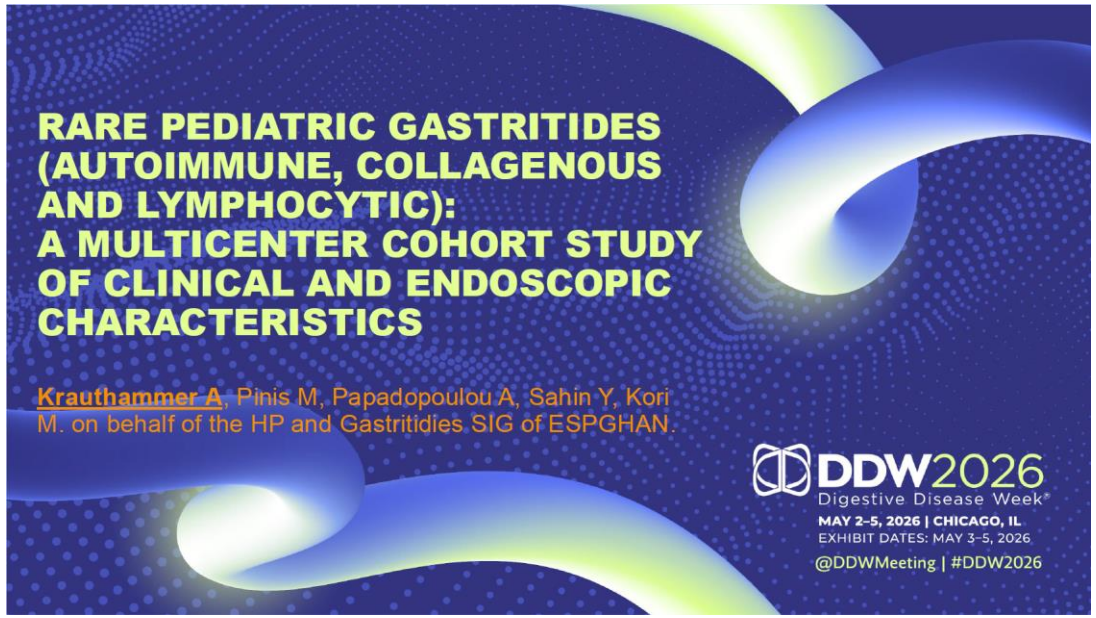


High LSM
Low Platelet Count

High Total Bilirubin
High ALT
Low BMI

Hallmark Genesets	C1	C2	C3	C4	C5
Fibrosis / ductal remodeling / epithelial structure					
EPITHELIAL MESENCHYMAL TRANSITION	3.67	2.42		-2.01	1.43
APICAL SURFACE	2.83	1.60		-1.69	
APICAL JUNCTION	2.27	1.55	1.54	-1.60	2.13
ANGIOGENESIS	2.08			-1.27	-1.91
HEDGEHOG SIGNALING	1.71			-1.90	
NOTCH SIGNALING	1.60				
Inflammation / Immune					
IL6 JAK STAT3 SIGNALING	1.97	1.73		-1.63	1.33
COMPLEMENT	1.81			-1.31	-1.58
ALLOGRAFT REJECTION	1.49				
IL2 STAT5 SIGNALING	1.44	2.00		-1.99	
INFLAMMATORY RESPONSE	1.42			-1.62	
TNFA SIGNALING VIA NFKB					1.55
INTERFERON ALPHA RESPONSE			1.56	1.55	1.45
Hepatic metabolism / detox					
OXIDATIVE PHOSPHORYLATION	2.32	1.76	2.95	3.75	3.81
XENOBIOTIC METABOLISM	2.11	1.93			2.60
FATTY ACID METABOLISM	2.03		3.03	4.12	3.78
CHOLESTEROL HOMEOSTASIS	1.76				1.41
ADIPOGENESIS	1.75	1.96	2.76	2.70	2.93
PEROXISOME			2.44	2.64	2.24
BILE ACID METABOLISM			1.62	2.24	1.88
HEME METABOLISM	-2.03	-1.77			-1.97
Cellular stress / ER stress					
PROTEIN SECRETION			1.72	1.91	1.79
UNFOLDED PROTEIN RESPONSE			1.47	1.56	1.51
P53 PATHWAY					1.45
DNA REPAIR			1.40	1.58	1.37
APOPTOSIS				-1.34	
REACTIVE OXYGEN SPECIES PATHWAY	-1.78				
Proliferation / regeneration					
PI3K AKT MTOR SIGNALING		-2.17	3.41	3.86	2.03
MTORC1 SIGNALING			2.30	2.82	2.02
G2M CHECKPOINT		1.52	1.34	1.96	1.66
MITOTIC SPINDLE				1.98	
MYC TARGETS V2				1.51	
E2F TARGETS	-1.54			1.90	1.31

Endoscopie (et trouvailles anormales…)



- Multicenter International ESPGHAN collaboration
- Currently 5 centers:

  Europe (n=2) and Middle East (n=3)
- Retrospective: 2010–2025
- Population: 0-18 years
- Follow-up through 2031

Distribution des gastrites chroniques non-Helicobacter pylori:

- Gastrite auto-immune (AIG) : 0.2% [5.4% si anémie]
- Gastrite collagénique (CG) : 0.01%
- Gastrite lymphocitaire (LG) : 0.21%

- Total pediatric UGE: N=10,662
- N = 60 (prevalence ~0.56% of UGE)

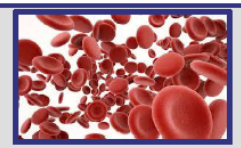
❑AIG (n=11, ~0.1%), CG (n=18, ~0.2%) and LG (n=31, ~0.3%)

- Males: n=29 (48.3%)
- Age: 10.4 ± 4.9 years

	AIG (Autoimmune)	CG (Collagenous)	LG (Lymphocytic)
Abnormal Weight Gain	0% (Absent)	11% (2/18)	32% (10/31) Significant (p=0.04)
Endoscopic Appearance	100% Inflamed / Polypoid	100% Inflamed / Polypoid	51.6% Normal Mucosa (16/31 patients) p < 0.001

Rare but real

- These Gastritides represent <1% of pediatric UGE
- This multicenter cohort confirms UGE prevalence rates AIG(0.1%), CG(0.17%) and LG(0.29%)



• IDA Signal

- Iron deficiency anemia is the universal anchor present in 78.3% of cases
- IDA is the primary prompt for investigation across all three entities

• The normal scope “trap”

- LG presents unique diagnostic challenge:
- ✓ -Highetst association with failure to gain weight (32%)
- ✓ -Highest rate of normal appearing mucosa (>50%)
- Consider taking biopsy in IDA/Failure to gain weight even if macroscopically normal

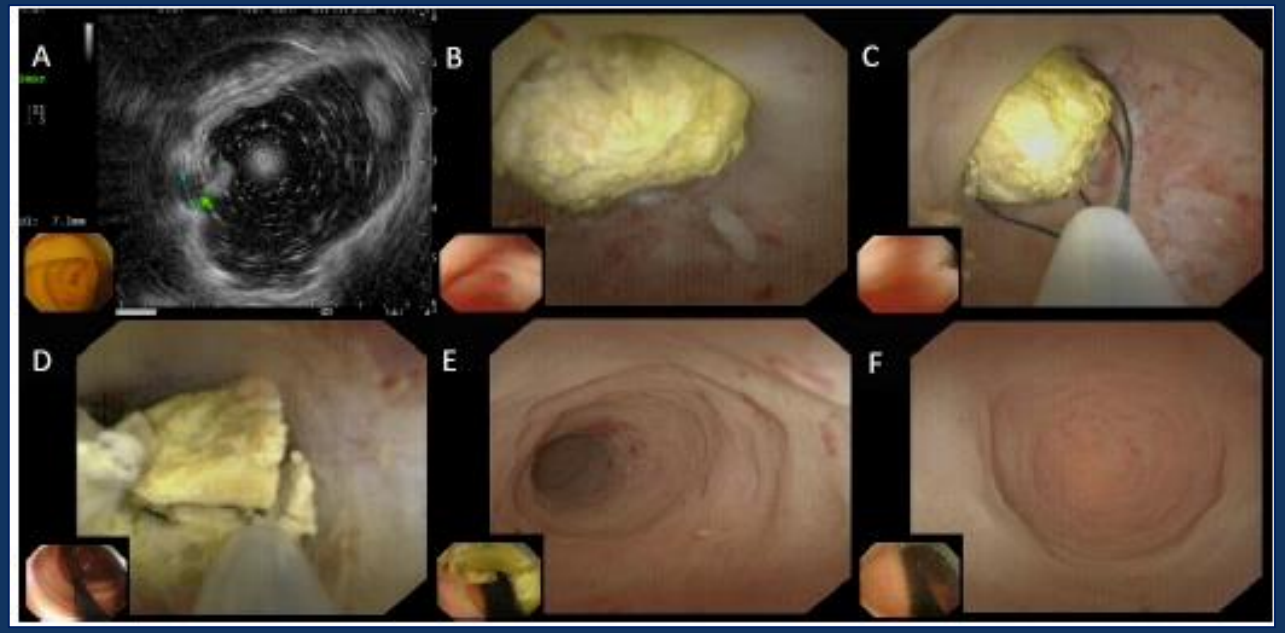
ENDOSCOPIC APPENDICITIS DIAGNOSTIC INTERVENTION (EADI) IN PEDIATRIC UNCOMPLICATED APPENDICITIS: A SINGLE CENTER STUDY

Yan-Ru Shen[1], De-Jin Zhong[1], Hao Hong[2], Yang-Bor Lu[1], Yung- Ning Huang[1], You-Xian Xie[1], Yu-Chieh Weng[1]

1Department of Digestive Disease, Xiamen Chang Gung Hospital, Hua Qiao University, Xiamen, Fujian, China.
2Department of Pediatrics, Xiamen Chang Gung Hospital, Hua Qiao University, Xiamen, Fujian, China.

DDW2026 Digestive Disease Week®
MAY 2–5, 2026 | CHICAGO, IL
EXHIBIT DATES: MAY 3–5, 2026
@DDWMeeting | #DDW2026

- Retrospective à centre unique
- Fevrier 2024 – Juin 2025
- Enfants entre 5 et 18 ans
- Appendicite non-compliquée au scan



83.3%
CT-visible appendicolith

22.5 min
Median procedure time

2.5 d
Median hospital stay

100%
Complete-case analysis
17/17; 95% CI 80.5-100

94.4%
Conservative sensitivity analysis
17/18; 95% CI 72.7-99.9

Endoscopic Ultrasound-Guided Liver Biopsy in Children Under 10 Years of Age: A Single Center Experience on its Feasibility, Safety, and Diagnostic Yield

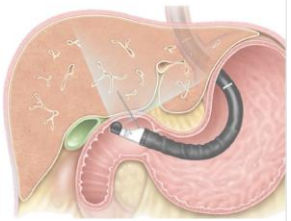
Lucia Gonzalez-Llanos[1,3], Javier Garcia-Marin[2], Paige Graf[3], Talia Schwartz[1,3], Garrett Sprague[1,3], Pamela Sylvester[4], David Vitale[1,3]

1. Division of Gastroenterology, Hepatology and Nutrition, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
2. Division of Gastroenterology, Hepatology and Nutrition, Children's Hospital at Montefiore, Bronx, NY
3. Department of Pediatrics, University of Cincinnati, Cincinnati, OH
4. Division of Pathology & Laboratory Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Cincinnati Children's
changing the outcome together

EUS Liver Biopsy

- Right lobe:
  - Approach from duodenal bulb
  - Needle primed with sterile saline and negative pressure syringe suction applied
  - Long pass (4-8 cm) of 19-gauge core needle
  - 1 actuation
- Left lobe:
  - Similar preparation and needle action
  - Approach through gastric mucosa



Diehl et al, Endoscopy Intl, 2015
Neito et al, Gastrointest Endoscopy, 2018

Cincinnati Children's

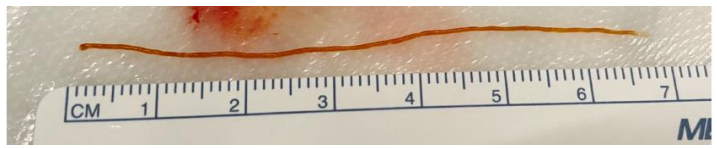


Table 2. Liver Biopsy Sample Data, n = 29	
Maximum Intact Specimen Length (cm)	3.2 (2.0 – 4.2)
Total Specimen Length (cm)	5.9 (4.4 – 7.4)
Number of Complete Portal Tracts (All Specimens)	12 (7 – 17.25)
Both Lobes Biopsied	19 (66%)
Technical Success	28 (97%)
Diagnostic Success	28 (97%)
Adverse Events	0.0%

THE EMERGING FIELD OF ENDOHEPATOLOGY IN THE PEDIATRIC POPULATION

-A SINGLE CENTER EXPERIENCE FROM THE UNITED STATES-

DDW 2026 – Chicago, IL

May 4, 2026

Amit Grover, MB BCh BAO

Boston Children's Hospital, Harvard Medical School

Where the world comes for answers

Boston Children's

Boston Children's Hospital Experience

June 2020 – October 2025

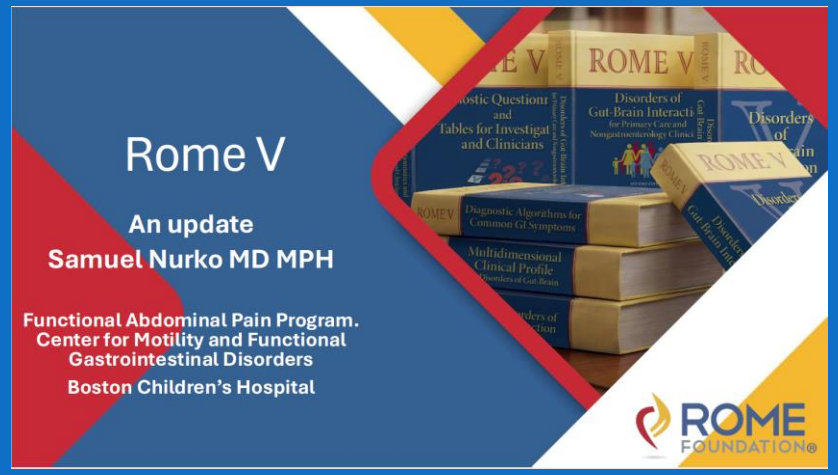
- 20 unique patients
  - 80% male
  - Mean age 17 years (range 4-31 y
- 14 (70%) – EUS LB
- 3 (15%) – EUS PPG
- 3 (15%) – EUS GVC
- 0 adverse events

19G FRANSEEN TIP FNB NEEDLE	
Total Cases (n)	14
Diagnostic Sample	12 (86%)
Ambulatory Setting	11 (79%)
Mean total specimen length (cm)	3.8
Mean number of complete portal triads	24

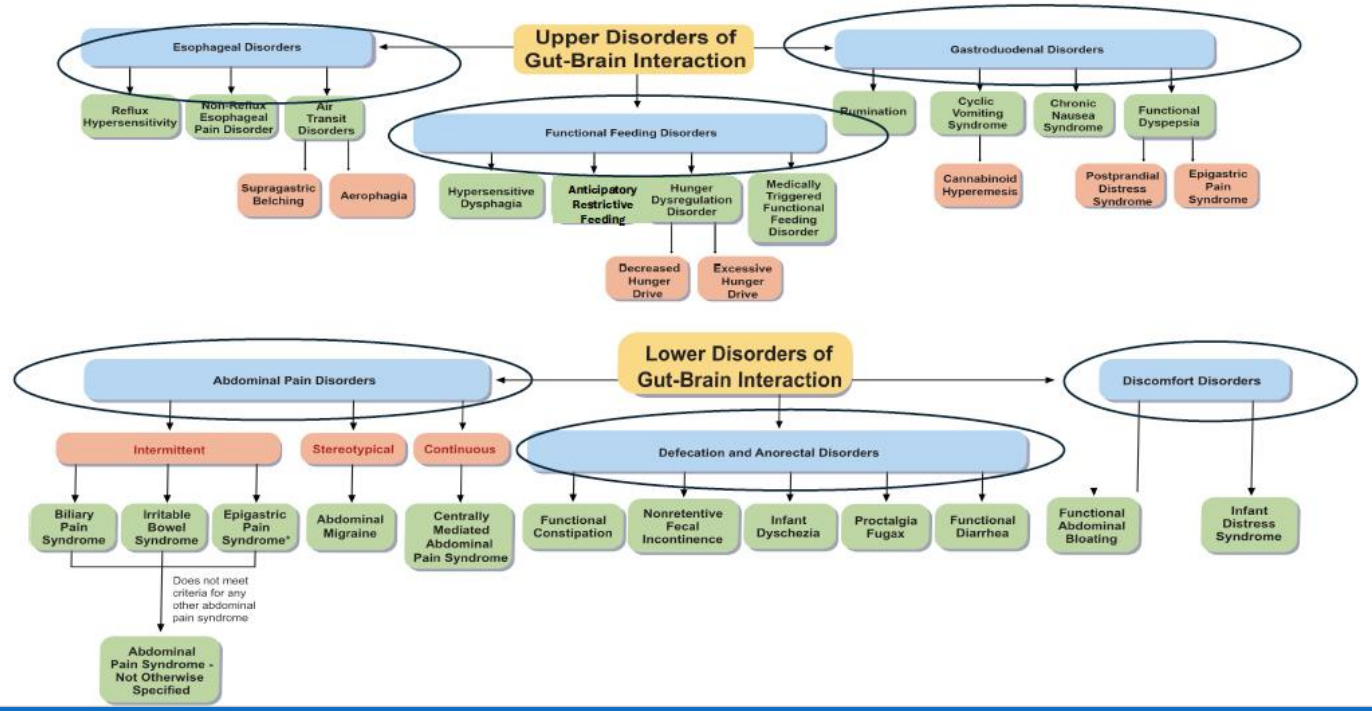
EUS GUIDED PORTAL PRESSURE GRADIENT MEASUREMENT (EUS PPG) – BCH Experience

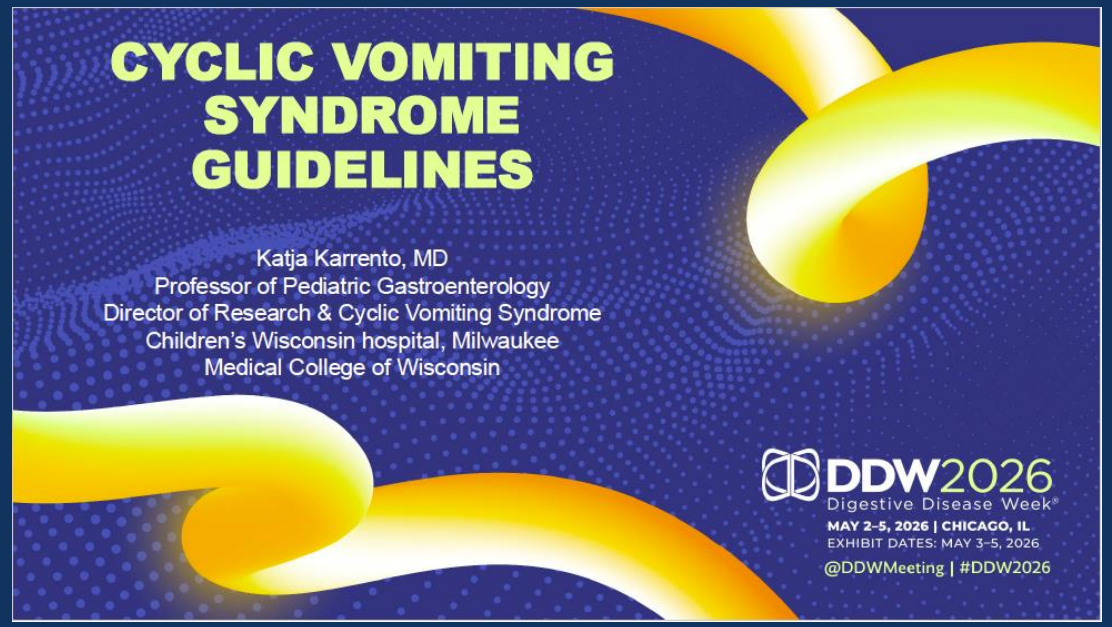
- Three patients (mean age 26 years, range 23-31) underwent EUS PPG
  - 2 had Fontan Associated Liver Disease and were undergoing EUS PPG as part of the transplant evaluation for possible combined heart-liver transplant
  - 1 had confirmed cirrhosis and was being evaluated for clinically significant portal hypertension
  - All cases were performed in the ambulatory setting under general anesthesia
  - All had success HV/PV pressures measured with PPG successfully calculated
  - 0 Adverse events

“Disorders of the Gut—Brain Interaction”


Rome V
An update
Samuel Nurko MD MPH
Functional Abdominal Pain Program.
Center for Motility and Functional
Gastrointestinal Disorders
Boston Children's Hospital
ROME V
Disorders of Gut-Brain Interacti
Diagnostic Algorithms for Common GI Symptoms
Multidimensional Clinical Profile
ROME FOUNDATION®

ROME V


Upper Disorders of Gut-Brain Interaction
Esophageal Disorders
Reflux Hypersensitivity
Non-Reflux Esophageal Pain Disorder
Air Transit Disorders
Supragastric Belching
Aerophagia
Functional Feeding Disorders
Hypersensitive Dysphagia
Anticipatory Restrictive Feeding
Hunger Dysregulation Disorder
Medically Triggered Functional Feeding Disorder
Decreased Hunger Drive
Excessive Hunger Drive
Gastroduodenal Disorders
Rumination
Cyclic Vomiting Syndrome
Chronic Nausea Syndrome
Functional Dyspepsia
Cannabinoid Hyperemesis
Postprandial Distress Syndrome
Epigastric Pain Syndrome
Lower Disorders of Gut-Brain Interaction
Abdominal Pain Disorders
Intermittent
Stereotypical
Continuous
Biliary Pain Syndrome
Irritable Bowel Syndrome
Epigastric Pain Syndrome*
Abdominal Migraine
Centrally Mediated Abdominal Pain Syndrome
Does not meet criteria for any other abdominal pain syndrome
Abdominal Pain Syndrome - Not Otherwise Specified
Defecation and Anorectal Disorders
Functional Constipation
Nonretentive Fecal Incontinence
Infant Dyschezia
Proctalgia Fugax
Functional Diarrhea
Discomfort Disorders
Functional Abdominal Bloating
Infant Distress Syndrome

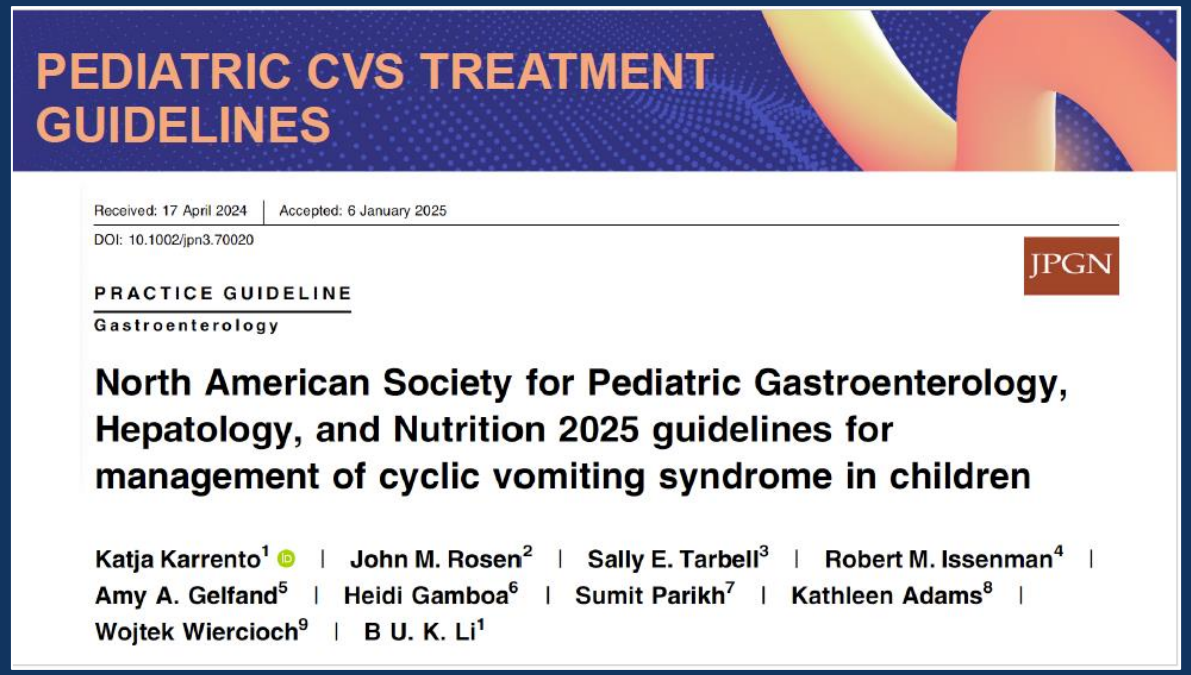


- 46% missed by Rome IV, 48% missed by NASPGHAN – *need new criteria*
- CVS patients have specific characteristics – *new criteria will be evidence-based*
- One time assessment is ***not*** sufficient – *8% incorrect, need follow-up, e.g. 6 months*
- Clinical judgement is invaluable!

- Épisode de debut *soudain*, *stéreotypés*, de vomissements à répétition, plusieurs fois par heure
- *4 ou plus* épisodes dans les derniers 12 mois
- Durée 2h - 7 jours
- Au moins 1 semaine entre les épisodes
- *Retour au "baseline"* entre épisodes

Trouvailles à faveur

✓ ATCD personels ou familiales de migraine
✓ Léthragie, diaphorèse, photophobie, nausée incessante, douleur abdominale
✓ Symptômes légers peuvent être présents ENTRE les épisodes



Prophylaxie non-pharmacologique

- Thérapies psychologique/congnitive
- Éviter les déclencheurs
- Hygiène sommeil
- Neuromodulation
- Supplements :
  - Riboflavin 100 mg (<40kg) / 200mg (≥40 kg) BID
  - Coenzyme Q10 (essai) 100 mg (<40kg) / 200mg (≥40 kg) DIE ou BID
  - Glycinate Mg : 9mg/kg/j HS (ad 400mg)

- β-bloqueurs
  - Sécuritaire, haute efficacité, bonne réponse longue-terme
  - Précaution asthme sévère
- Antagonistes 5-HTr
- Antagonistes NK-1r
- Antidepresseur TCA : si pas de réponse aux autres agents
- Anticonvulsants si réfractaire

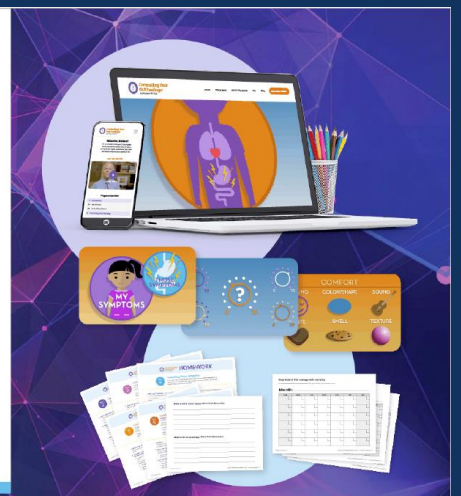
A four-week web-based video mind-gut intervention improves functional abdominal pain associated somatic stress and anxiety in children.

Alain J. Benitez MD*, MSTR

May 2, 2026

Children's Hospital of Philadelphia

Perelman School of Medicine University of Pennsylvania



Children's Hospital of Philadelphia RESEARCH INSTITUTE

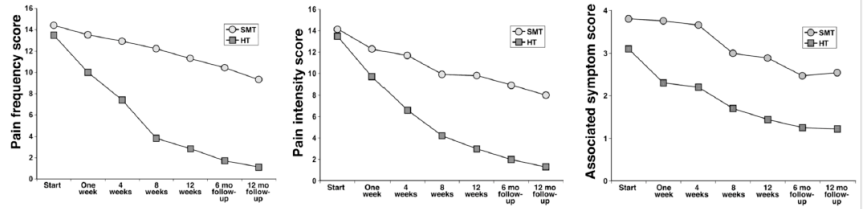
*For research purposes only; not acting in a clinical capacity

1

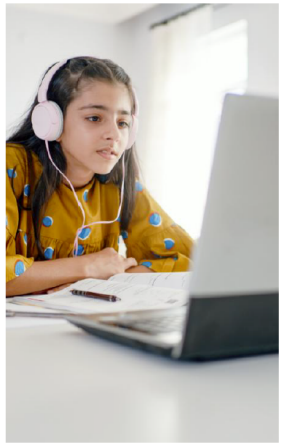
Gut-brain therapies are effective in pediatric FAPDs

IBS or FAP = 53

Hypnotherapy **(HT)**
vs
Standard medical care **(SMT)**

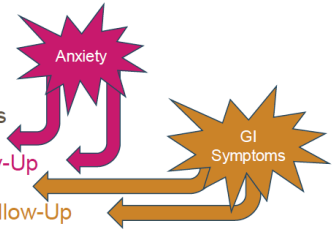


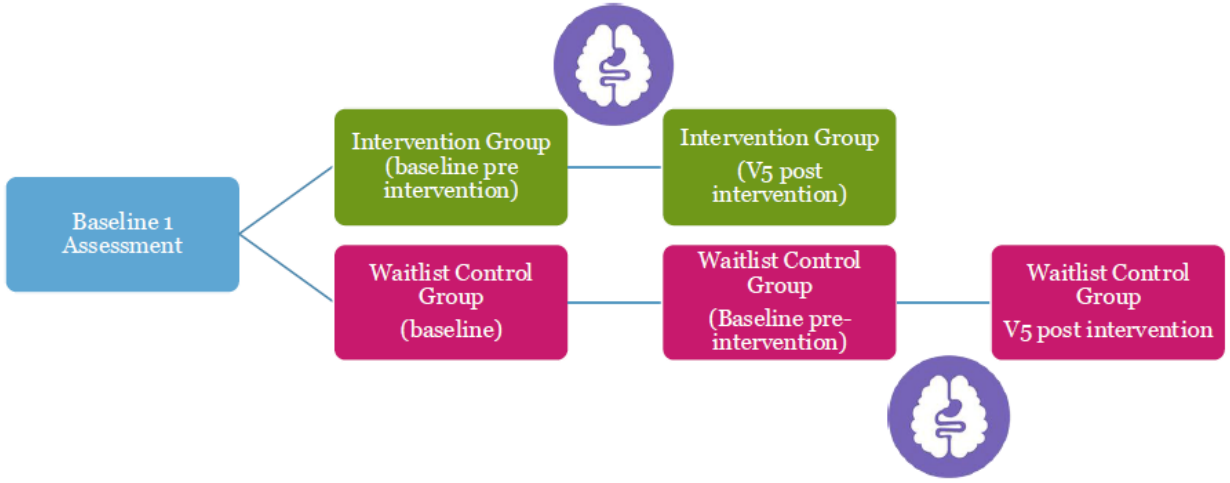
Controlling Your Gut Feelings ® (CYGF): a web-based video program

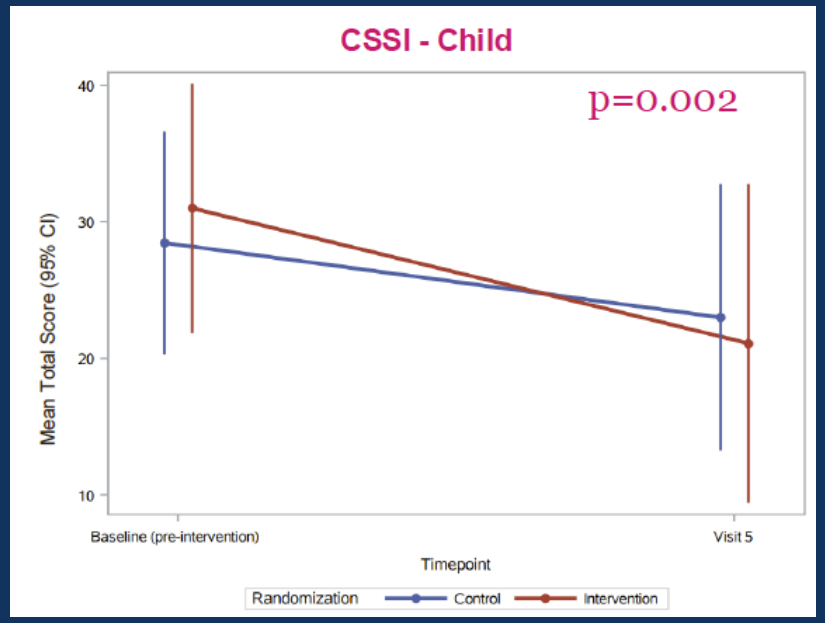


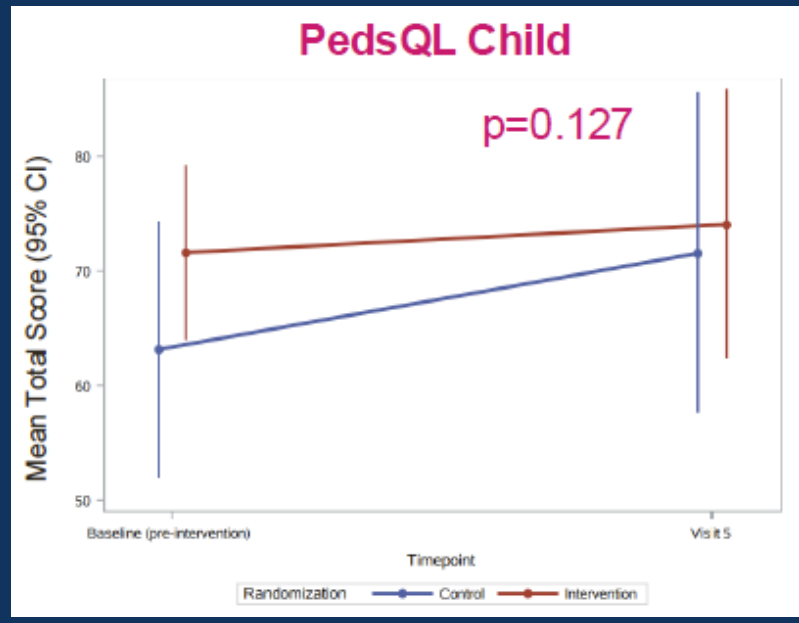
- Web-based self-paced video program
- Designed to address GI symptoms and related anxiety
- Medical hypnosis
- Cognitive behavioral therapy (CBT) strategies
- Motivational Interviewing
- Downloadable Homework
- S1: Information for Parents
- S2: Information for Child and Parents
- S3: Controlling That Worrying
- S4: Controlling That Worrying Follow-Up
- S5: Controlling Those Symptoms
- S6: Controlling Those Symptoms Follow-Up
- S7: Conclusion

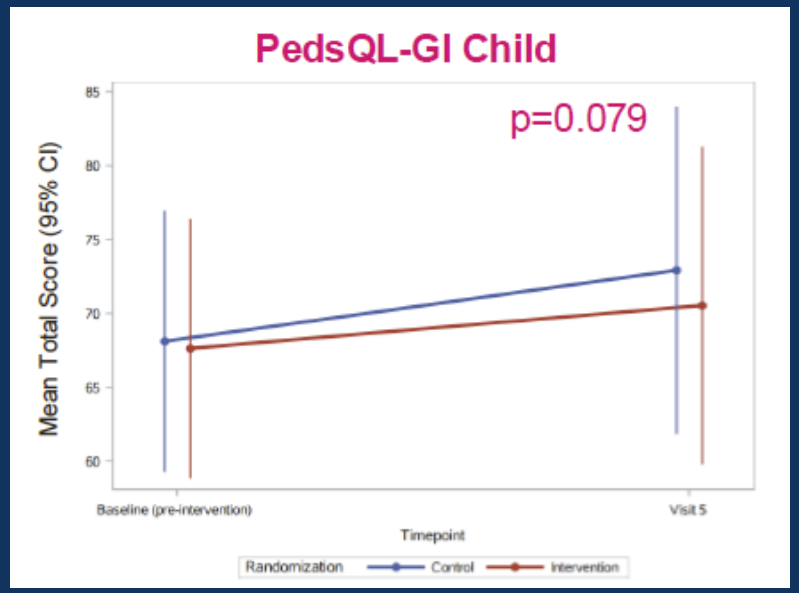
CYGF

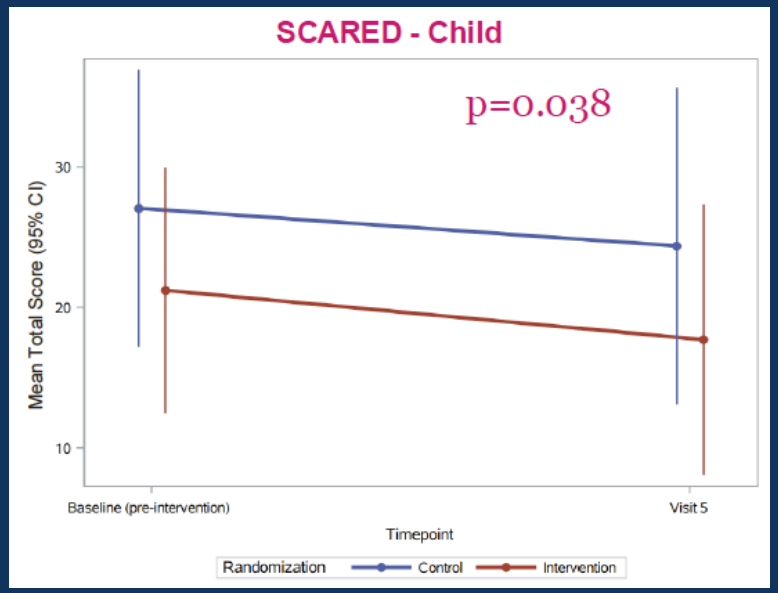





CSSI - Child
p=0.002
Mean Total Score (95% CI)
40
30
20
10
Baseline (pre-intervention)
Visit 5
Timepoint
Randomization
Control
Intervention


PedsQL Child
p=0.127
Mean Total Score (95% CI)
80
70
60
50
Baseline (pre-intervention)
Visit 5
Timepoint
Randomization
Control
Intervention


PedsQL-GI Child
p=0.079
Mean Total Score (95% CI)
85
80
75
70
65
60
Baseline (pre-intervention)
Visit 5
Timepoint
Randomization
Control
Intervention


SCARED - Child
p=0.038
Mean Total Score (95% CI)
30
20
10
Baseline (pre-intervention)
Visit 5
Timepoint
Randomization
Control
Intervention

frontiers in Nutrition

Front Nutr. 2025 Sep 3;12:1578181. doi: 10.3389/fnut.2025.1578181

Constipation symptoms are associated with worse cognitive outcomes in older adults without dementia

Xiaochang Liu [1,2,3,†], Juan Zhou [1,2,3,†], Xinyan Xie [1,2,4,†], Wenzhe Zheng [1,2,3,†], Dan Liu [1,2,3], Guirong Cheng [1,2,3], Feifei Hu [1,2,3], Junyi Wang [1,2,3], Cheng Cai [1,2,3], Jing Liu [1,2,3], Qianqian Nie [1,2,3], Shiyue Li [1,2,3], Dan Song [1,2,3], Yuyang Cui [1,2,3], Jingjing Zhang [1,2,3], Hua Meng [1,2,3], Wei Tan [3,*], Yan Zeng [1,2,3,*]

Columbia University
College of Physicians and Surgeons

NewYork-Presbyterian
Morgan Stanley Children's Hospital
Columbia University Medical Center

Reframing Pediatric Functional Constipation: A New Era of Insight and Management

frontiers | Frontiers in Neurology

PUBLISHED 04 June 2025
DOI 10.3389/fneur.2025.1600952

Check for updates

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Constipation and risk of cognitive impairment and dementia in adults: a systematic review and meta-analysis

Qiyue Wang, Ting Yi and Xuan Jiang*

Department of Gastroenterology, Beijing Tsinghua Changgung Hospital, School of Clinical Medicine, Tsinghua Medicine, Tsinghua University, Beijing, China

Pharmacological treatment: Disimpaction

Good Practice Statements

- The GDG suggests that consideration and management of **fecal impaction is vital to ensure long term therapeutic success** with any maintenance therapy. The GDG acknowledges that the lack of a clear definition for fecal impaction influences assessment in practice and is a barrier to achieving successful disimpaction.

  The GDG **suggests that high dose polyethylene glycol or enemas can be used** as treatment options for fecal impaction.

  The GDG also **recognizes other treatments that have utility in disimpaction** and may be used under locally agreed standardized protocols.

TABLE 2 Diagnostic criteria for refractory constipation in children (all four criteria must be present).

1. Must meet ROME IV criteria for functional constipation
2. Failure of age and developmentally appropriate conventional therapies to improve symptoms after a minimum of 3 months on the following therapies
   a. Daily use of a stimulant laxative at appropriate dosage (see Table 3 for dosing recommendations) regardless of osmotic laxative use
   b. Behavioral interventions
   c. Biomechanical interventions (i.e., correct positioning on the toilet)
3. Ongoing symptoms of constipation
   a. ≤2 voluntary defecations per week

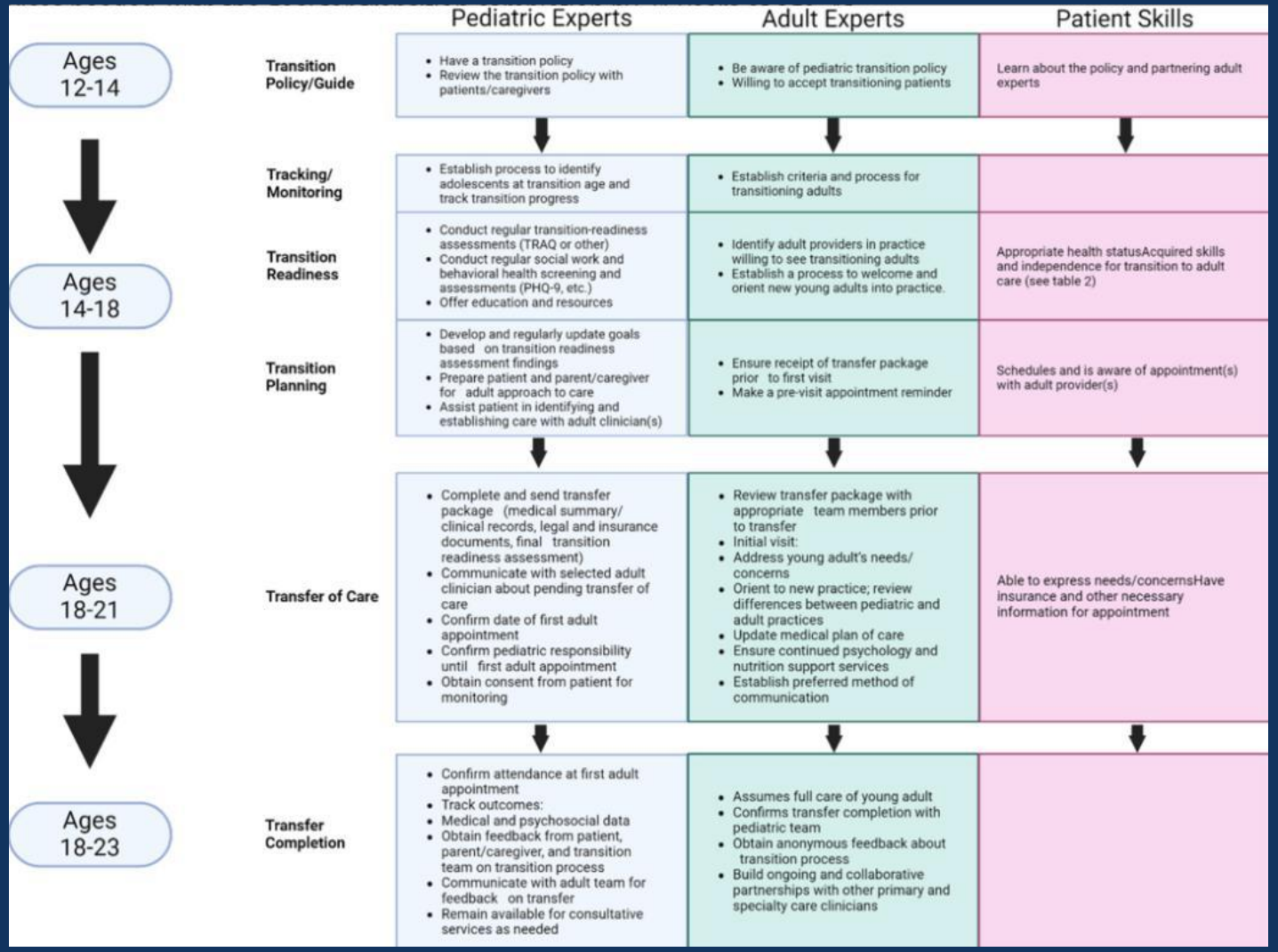
   and/or

   b. ≥1 episode of fecal incontinence per week
4. Impaired QoL for the patient or family due to constipation symptoms

Pharmacological treatment: Maintenance

Good Practice Statements

- The GDG suggests that **lactulose has a therapeutic role** for FC in children.
- The GDG suggests that **bisacodyl has a therapeutic role** for FC in children.
- The GDG suggests that **senna has a therapeutic role** for FC in children.
- The GDG suggests that **sodium picosulfate has a therapeutic role** for FC in children.
- The GDG suggests that **liquid paraffin has a therapeutic role** for FC in children. However, **routine use is not recommended** due to the potential significant side effects.
- The GDG **does not suggest the use of lubiprostone** as a treatment for FC in children.
- The GDG **does not suggest the use of domperidone** as a treatment for FC in children.
- General statement regarding rectal therapies: The GDG acknowledges the **potential psychosocial impact of all per rectum therapies.** The decision to consider such therapies should be shared with children and their families, taking key factors into account.
- The GDG suggests **enemas have a maintenance therapeutic role** for FC in select children.
- The GDG suggests **rectal suppositories have a therapeutic role** for FC in select cases, either as an adjunct or as an alternative when other therapies are not effective or appropriate.
- The GDG suggests **transanal irrigation has a therapeutic role** for FC in select cases (where other therapies are not effective or appropriate) and under specialized expert care.
- The GDG suggests **botulinum toxin A injections have a therapeutic role** for FC in select cases (refractory to conventional treatments) under specialized expert care.



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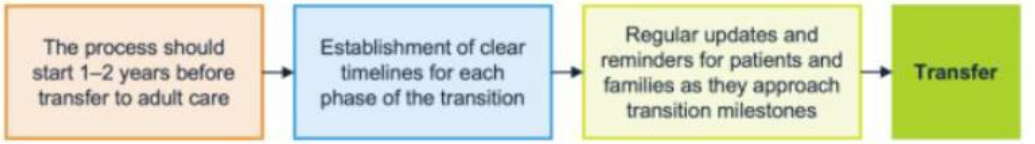
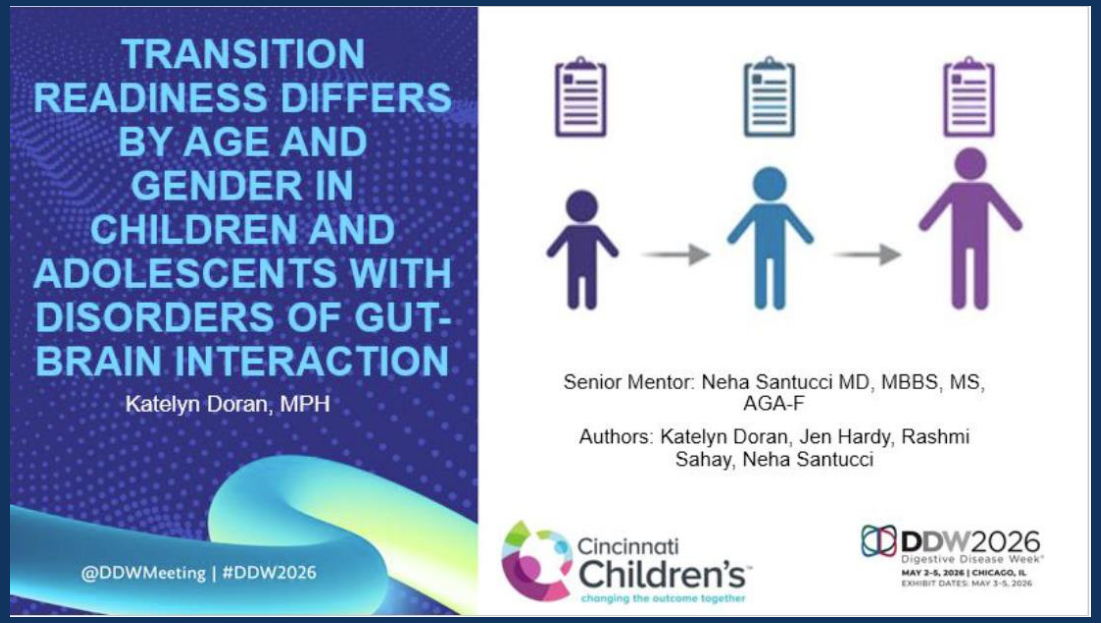
Clinical Gastroenterology and Hepatology
Available online 2 April 2026
In Press, Uncorrected Proof What's this?

American Gastroenterological Association-North American Society for Pediatric Gastroenterology, Hepatology and Nutrition Pediatric Functional Constipation Clinical Care Pathway

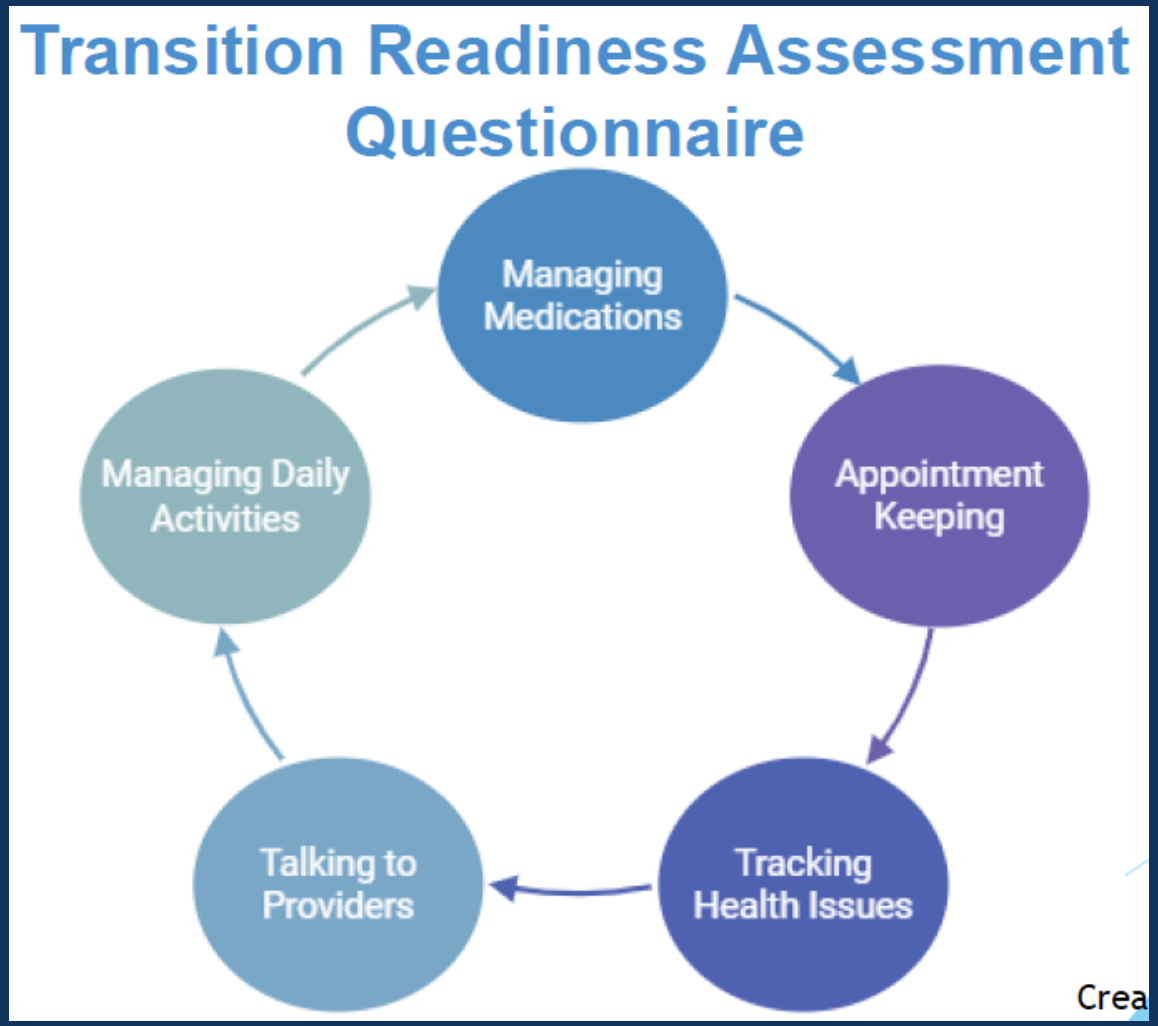
Leonel Rodriguez [1], Lusine Ambartsumyan [2], Kayla Baumgartner [3], Carlo Di Lorenzo [4], Ada M. Fenick [5], Jose M. Garza [6], Ajay Kaul [7], Julie Khlevner [8], Samuel Nurko [9], Miguel Saps [10], Julie Shotwell [11], Maggie Stoeckel [1 12], Michael Camilleri [13]

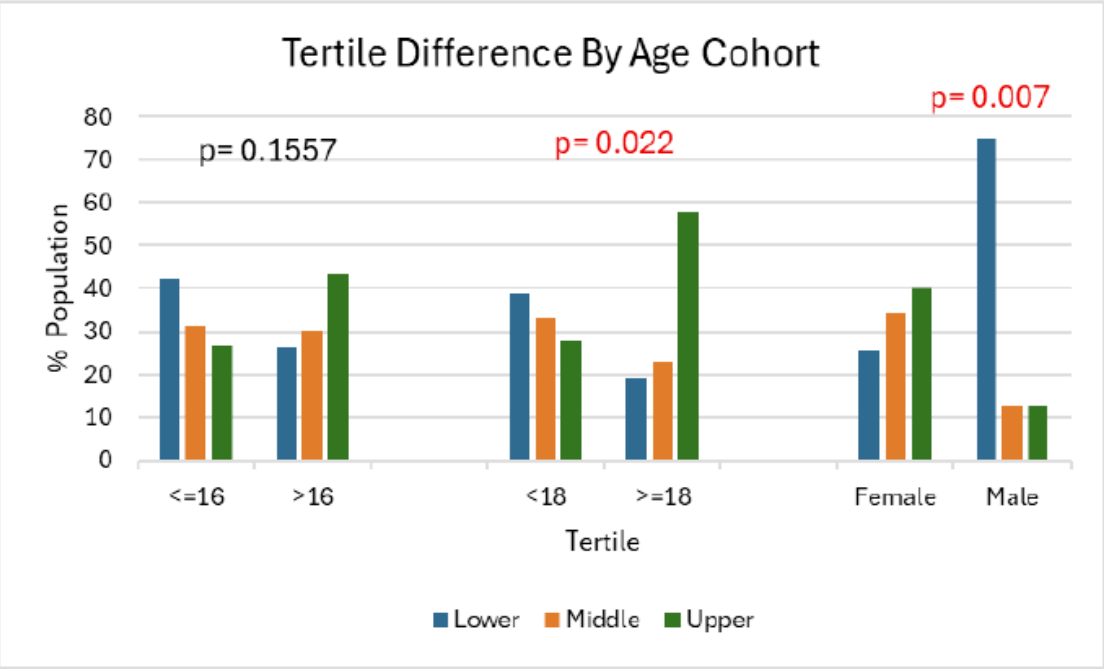




Methods

- **Inclusion Criteria**: Patients ages 15-25 years seen in DGBI clinic between February 2021 and October 2025
- **Exclusion Criteria:** Organic GI disorders, neurodevelopmental disorders





	p-value	
Diagnosis	**Kruskall Wallace**	**Wilcoxon sum**
FD v IBS	0.8139	0.5172
FD v FNV	0.8867	0.4652
FNV v IBS	0.4415	0.7913
FAP v FC	0.2088	0.4198

FD= functional dyspepsia, IBS= irritable bowel syndrome, FNV= functional nausea and vomiting, FAP = functional abdominal pain, FC = functional constipation

Merci beaucoup de votre attention