CURSO DE AVANCES EN GASTROENTEROLOGÍA

PERSPECTIVAS FUTURAS EN GASTROENTEROLOGÍA

17 - 19 Julio 2024 - Hotel InterContinental, Stgo.

SChGE

Inteligencia Artificial (IA) y Avances en Endoscopia digestiva alta y Colonoscopia

Carlos Rueda- Gastroenterólogo
INCANCER- CLINICA ALEMANA

Julio-2024-Santiago

Conflicto de intereses

- Gastroenterología Latinoamericana
- Órgano que difunde nuestro quehacer diario y científico, hace más de 30 años
- Editor

DDW 2024- WASHINGTON D.C –USA
“TODO SE TRATA DE TU CAMINO”

CURSO DE AVANCES EN GASTROENTEROLOGÍA
PERSPECTIVAS FUTURAS EN GASTROENTEROLOGÍA
17 - 19 Julio 2024 - Hotel InterContinental, Stgo. SChGE

- Asistentes 25.000 a 30.000
  5 días de congreso, 1 de ellos es para temas especiales , 4 generales
- 408 sesiones, de 1 a 2 horas cada una, 4 a 6 conferencias por sesión
- e-Posters todos los días
- Simposios de AGA , todo un día o de ASGE
- Desayunos con el profesor
- Logística impresionante

Modalidad online logística

CURSO DE AVANCES EN GASTROENTEROLOGÍA
PERSPECTIVAS FUTURAS EN GASTROENTEROLOGÍA
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- Inscribirse
- Escoger los tópicos a los que quieres participar
- Estar atento a las horas, que se presenta, mismo huso horario que Chile
- Largas jornadas frente al computador o a la App , mañana y tarde por 5 días
- Cuando liberan todas las presentaciones… ahí empieza lo entretenido

Sat, May 18

Incorporating GI Cancer Screening Guidelines Into Practice - Moving Beyond Endoscopy and
8:00am-9:30am
151A - Walter E. Washington
Session Numbe...

Artificial Intelligence in GI Cancer Screening an Center **d**
10:00am-11:30am
152AB - Walter E. Washington

Center
Sp174: AI & MACHINE LEARNING PRIMER GI CANCER
Dennis Shung
10:00am-10:20am
152AB - Walter E. Washington Session Numbe...
Center

Sp175: AI IN ENDOSCOPY FOR AND SURVEILLANCE
Prateek Sharma
10:20am-10:40am
152AB - Walter E. Washington Session Numbe...
Center

Sp176: MACHINE LEARNING FOR GI CANCER... Ajay Goel
10:40am-11:00am

152AB - Walter E. Washington Session Numbe...
Center

Sat, May 18

90: MACHINE LEARNING ANALYSIS OF ULTRASONOGRAPHY...
Venkata Sandeep Akshintala
11:00am-11:10am
152AB - Walter E. Washington Session Numbe...
Center

91: A CIRCRNA BASED-LIQUID BIOPSY NONINVASIVE AND EARLY...
Yuan Li
11:10am-11:20am
152AB - Walter E. Washington Session Numbe...
Center

92: USE OF DEEP LEARNING TO TUMOR MORPHOLOGICAL...
Bahar Saberzadeh Ardestani
11:20am-11:30am
152AB - Walter E. Washington Session Numbe...
Center

ASGE AI Institute for Gastroenterology Presents: to Use AI in Your Practice; ADD THE...
12:45pm-1:30pm
ASGE Learning Center, Hall C - Walter

Reducing CRC Incidence Through Screening an **d**
Washington Convention Center
2:00pm-3:30pm

152AB - Walter E. Washington
Center

Sat, May 18

Early-onset GI cancers: Risk Factors, Screening Disparities
4:00pm-5:30pm
151B - Walter E. Washington
Session Numbe...

Center
225: MODELING THE TUMOR OF EARLY AND...
David Cohen
4:00pm-4:15pm
151B - Walter E. Washington Session Numbe...
Center

226: CATCHING CANCERS EARLY? AGE STAGE AT DIAGNOSIS OF...
Jill Tinmouth
4:15pm-4:30pm
151B - Walter E. Washington Session Numbe...
Center

Sp471: AGA GUIDELINE: ARTIFICIAL FOR COLORECTAL...
Charles Kahi, Theodore R. Levin
10:30am-10:35am
146AB - Walter E. Washington Session Numbe...
Center

Colorectal Cancer Screening and Surveillance: Risk Populations, Including Hereditary...
Charles Kahi, Theodore R. Levin
10:00am-11:30am
Session Numbe...
Ballroom A - Walter E. Washington

Center
395: FAECAL IMMUNOCHEMICAL TEST TO COLORECTAL NEOPLASIA IN...
Elsa van Liere
10:30am-10:45am
Ballroom A - Walter E. Washington Session Numbe...
Center

396: ADENOMA DETECTION RATES ON AND SURVEILLANCE...
Aws Alameri
10:45am-11:00am
Ballroom A - Walter E. Washington Session Numbe...
Center

397: TRENDS IN THE ASSOCIATION OF HISTORY OF COLORECTAL...
Zoe Matticks
11:00am-11:15am
Ballroom A - Walter E. Washington Session Numbe...
Center

Sun, May 19

398: THE ASSOCIATION BETWEEN THE DEFINITION OF METABOLIC...
Wei-Yuan Chang
11:15am-11:30am
Ballroom A - Walter E. Washington Session Numbe...
Center

AI for Cancer Screening
2:00pm-3:30pm
145A - Walter E. Washington

Center
The Current Insights in Bariatric Endoscopy
2:00pm-3:30pm
209ABC - Walter E. Washington
Session Numbe...

Center
513: MULTICENTER PILOT RANDOMIZED TRIAL EVALUATING THE... Barham K. Abu Dayyeh
2:02pm-2:09pm
209ABC - Walter E. Washington Session Numbe... Center

514: CLINICAL OUTCOME OF THREE TECHNIQUES OF...
Milutin M Bulajic
2:12pm-2:19pm
209ABC - Walter E. Washington Session Numbe...
Center

515: DUODENAL RECELLULARIZATION ELECTROPORATION IN POORLY...
Adrian Sartoretto
2:22pm-2:29pm
209ABC - Walter E. Washington Session Numbe...

Sun, May 19

516: ENDOSCOPIC ABLATION OF THE FUNDUS IN ADULTS WITH... Christopher McGowan
2:32pm-2:39pm
209ABC - Walter E. Washington Session Numbe...
Center

517: EFFECT OF ENDOSCOPIC GASTRIC ON HISTOLOGIC... Pichamol Jirapinyo
2:42pm-2:49pm
209ABC - Walter E. Washington Session Numbe...
Center

2:52pm-2:59pm

227: EARLY-ONSET COLORECTAL CHARACTERISTICS AND... Young-Rock Hong
4:30pm-4:45pm
151B - Walter E. Washington Session Numbe...
Center

228: RISK FACTORS ASSOCIATED WITH ADENOMAS IN...
Divya Dasani
4:45pm-5:00pm
151B - Walter E. Washington Session Numbe...
Center

Sat, May 18

229: TO SCREEN OR NOT TO SCREEN: YOUNG PEOPLE CHOOSE TO... Rebecca Ekeanyanwu
5:00pm-5:15pm
151B - Walter E. Washington Session Numbe...
Center

230: GLOBAL BURDEN OF YOUNG-ONSET CANCER: A SYSTEMATIC...
Yunhao Li
5:15pm-5:30pm
151B - Walter E. Washington Session Numbe...
Center

Sun, May 19

High Risk Colon Cancer: The ABCs Of Genetic $$$
6:30am-7:45am

102AB - Walter E. Washington

Center
Immuno-Oncology for the Gastroenterologist: Advances and Implications for
8:00am-9:30am
103AB - Walter E. Washington
Session Numbe...

Center
Sp409: IMMUNO-ONCOLOGY PRIMER FOR GASTROENTEROLOGIST
Frank A. Sinicrope
8:00am-8:15am
103AB - Walter E. Washington Session Numbe...
Center

Sp410: IMMUNOTHERAPY MANAGEMENT MMRD RECTAL CANCER
Guillermo Argiles
8:15am-8:30am
103AB - Walter E. Washington Session Numbe...
Center

311: THE PI3K/AKT/MTOR SIGNALING THE SURVIVAL AND... Rui LIAO
8:30am-8:45am
103AB - Walter E. Washington Session Numbe...
Center

Sun, May 19

312: LOW DOSE DOUBLE EPIGENETIC IMPROVES IMMUNOTHERAPY...
Tamas Gonda
8:45am-9:00am
103AB - Walter E. Washington Session Numbe...
Center

Sp411: VACCINES FOR GI CANCERS: WE (ALMOST) THERE
Ajay Bansal
9:00am-9:15am
103AB - Walter E. Washington Session Numbe...
Center

Sp412: MANAGEMENT OF COMPLICATIONS OF
Yinghong Wang
9:15am-9:30am
103AB - Walter E. Washington Session Numbe...
Center

2024 AGA Guideline Highlights
10:00am-11:30am
146AB - Walter E. Washington
Session Numbe...

Center
Sp470: AGA GUIDELINE: ARTIFICIAL FOR COLORECTAL...
Benjamin Lebwohl, Shahnaz Sultan
10:10am-10:30am
146AB - Walter E. Washington Session Numbe...
Center

Sun, May 19

518: AI-ENABLED ELUCIDATION OF PATHOPHYSIOLOGY IN TYPE... Farah Abdul Razzak

Advances in Generative AI/NLP in
4:00pm-5:30pm
Session Numbe...

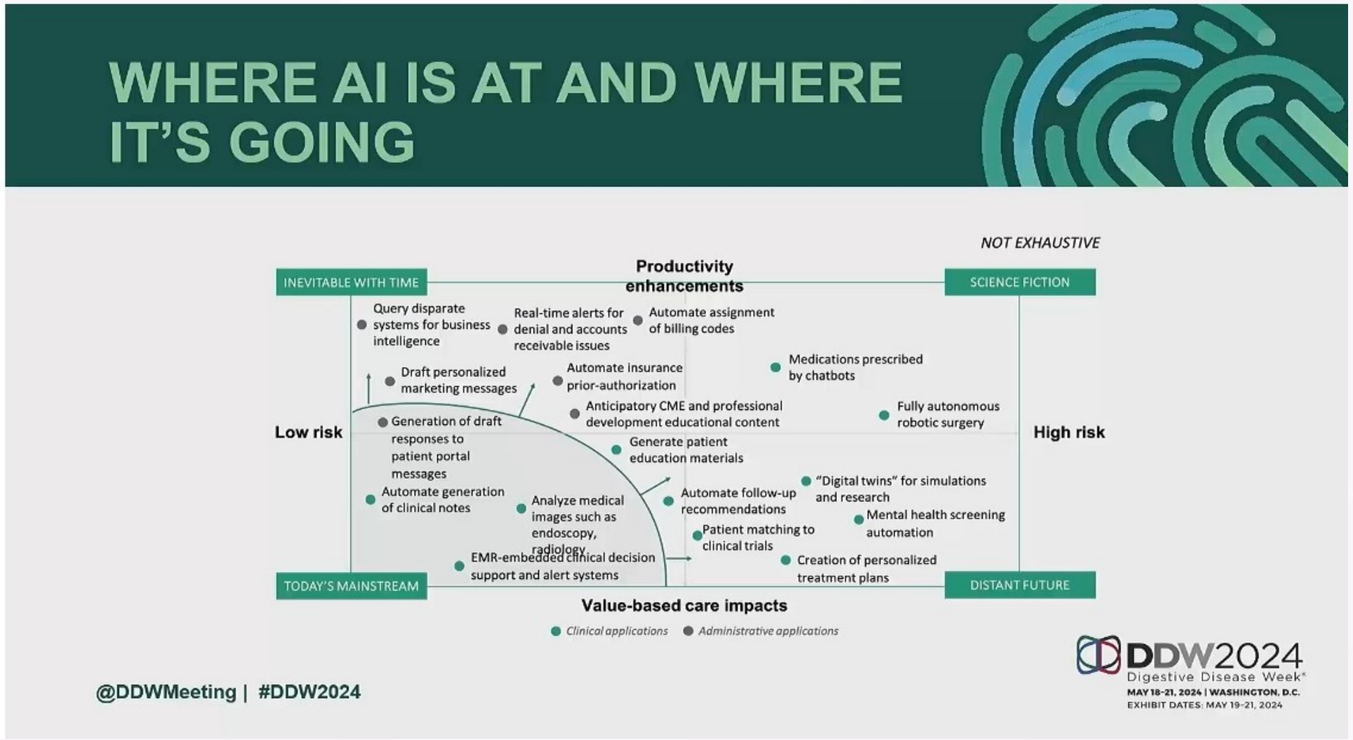
Sp631: STATE-OF-THE ART THE FUTURE OF...
Christopher C. Thompson
3:12pm-3:27pm
209ABC - Walter E. Washington Session Numbe...
Center
152AB - Walter E. Washington

Center

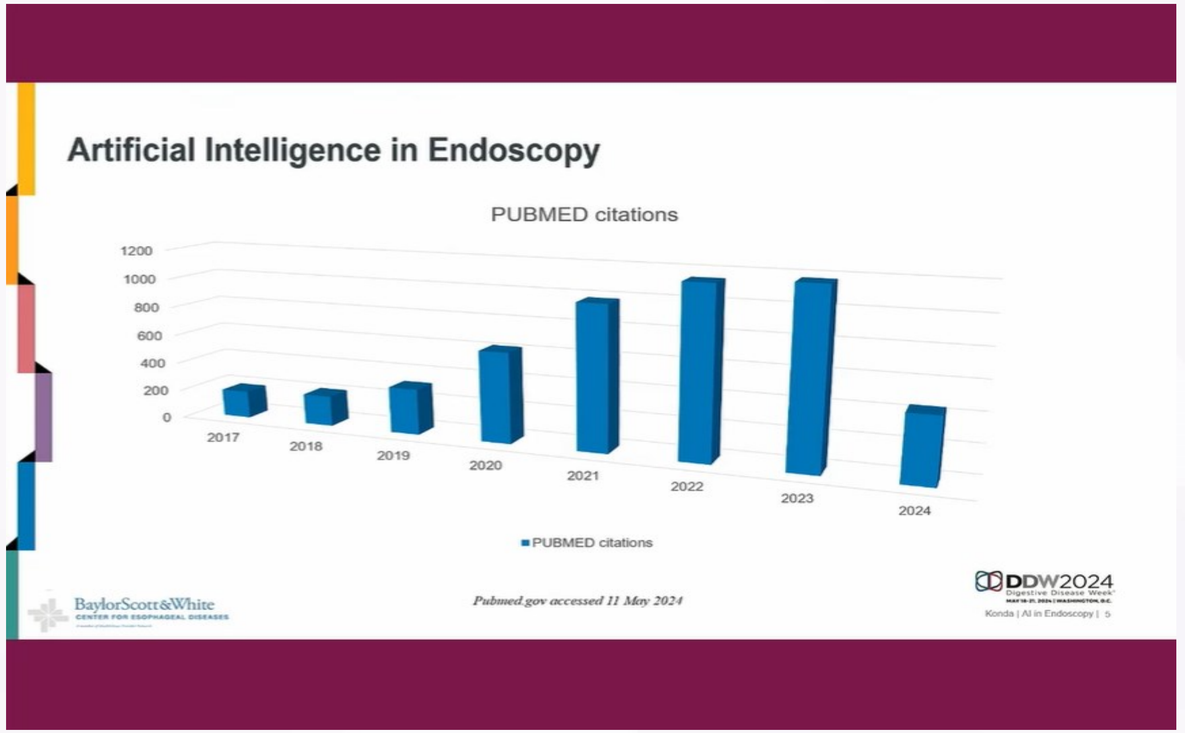
Contenido a tratar

- IA o AI , relevancia dentro de nuestra practica en la Gastroenterología
- Tips en Endoscopia alta y colonoscopia
- Eposters
- Mensaje a casa

IA o AI , relevancia dentro de nuestra practica en la Gastroenterología



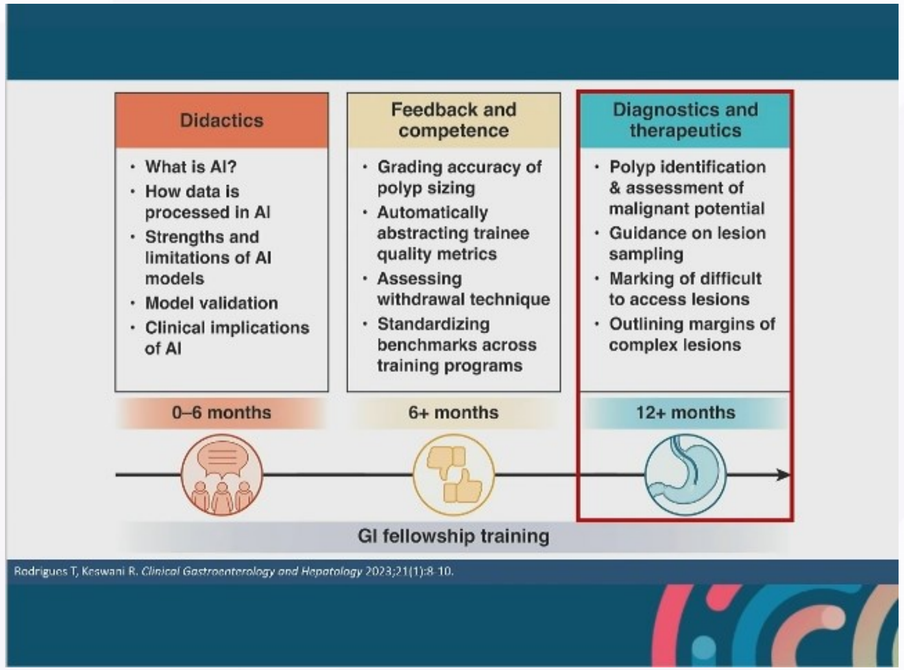
IA o AI , relevancia dentro de nuestra practica en la Gastroenterología

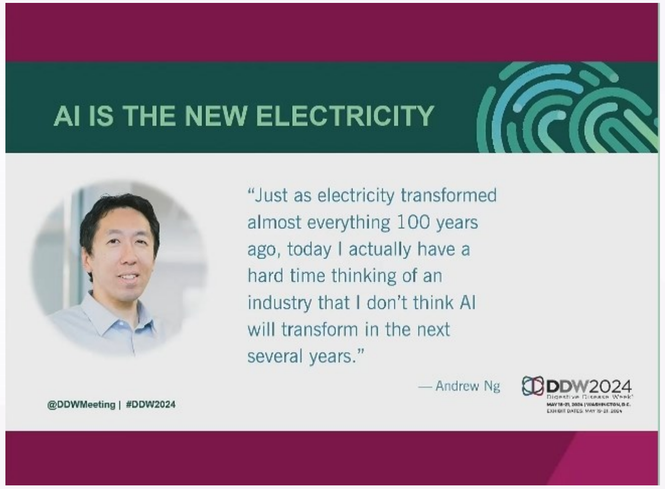


IA o AI , relevancia dentro de nuestra practica en la Gastroenterología

- Ante todo lo que se ha dado en los últimos 5 años, no podemos ocultar el sol con las manos
- Hoy en día se introduce en el plan de formación de los becados de Gastroenterología
- Hay que aprender a conversar con el ChatGPT (Generative Pretrained Transformer) o lo que se llama LLM (Large Language Models), interactuar debidamente para obtener provecho
- Los mas alegres son los administradores… se abre un océano….

IA o AI , relevancia dentro de nuestra practica en la Gastroenterología

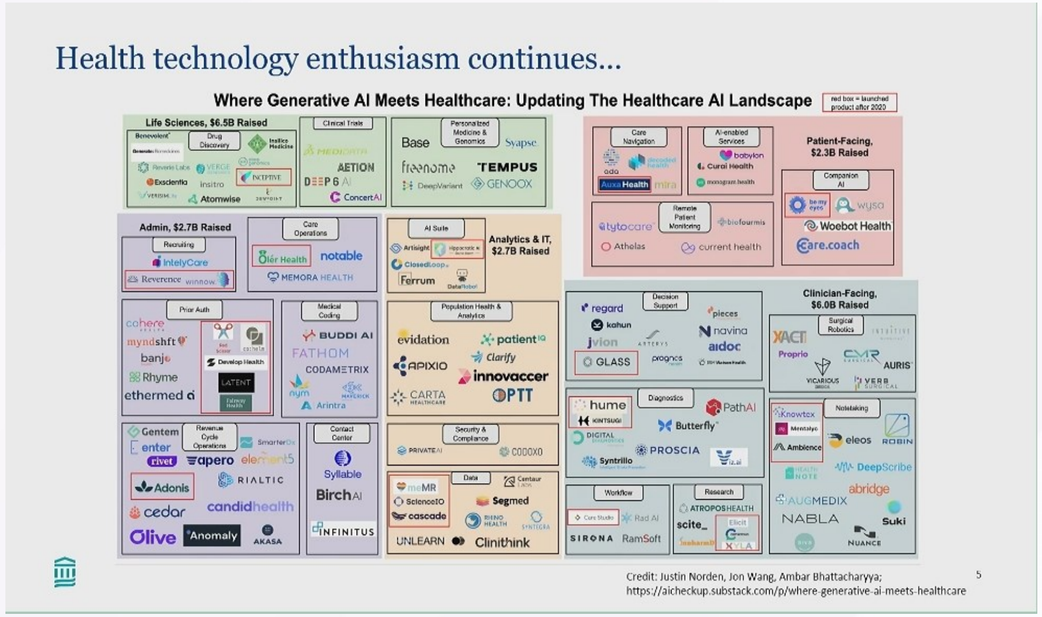


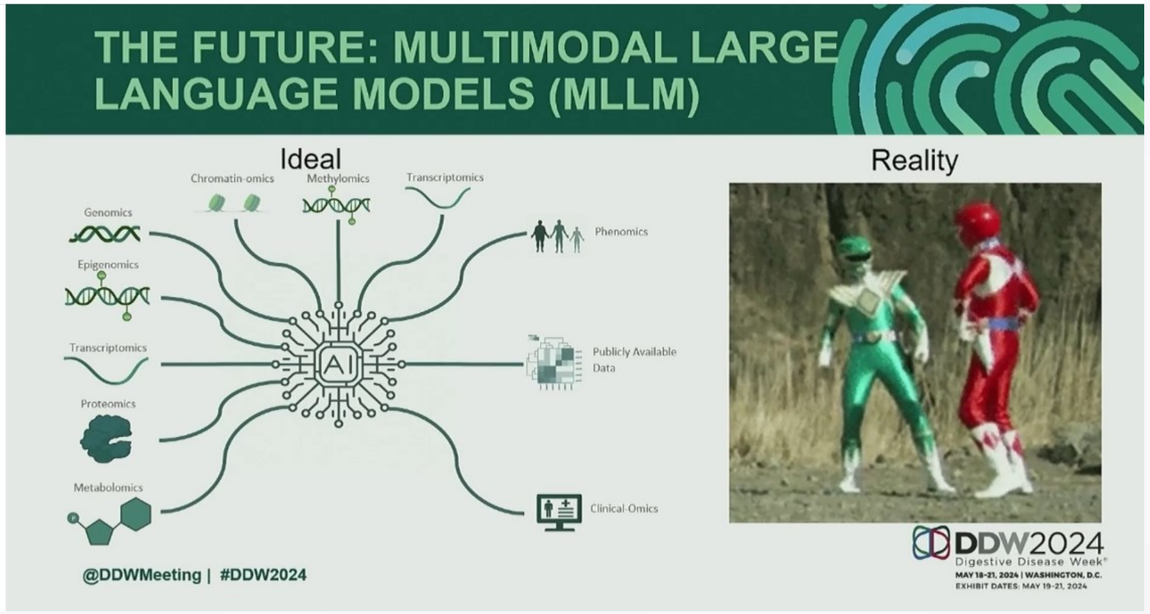


IA o AI , relevancia dentro de nuestra practica en la Gastroenterología

- ChatGPT– origen es Open AI, de Google, información hasta 2021
- Bing Chat de Microsoft , está conectada a la web, podría ser mas exacta
- Recomendación final… debemos usarla día a día, nuestros pacientes ya lo están naciendo
- En USA, se dan las agendas por este método, se dan indicaciones d preparación de procedimientos y se manejan los post procedimientos

El hoy y el mañana





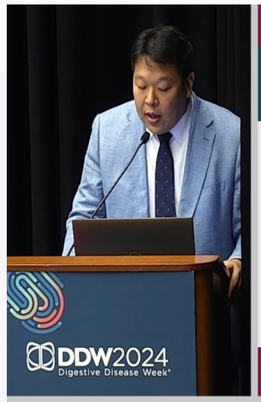
Endoscopia digestiva alta y colonoscopia, algunos tópicos

- Entre 1300 presentaciones , hay muchas dedicadas a este campo
- Llama la atención que la AI o IA, y su uso se impone en el día a día,. Como ayuda, no solo en lo diagnostico, sino en lo terapéutico, como un asistente, en una ESD o resección difícil, usando inclusive Robot tipo Davinci
- Por tanto se dividen por órganos digestivos
- Escogí 2 de Colon y una de Endoscopia alta

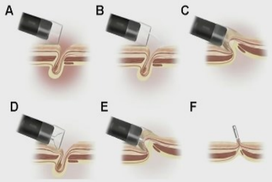
Endoscopia digestiva alta y colonoscopia, algunos tópicos

- Una de colonoscopia es sobre el manejo de Divertículo colónico sangrante, donde se enfatiza cuál es su manejo correcto, desde el punto de vista terapéutico, sale muy bien evaluado la ligadura elástica en el colon izquierdo y en el derecho el manejo con clips hemostático
- Sin embargo, deben tenerse pasos endoscópicos , claves como aspiración del divertículo, con cup instalado , clips dentro del cup, uso de un clip como marca para poder llegar después con el ligador
- Uso de la energía bipolar solo si el vaso está en el cuello del divertículo

Endoscopia digestiva alta y colonoscopia, algunos tópicos



EVERT DIVERTICULUM



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Diverticular Disease
When to Watch, When to Treat, and When to Cut

BOWEL PREP PER GUIDELINES

- 4-6 L polyethylene glycol (ACG Guidelines)
  - CURE Hemostasis Group used 6-8 L
  - Optional via NGT
  - Optional - 10mg IV Metoclopramide or 250 mg IV Erythromycin
- Unprepped colonoscopy or enema only NOT recommended.
  - Cannot see stigmata (visible vessel, adherent clots, red spots) w/o cleansed colon.
  - Asia – most R sided diverticular bleeding. West – L sided diverticular bleeding.

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American Journal of Gastroenterology 111(April 4):458-474, April 2016. | DOI: 10.1038/ajg.2016.41

DIRECT CLIPPING METHOD

Technically challenging:

- Clip opening span is greater than the diameter of the diverticulum.
- Diverticula is convex inward
- Tissue tolerance from trauma is low (perforation)

Tips:

- Use 11mm clip and clear cap.
- Invert TIC with suction
- Open clip inside the channel or cap. As you push out the clip, it will open incrementally in controlled fashion.

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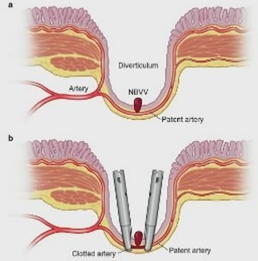

STUDIES OF ENDOSCOPIC THERAPY FOR DEFINITIVE DIVERTICULAR HEMORRHAGE

Results from studies reporting rates of both early rebleeding (occurring within 30 days) and late rebleeding (occurring after 30 days) are listed.

Study	Design	Treatment modality	N	Hemostasis achieved	Early rebleeding (less than 30 days)	Late rebleeding (greater than 30 days)
Prakash et al. (1999)[19]	Retrospective	Epinephrine injection and/or thermal coagulation	5	5 (100%)	0	0
Jensen et al. (2000)[3]	Prospective	Epinephrine injection and/or bipolar coagulation	10	10 (100%)	0	0
Yen et al. (2008)[19]	Retrospective	Hemoclip	11	11 (100%)	0	2 (18.2%)
Kaltenbach et al. (2012)[11]	Retrospective	Epinephrine injection and/or hemoclip	24	21 (88%)	0	5 (21%)
Ishii et al. (2012)[19]	Retrospective	Band ligation	31	27 (87%)	3 (10%)	0
Nakano et al. (2015)[19]	Retrospective	Hemoclip	39	39 (100%)	15 (38%)	7 (28%)
Nakano et al. (2015)[19]	Retrospective	Band ligation	61	61 (100%)	9 (15%)	12 (20%)
Jensen (2018)[4]	Prospective	Hemoclip or multipolar electrocoagulation	81	81 (100%)	4 (5%)	Not available
Nagata et al. (2019)[9]	Prospective	Hemoclip	47	47 (100%)	10 (21%)	8 (17%)
Nagata et al. (2018)[11]	Prospective	Band ligation	61	61 (100%)	6 (10%)	4 (7%)
Kaltenbach et al. (2020)[20]	Retrospective	OTSC	7	7 (100%)	0	0
Wongpongsalee et al. (2020)[24]	Prospective	Hemoclip or MPEC	74	74 (100%)	6 (8.1%)	23 (31.1%)

Source: Dr. Cusumano, Dr. Palji, Dr. Jensen

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TAKE HOME POINTS

- Endoscopic hemostasis is more durable than spontaneous hemostasis, so we should aim to identify and treat diverticular bleeding.
- Band Ligation appears superior to clipping.
- Direct clipping appears superior to indirect clipping, but may be technically difficult.
- Bipolar cautery should be reserved for vessels at the “neck”
- Prep is important and can maximize visualization of high-risk stigmata.
- Use a clear cap, generous water irrigation, and epinephrine/gel to maximize intraprocedural hemostasis.
- Consider repeating colonoscopy when the patient rebleeds.
- Prior to d/c, review indications for anti-thrombotics and stop NSAIDS if possible.

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AFTER R0 ER OF HIGH-RISK T1 EAC: INTERNATIONAL RETROSPECTIVE COHORT STUDY (SU1269)

•106 HR-T1 patients

•Treated with ER in 11 international centers between 2008-2019

Chan M.W.[1], Haidry R.[2,3], Norton B.[2,3], Di Pietro M.[4], Hadjinicolaou A.V.[4], Barret M.[5], Doumbe-Mandengue P.[5], Seewald S.[6], Bisschops R.[7], Nafteux P.[8], Bourke M.J.[9], Gupta S.[9],Mundre P.[10], Lemmers A.[11], Vuckovic C.[11], Pech O.[12], Leclercq P.[13], Coron E.[14], Meijer S.L.[15], Bergman J.J.G.H.M.[1], Pouw R.E

ENDOSCOPIC RESECTION WITH CLOSE SURVEILLANCE FOR T1B DISEASE

Roos Pouw, MD, PhD

Gastroenterologist

Amsterdam UMC, The Netherlands

DISCLOSURES

• 43 HR-T1a	(m3 with LVI a/o poor differentiation)
• 27 LR-T1b	(sm1, no LVI, well/moderately differentiated)
• 36 HR-T1b	(sm2/3, a/o LVI, a/o poor differentiation)

DDW2024 Digestive Disease Week®
MAY 18-21, 2024 | WASHINGTON, D.C.
EXHIBIT DATES: MAY 19-21, 2024

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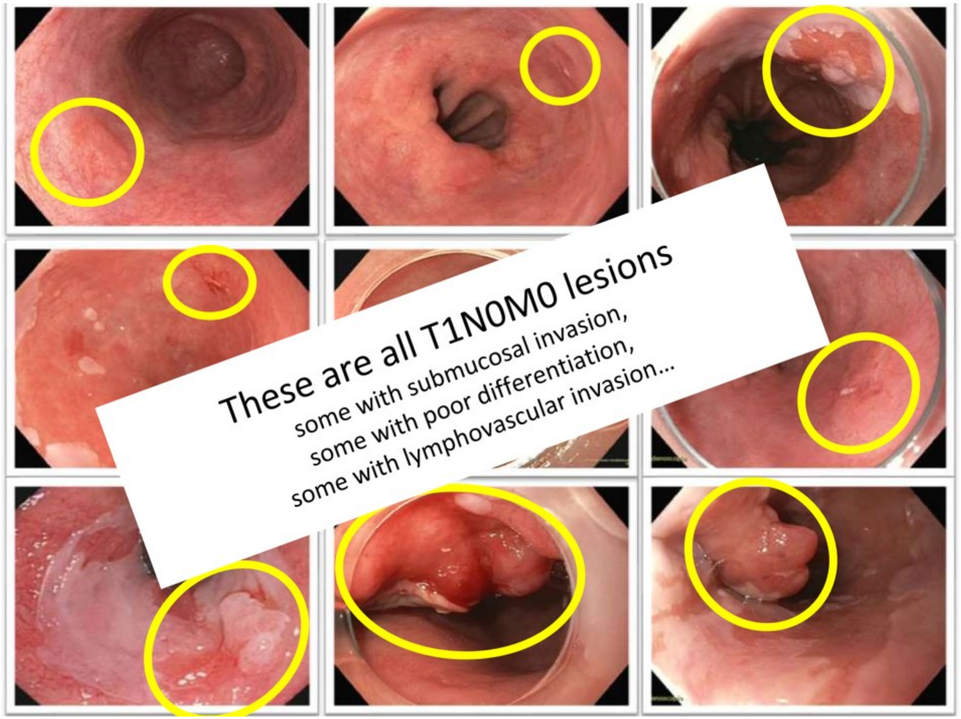

These are all T1N0M0 lesions
some with submucosal invasion,
some with poor differentiation,
some with lymphovascular invasion...


Patient preference
Risk of unrelated death
Risk of lymph node metastasis?
Risk of local recurrence?
Surgical risks (mortality 0-4%, complications 50%)

ROLE OF SURGERY?

- Surgery used to be the standard curative treatment option for this indication, *before* EMR/ESD made it possible to remove T1b lesions radically
- But, just because it used to be the standard, does this mean surgery is the best treatment?
- mortality: 0-4%
- anastomotic leakage: ±10%
- anastomotic stricture: 10-43%
- long-term, possibly life-long, symptoms related to the digestive tract

Westerterp, Virchows Arch 2005 (PMID 15838647)
Van Heijl, Ann Surg 2010 (PMID 20485137)
Schandl, J Cancer Surviv 2022 (PMID 36219375)

NEW INSIGHTS

- Risk of N+ in T1b EAC appears to be much lower than reported (< 26%)
- The vast majority of patients in whom the tumor was already endoscopically removed, undergo *unnecessary* invasive surgery
- Surgery is not a guarantee for cure!

Scholvinck, Surg Endosc 2016 (PMID 27357927)
Manner, Am J Gastroenterol 2008 (PMID 18785950)
Alvarez Herrero, Endoscopy 2010 (20960392)

METHODS

18 international centers

> 141 patients

5 year follow-up

Outcomes

Primary:
1. 5-year disease-specific survival
2. Overall survival

Secondary:
1. Lymph node metastasis
2. Local recurrence not eligible to endoscopic therapy
3. Distant metastasis
4. Quality of life

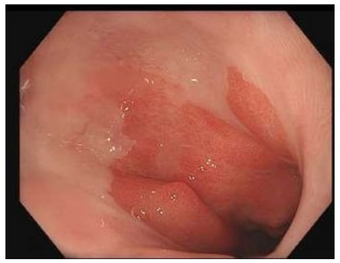
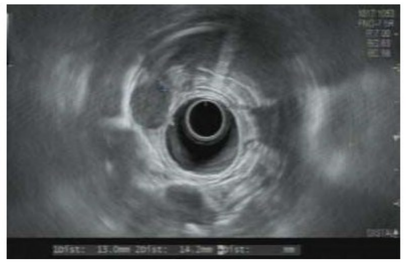
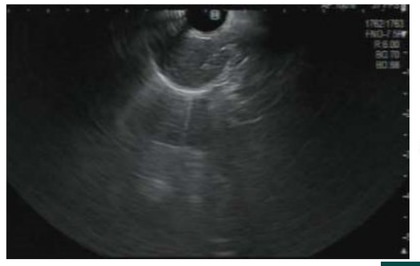
PRELIMINARYRESULTS

103 High-risk T1b	54 Low-risk T1b
Median FU 21 mo (IQR12-36)	Median FU 22 mo (IQR11-42)
3 Distant Met (3%) 7 LNM (7%) 5 Recurrence* (5%) 4 Death** (4%)	0 Distant Met 2 LNM (4%) 2 Recurrence* (4%)
7 Unrelated death (7%) 7 Completed 5-yr FU	3 Unrelated death (6%) 4 Completed 5-yr FU

*i.e. intraluminal tumor reccurent ineligible for re-ER
** 1 primary lung ca, 1 metastasized NET, 1 wished no further treatment

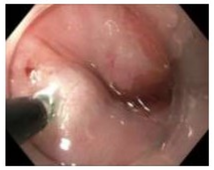
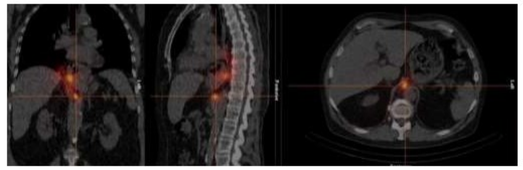
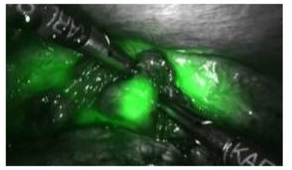
MALE, 58YO (ASA2)

- During follow-up: EUS-FNA suspicious lymph node at 24cm: positive
- PET-CT: no other signs of metastasis
- Policy MDT: selective surgical LN resection
  - endoscopic surveillance: 3-monthly EGD, EUS and PET-CT
- no signs of further metastasis, now 30 months after the lymph node resection
- Day before surgery:

SENTINEL NODE NAVIGATED SURGERY

- Injection of a tracer+indicyanin green around the ER-scar
- SPECT/CT

- Day of surgery:
- Identification with gammaprobe and near infra-read camera + resection of sentinel nodes

Frederiks, Ann Surg Onc 2023 (PMID: 36959491)

WHAT BOUNDARIES ARE GOING TO GET PUSHED?

- High-risk T1 EAC (sm-invasion, LV-invasion, poor differentiation):
  - Endoscopic follow-up in expert centers, in selected cases, instead of referring all patients for surgery
- After histological R1v resection of EAC:
  - Expert histology review
  - Endoscopic re-assessment first, and surgery only for those patients with residual neoplasia

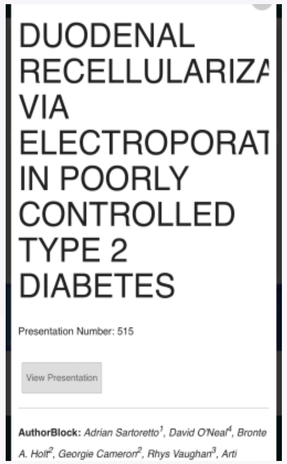
CONCLUSIONS

As therapeutic modality for N+ disease?

- Indications for endoscopic and surgical treatment of T1b EAC are shifting due to technical advancements.
- For T1b EAC, strict endoscopic follow-up in selected patients, instead of surgery, appears feasible and safe.
- Better risk stratification will allow for more patient-tailored treatment, with additional treatment (surgery, chemotherapy, a/o radiotherapy) only if necessary.

Contenido a tratar

E-Posters



DUODENAL RECELLULARIZA VIA ELECTROPORAT IN POORLY CONTROLLED TYPE 2 DIABETES

Presentation Number: 515

View Presentation

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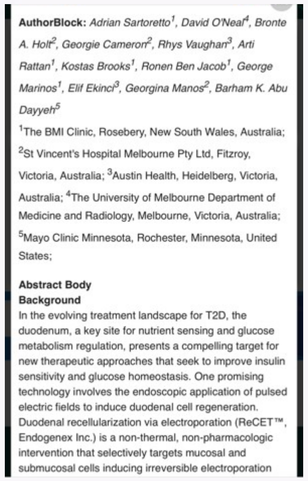

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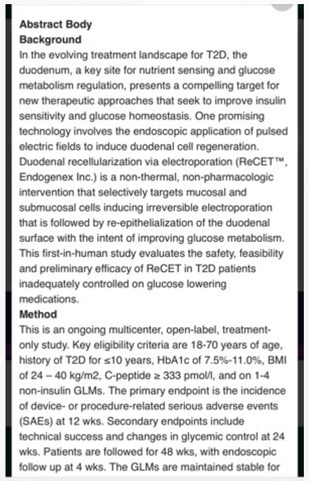
Abstract Body
Background
In the evolving treatment landscape for T2D, the duodenum, a key site for nutrient sensing and glucose metabolism regulation, presents a compelling target for new therapeutic approaches that seek to improve insulin sensitivity and glucose homeostasis. One promising technology involves the endoscopic application of pulsed electric fields to induce duodenal cell regeneration. Duodenal recellularization via electroporation (ReCET™, Endogenex Inc.) is a non-thermal, non-pharmacologic intervention that selectively targets mucosal and submucosal cells inducing irreversible electroporation



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In the evolving treatment landscape for T2D, the duodenum, a key site for nutrient sensing and glucose metabolism regulation, presents a compelling target for new therapeutic approaches that seek to improve insulin sensitivity and glucose homeostasis. One promising technology involves the endoscopic application of pulsed electric fields to induce duodenal cell regeneration. Duodenal recellularization via electroporation (ReCET™, Endogenex Inc.) is a non-thermal, non-pharmacologic intervention that selectively targets mucosal and submucosal cells inducing irreversible electroporation that is followed by re-epithelialization of the duodenal surface with the intent of improving glucose metabolism. This first-in-human study evaluates the safety, feasibility and preliminary efficacy of ReCET in T2D patients inadequately controlled on glucose lowering medications.
Method
This is an ongoing multicenter, open-label, treatment-only study. Key eligibility criteria are 18-70 years of age, history of T2D for ≤10 years, HbA1c of 7.5%-11.0%, BMI of 24 – 40 kg/m2, C-peptide ≥ 333 pmol/l, and on 1-4 non-insulin GLMs. The primary endpoint is the incidence of device- or procedure-related serious adverse events (SAEs) at 12 wks. Secondary endpoints include technical success and changes in glycemic control at 24 wks. Patients are followed for 48 wks, with endoscopic follow up at 4 wks. The GLMs are maintained stable for

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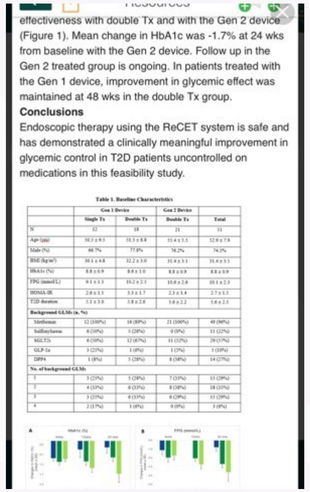
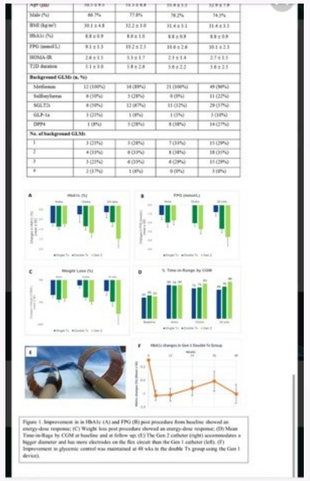
Results
Fifty-one patients have been enrolled and treated with two versions of catheters (Table 1). Technical success was 100%, with a mean treated length of 11.2 ± 2.7 cm, and median procedure time of 68 min (IQR 46 – 88). No device/procedure-related SAEs occurred. Incidence of device/procedure-related adverse events (AEs) were less frequent with the Gen 2 vs. Gen 1 device (10/21 vs 23/30, p<0.05). The most reported AEs were sore throat 49% (25/51) and transient diarrhea 22% (11/51). AEs were mild (76%) or moderate (24%) in severity. At 4 wks, the treated areas showed complete healing, were mostly unidentifiable endoscopically with no signs of stricture, ulceration, or other significant findings.
Glycemic control was significantly improved post-procedure from baseline with a trend towards greater effectiveness with double Tx and with the Gen 2 device (Figure 1). Mean change in HbA1c was -1.7% at 24 wks from baseline with the Gen 2 device. Follow up in the



effectiveness with double Tx and with the Gen 2 device (Figure 1). Mean change in HbA1c was -1.7% at 24 wks from baseline with the Gen 2 device. Follow up in the Gen 2 treated group is ongoing. In patients treated with the Gen 1 device, improvement in glycemic effect was maintained at 48 wks in the double Tx group.
Conclusions
Endoscopic therapy using the ReCET system is safe and has demonstrated a clinically meaningful improvement in glycemic control in T2D patients uncontrolled on medications in this feasibility study.

Table 1. Baseline Characteristics

	Gen 1 Device	Gen 2 Device		
	Single Tx	Double Tx	Double Tx	Total
N	12	18	21	51
Age (yrs)	58.3 ± 9.3	55.3 ± 8.8	55.4 ± 5.3	52.9 ± 7.9
Male (%)	66.7%	77.8%	76.2%	74.5%
BMI (kg/m²)	30.1 ± 4.8	32.2 ± 3.9	31.4 ± 3.3	31.4 ± 3.3
HbA1c (%)	8.8 ± 0.9	8.8 ± 1.0	8.8 ± 0.9	8.8 ± 0.9
FPG (mmol/L)	9.1 ± 1.3	10.2 ± 2.3	10.4 ± 2.4	10.1 ± 2.3
HOMA-IR	2.6 ± 1.1	3.3 ± 1.7	2.3 ± 1.4	2.7 ± 1.5
T2D duration	5.1 ± 3.9	5.8 ± 2.8	5.8 ± 2.2	5.8 ± 2.5
Background GLMs (n, %)				
Metformin	12 (100%)	16 (89%)	21 (100%)	49 (96%)
Sulfonylurea	4 (33%)	3 (28%)	0 (0%)	11 (22%)
SGLT2i	8 (50%)	12 (67%)	11 (52%)	29 (57%)
GLP-1a	3 (25%)	1 (6%)	1 (5%)	5 (10%)
DPP4	3 (8%)	5 (28%)	8 (38%)	14 (27%)
No. of background GLMs				
1	5 (25%)	5 (28%)	7 (33%)	11 (29%)
2	4 (33%)	6 (33%)	8 (38%)	18 (35%)
3	3 (25%)	6 (33%)	6 (29%)	15 (29%)
4	2 (17%)	1 (6%)	0 (0%)	3 (6%)

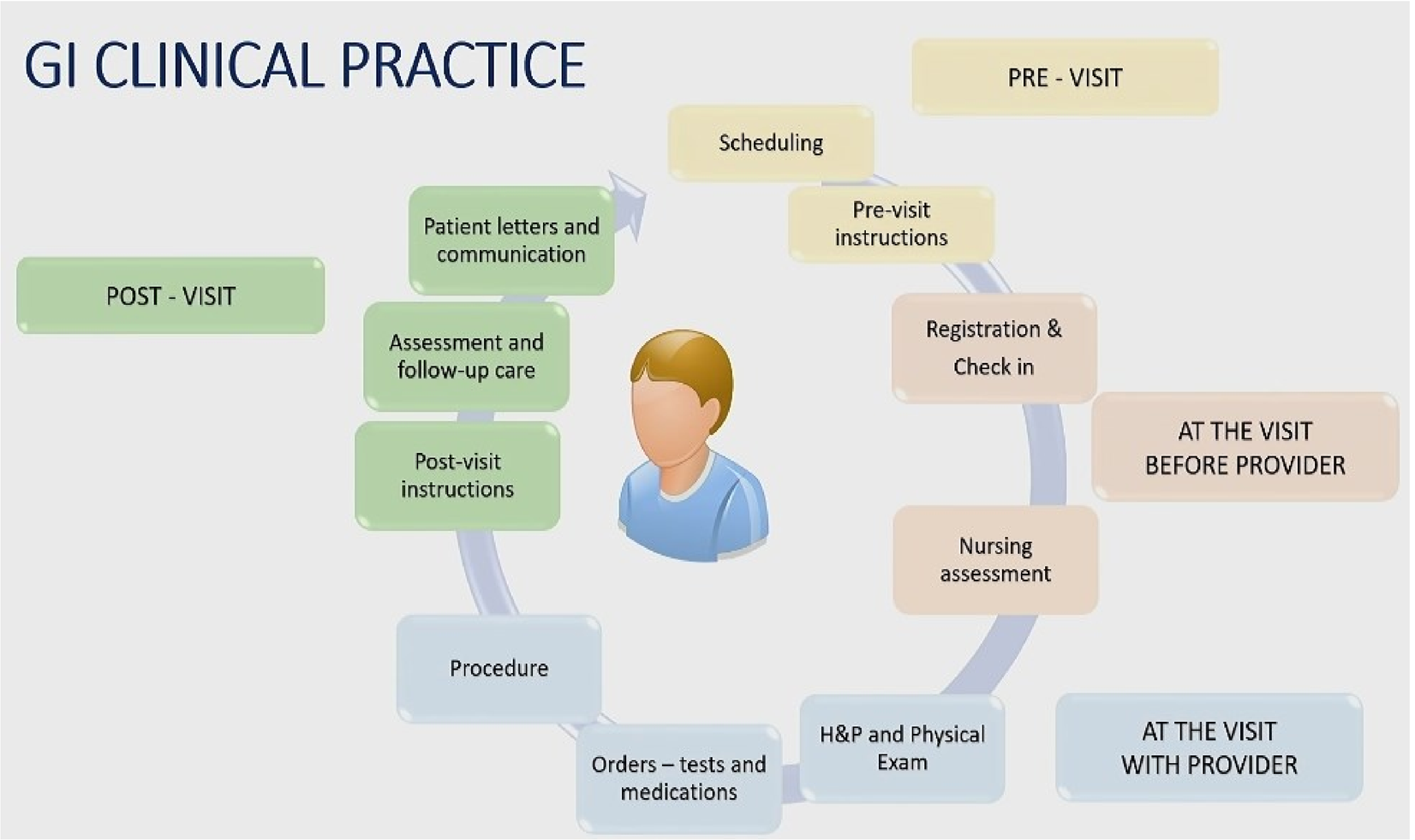


Contenido a tratar

Mensaje a casa

- No dejemos de evaluar los ePosters, muestra la cresta de la ola, datos super valiosos
- La IA o AI, llego para quedarse, debemos implementarla en nuestros servicios, conversar con ingeniero
- Mirar como NEJM hace dos años un NEJM AI , y también BMJ AI
- Aprender el LLM, dialogar con los diferentes bot, se convierte en Pub Med si lo sabemos usar
- El Futuro llego, esta aquí….. disfrutémoslo

El Futuro es ahora …… no lo dejemos pasar

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