2025 GI-TAP/TIPES Joint Meeting

08:20~12:40 (Sat.) Oct. 4, 2025

Venue: Hotel Indigo Taipei North, 4F Brick-Tile

TIME	TOPIC	SPEAKER	CHAIR
8:00~8:20	**Registration**		
8:20~8:30	Welcome and Opening	**Hsiu-Po Wang,** President, TIPES **Christopher Khor,** President, GI-TAP	
8:30~8:45	Biodegradable pancreatic stents - features and endoscopy utility	**Christopher Khor** Singapore General Hospital	**Hsiu-Po Wang** National Taiwan University Hospital **Christopher Khor** Singapore General Hospital
8:45~8:55	Q & A Abstract		
8:55~9:10	Application of biodegradable biliary stent in liver transplantation	**Ming-Che Lee** Taipei Medical University, Taipei, Taiwan	
9:10~9:20	Q & A Abstract		
9:20~9:35	EUS for endohepatology: Is it here to stay?	**Nonthalee Pausawasdi** Siriraj Hospital	**Pradermchai Kongkam** King Chulalongkorn Memorial Hospital **Cheuk-Kay Sun** Shin Kong Wu Ho - Su Memorial Hospital
9:35~09:45	Q & A Abstract		
09:45~10:00	Any limitations and drawbacks of EUS-guided gastrojejunostomy (EUS-GJ)?	**Yu-Ting Kuo** National Taiwan University Hospital	
10:00~10:10	Q & A Abstract		
10:10~10:25	**Coffee Break**		
10:25~10:40	RFA for locally advanced PDAC: who might benefit?	**Pradermchai Kongkam** King Chulalongkorn Memorial Hospital	**Nonthalee Pausawasdi** Siriraj Hospital **Hsiu-Po Wang** National Taiwan University Hospital
10:40~10:50	Q & A Abstract		
10:50~11:05	Small FCSEMS or plastic stents for EUS-HGS?	**Weng-Fai Wong** National Taiwan University Hospital	
11:05~11:15	Q & A Abstract		
11:15~11:30	Smaller metallic stenting for unresectable MBO? (Online)	**ReiKo Yamada** Mie University	**Nai-Jen Liu** Lin -Ko Chang Gung Memorial Hospital **Chiung-Yu Chen** National Cheng Kung University Hospital
11:30~11:40	Q & A Abstract		
11:40~11:55	Genetic and molecular testing for biliopancreatic malignancy – experience of Taiwan	**Chien-Jui Huang** National Cheng Kung University Hospital	
11:55~12:05	Q & A Abstract		
12:05~12:20	Endoscopic therapy of post-operative biliary strictures (Online)	**Ryan Ponnudurai** Prince Court Medical Centre	
12:20~12:30	Q & A Abstract		
12:30~12:40	**Closing**	**Hsiu-Po Wang,** President, TIPES **Christopher Khor,** President, GI-TAP	

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Program Directors



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Singapore



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GI-TAP



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Yu-Ting Kuo
Taiwan



Weng-Fai Wong
Taiwan



Chien-Jui Huang
Taiwan

▲Hybrid event報名連結

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Abstract-1

Biodegradable Pancreato-Biliary Stents - Features and Utility

Dr Christopher Khor, Singapore General Hospital

Biodegradable pancreatobiliary stents are used as a strategy to reduce follow up visits or repeat endoscopy after ERCP. Experience with delayed degradation is limited. We describe our experience with consecutive cases of biodegradable biliopancreatic stents (ARCHIMEDES^{TM}, amg International GmbH) over a 2.5 year period in patients who underwent ERCP. Pancreatic

and biliary stents were inserted in 81.5% and 19.5% of patients respectively. The stents were available in three different degradation profiles– fast (12 days), medium (20 days) and slow (11 weeks). The primary outcomes were post-ERCP pancreatitis (PEP) (with pancreatic stent placement) and post-ERCP cholangitis (PEC) (with biliary stent placement). The secondary outcome was the rate of delayed stent degradation, defined by an intact stent or stent fragments seen in-situ on routine follow up imaging after the expected degradation time. Adverse events that occurred with these stents will be discussed.

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Abstract-2

Clinical application of biodegradable biliary stent in liver transplantation

Ming-Che Lee, M.D.

Division of General Surgery, Department of Surgery, Shuang Ho Hospital, Taipei Medical University

Department of Surgery, School of Medicine, College of Medicine, Taipei Medical University

TMU Research Center for Organ Transplantation, Taipei Medical University

Abstract:

Liver transplantation (LT) especially live donor liver transplantation presents a high risk of biliary complication after transplantation. Conventional balloon dilatation followed by multiple plastic stents or self-expandable metal stents by either endoscopic or percutaneous route is the standard of care in management of biliary stricture after LT. Although the clinical use of biodegradable stents in biliary stricture has shown promising results, however, biodegradable stents is still in their infancy era, and improvements are still needed for currently available stents on the markets in terms of material degradation rate and mechanical support. It is expected that more innovative technologies such as new biodegradable materials, novel stent structure designs, advanced stent fabrication methods and drug delivery technologies will be applied in developing new biodegradable biliary stents. Today the application of biodegradable biliary stent, ARCHIMEDES™ stent, in deceased and live liver transplantation will be demonstrated.

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Abstract-3

EUS For Endohepatology: Is It Here To Stay?

Nonthalee Pausawasdi, MD., FJGES

Division of Gastroenterology, Department of Medicine

Faculty of Medicine Siriraj Hospital, Bangkok, Thailand

Introduction

Endo-hepatology, the integration of advanced endoscopic techniques into hepatology practice, is transforming the diagnosis and treatment of liver diseases and their complications. Traditionally, the evaluation of liver disorders and portal hypertension has relied on radiological imaging, percutaneous biopsy, or hemodynamic studies such as hepatic venous pressure gradient (HVPG) measurement. However, endoscopic ultrasound (EUS) and therapeutic endoscopy now provide a minimally invasive platform that combines diagnostic precision with therapeutic intervention. This evolution not only addresses diagnostic limitations but also expands treatment options, especially in complex cases such as portal hypertension, variceal bleeding, and fatty liver disease.

Non-Alcoholic Fatty Liver Disease (NAFLD)

NAFLD is the most common cause of chronic liver disease worldwide, with a rising prevalence linked to obesity and metabolic syndrome. Accurate histological assessment remains the gold standard for diagnosis, staging, and risk stratification. EUS-guided liver biopsy (EUS-LB) has emerged as a precise and safer alternative to percutaneous and transjugular biopsy. Evidence suggests that EUS-LB yields longer, less fragmented tissue cores with higher adequacy rates, increasing the likelihood of obtaining diagnostically useful samples. Importantly, EUS allows access to both the right and left hepatic lobes, enhancing sampling accuracy and reducing sampling variability. This approach is especially beneficial in obese patients or those at higher risk of bleeding or other complications from percutaneous techniques. Moreover, the ability to combine EUS-LB with concurrent endoscopic evaluation of the gastrointestinal tract underscores its efficiency in comprehensive patient assessment.

Portal Vein Pressure Measurement

Portal hypertension is a key driver of morbidity and mortality in cirrhosis, underpinning complications such as varices, ascites, and hepatic encephalopathy. While HVPG measurement has long been the reference standard, it provides only an indirect estimate of portal pressure and requires fluoroscopy, limiting its availability to specialized centers. EUS-guided portal pressure gradient (EUS-PPG) measurement offers a novel approach, enabling direct pressure assessment of both the portal and hepatic veins during a single procedure. Early clinical studies demonstrate feasibility, reproducibility, and correlation with HVPG values. In addition, the minimally invasive nature of EUS-PPG permits repeated measurements, allowing dynamic monitoring of disease progression and treatment response. This technique holds promise for personalized therapy and may broaden access to hemodynamic assessment in clinical practice.

Variceal Bleeding Management

Variceal hemorrhage remains one of the most life-threatening complications of cirrhosis. Standard therapies such as endoscopic variceal ligation (EVL) and sclerotherapy are effective but have limitations, particularly in the management of gastric varices or refractory bleeding. EUS-guided therapies are redefining the therapeutic landscape. Through real-time vascular imaging, EUS facilitates precise targeting of feeding vessels and collaterals. Techniques such as EUS-guided coil embolization and cyanoacrylate injection have demonstrated high success rates in controlling bleeding and reducing recurrence, especially in patients who fail conventional approaches. Beyond acute management, these strategies may also have a role in secondary prophylaxis, reducing the risk of rebleeding and improving long-term outcomes.

Conclusion

Endo-hepatology represents a paradigm shift in the management of liver diseases by merging endoscopic innovation with hepatology expertise. EUS-guided approaches—from liver biopsy to portal pressure measurement and variceal therapy—offer enhanced diagnostic accuracy, minimally invasive alternatives, and tailored therapeutic options. As the evidence base expands and technologies continue to evolve, endo-hepatology is poised to become an integral component of liver disease management. Its multidisciplinary nature underscores the importance of collaboration between hepatologists and endoscopists, ultimately advancing patient care and shaping the future of hepatology.

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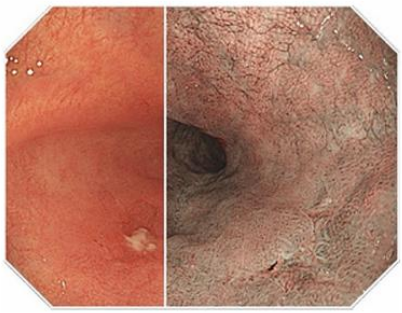
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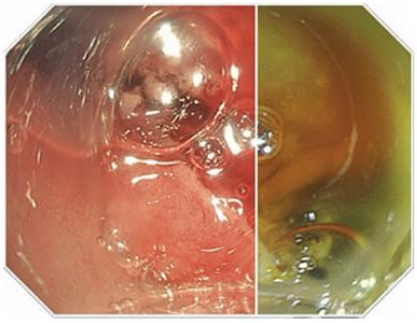
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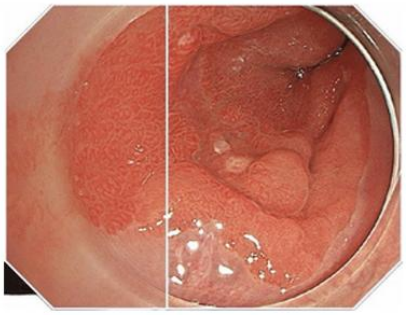
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Abstract-4

Any Limitations and Drawbacks of EUS-guided Gastrojejunostomy

Yu-Ting Kuo, MD MSc

Division of Endoscopy, Department of Integrated Diagnostics & Therapeutics,

National Taiwan University College of Medicine, Taipei, Taiwan

Abstract

Endoscopic ultrasound (EUS)-guided gastrojejunostomy (EUS-GJ) has emerged as a minimally invasive alternative to surgical gastrojejunostomy and enteral stenting for malignant gastric outlet obstruction (mGOO) and selected benign conditions. While EUS-GJ offers durable patency and reduced reintervention rates, several limitations and drawbacks remain to be addressed. First, the procedure is technically demanding and requires advanced endoscopic expertise, restricting its availability to high-volume centers. Second, the risk of stent misdeployment (SM)—particularly in cases with unfavorable bowel orientation—remains the most important cause of technical failure and adverse events such as peritonitis, bleeding, or perforation. Third, the learning curve is steep, and outcomes are significantly influenced by operator experience and institutional expertise. In addition, the high cost of lumen-apposing metal stents (LAMS) and dedicated devices limits widespread adoption in resource-limited settings. Finally, long-term data are relatively scarce compared with surgical approaches, and uncertainty remains regarding outcomes in benign etiologies and younger patient populations.

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Abstract-5

EUS-Guided Radiofrequency Ablation (EUS-RFA) for Locally Advanced Pancreatic Ductal Adenocarcinoma (LA-PDAC)

Background and Rationale

Pancreatic Ductal Adenocarcinoma (PDAC), particularly the **Locally Advanced (LA-PDAC)** stage, continues to pose a significant therapeutic challenge with a dismal prognosis. For patients with unresectable LA-PDAC, standard management involves systemic chemotherapy, often combined with radiation, but local tumor control and long-term survival remain suboptimal. **Endoscopic Ultrasound-guided Radiofrequency Ablation (EUS-RFA)** has emerged as a novel, minimally invasive locoregional therapy that offers direct tumor cytoreduction and potential for immunomodulation within the tumor microenvironment.

Aims

This presentation aims to review the current status, technical aspects, safety profile, and clinical efficacy of EUS-RFA as a therapeutic option for LA-PDAC. Furthermore, we will discuss its potential role in combination with systemic therapies to enhance overall treatment outcomes.

Methodology/Technical Aspects

EUS-RFA utilizes a specialized catheter inserted through an EUS scope to deliver high-frequency alternating current directly into the tumor, inducing **coagulative necrosis**. Key technical considerations for LA-PDAC include:

1. **Precise Targeting:** Accurate positioning of the RFA probe to maximize tumor coverage while sparing critical peripancreatic structures (e.g., major vessels, bile duct).
2. **Safety Measures:** Techniques such as saline injection around the target area and real-time monitoring of impedance and hyperechoic bubble formation.
3. **Combination Therapy:** Integrating EUS-RFA into multidisciplinary treatment plans, often performed before, during, or after systemic chemotherapy.

Key Findings and Clinical Outcomes

Accumulating data from feasibility studies and case series suggest that EUS-RFA for LA-PDAC is **technically feasible with a high success rate (approaching 100%)** and a **favorable safety profile**. The most common adverse event is mild abdominal pain, with a low incidence of severe complications (e.g., pancreatitis,

bleeding). Preliminary clinical outcomes show:

- **Local Control:** Significant tumor volume reduction and induction of tumor necrosis.
- **Survival Benefit:** Encouraging trends in median Overall Survival (OS), often surpassing historical controls for unresectable disease, especially when combined with chemotherapy.
- **Potential for Conversion:** In select cases, EUS-RFA may downstage borderline or locally advanced tumors, potentially converting them to resectable status.

Conclusion

EUS-RFA is a **promising, safe, and effective** local treatment modality that can be integrated into the comprehensive management of LA-PDAC. Further large-scale, prospective, and randomized controlled trials are essential to solidify its definitive role in the treatment paradigm and confirm its impact on long-term survival and quality of life.

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Abstract-6

Small FCSEMS or Plastic Stents for EUS-HGS

Weng-Fai Wong MD, MSc

National Taiwan University Hospital

Abstract

Endoscopic ultrasound–guided hepaticogastrostomy (EUS-HGS) is a rescue procedure after failed endoscopic retrograde cholangiopancreatography (ERCP), especially in patients with malignant biliary obstruction. Choosing between metal and plastic stents, particularly dedicated plastic stents, requires different considerations from those in transpapillary ERCP stenting. To reduce the risk of bile leakage, fully covered self-expandable metal stents (FCSEMS) are usually preferred for EUS-HGS. However, FCSEMS have important drawbacks. The main concern is blockage of intrahepatic bile duct side branches, which may lead to cholangitis or liver abscess. In addition, the large diameter of metal stents can cause de novo bile duct narrowing due to tissue overgrowth. Plastic stents, with their smaller size, may better fit the narrow intrahepatic ducts and avoid these problems. Nevertheless, there are concerns about bile leakage and peritonitis when using small-caliber stents. This presentation discusses the advantages and disadvantages of FCSEMS and plastic stents in EUS-HGS and summarizes real-world experience reported in the literature.

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Abstract-7

Smaller metallic stenting for unresectable malignant biliary obstruction (MBO)

Background and Aim:

Endoscopic biliary stenting is the standard palliative treatment for patients with unresectable malignant biliary obstruction (MBO). Self-expandable metallic stents (SEMS) are widely used due to superior patency compared with plastic stents. However, the optimal stent diameter remains controversial. Larger-diameter SEMS have traditionally been preferred for longer patency, but recent evidence suggests that smaller-diameter SEMS may balance effective drainage with reduced adverse events. This study aimed to evaluate the clinical outcomes of smaller SEMS in unresectable MBO.

Methods:

We retrospectively analyzed consecutive patients with unresectable distal MBO who underwent endoscopic SEMS placement between January 1st 2017 and March 31th 2025. Patients were classified into 6 mm, 8 mm, and 10mm SEMS. Primary outcome was cumulative incidence of recurrent biliary obstruction (TRBO) after 6 months. Secondary outcomes included incidence of stent-related adverse events.

Results:

A total of 301 patients were included (6 mm SEMS: n = 98, 8 mm SEMS: n = 94, 10 mm SEMS: n = 118). Non-RBO rates after 6 months was 68.7 % in 6 mm SEMS group, 68.6% in 8 mm SEMS group, and 64.3 % in 10 mm SEMS group ($p = 0.831$, log-rank test). Notably, the incidence of pancreatitis was significantly lower in 6 mm SEMS group comparing with 8 mm (2.0 % vs. 13.8 %, $p < 0.001$) and 10 mm (2.0 % vs. 16.9 %, $p < 0.001$).

Conclusions:

6 mm SEMS achieved comparable patency to conventional larger SEMS while reducing stent-related pancreatitis in MBO. These findings highlight the potential role of smaller metallic stents as a safer and equally effective alternative in palliative biliary drainage strategies.

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Abstract-8

Genetic and molecular testing for biliopancreatic malignancy – experience of Taiwan

In the past decade, many target therapeutic drugs and immunotherapy drugs has been developed in the treatment of pancreato-biliary malignancies. Thus genetic and molecular testing plays an important role in the diagnostic and treatment course. Most of the pancreato-biliary cancers are in late stage during diagnosis, which made the endoscopic diagnosis more and more important. Endoscopic tissue sampling for genetic and molecular testing is suggested for almost every patients before the started treatment. During this session, I will discuss about the experience about the molecular diagnosis of pancreato-biliary cancer by endoscopic method in Taiwan !

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ABSTRACT-9

The presentation will focus on a complex surgical complication resulting in biliary strictures and possible long term endoscopic therapy. Many surgical classifications have been developed to categorize the site of damage and also to then prognosticate success of therapy.

Preoperative assessment with adequate imaging followed by bridging the stricture is paramount to a successful outcome. Many classic approaches, the hallmark being stents to analysing the different stents available: plastic, to metal to biodegradable, to more novel attempts of plugging the leak and fusion with magnets .

The outcome of endoscopic therapy is hopefully to relieve the leak/ stricture and to prevent a repeat laparotomy with its morbidities.

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