MDFORLIVES IN-DEPTH INSIGHT REPORT

Advanced Gastroenterology Care: Where Innovation Meets Real-World Friction

A global peer report on advanced IBD sequencing, intestinal ultrasound adoption, incretin-related GI complexity, early-onset colorectal cancer, and the evidence threshold for emerging microbiome therapeutics.

Gastroenterologists · 5 countries · Global peer perspectives

31	37	5	83.8%
Complete responses	Survey records	Countries represented	Completion rate

THE CLINICAL QUESTION

How are gastroenterologists deciding which new therapies and diagnostics are ready to change everyday practice?

The responses suggest that novelty is not the deciding factor. Gastroenterologists are adopting new approaches when the evidence, workflow, and risk profile feel actionable, while keeping a higher threshold for strategies that still carry safety, training, or diagnostic uncertainty.

That pattern appears across very different areas of practice: combination IBD therapy remains mostly late-line, intestinal ultrasound has a large planned-or-partial adoption group, GLP-1 related symptoms create new diagnostic work, and early-onset colorectal cancer concern is lowering the threshold for investigation in younger symptomatic patients.

> **Coverage:** United States, United Kingdom, Italy, France, Germany. Survey findings are presented as the opinions and practice patterns reported by participating professionals.

EXECUTIVE SUMMARY

The pattern in one view

The survey captures a specialty in transition. The strongest findings are not isolated technology preferences. They reveal how gastroenterologists are filtering innovation through evidence, workflow, diagnostic certainty, and the practical consequences of getting a decision wrong.

01 / SIGNAL
Combination therapy remains late-line
More than half reserve dual advanced therapy for refractory patients approaching surgery, despite growing interest in deeper disease control.

02 / SIGNAL
IUS has crossed the interest threshold
Most respondents are already partially integrating intestinal ultrasound or planning to do so, but full implementation remains less common.

03 / SIGNAL
Incretin use is widening GI responsibility
Dysmotility, diagnostic ambiguity, procedural planning, and post-treatment metabolic shifts are all appearing in the GI workload.

04 / SIGNAL
Younger CRC risk is changing caution
Most respondents report some move toward earlier investigation or lower practical thresholds in younger at-risk patients.

> **Reading across the findings:** The six findings describe different technologies and disease areas, yet the same filter keeps appearing: clinicians move faster when an innovation is objective, interpretable, and operationally feasible, and more slowly when long-term safety, training, or diagnostic ambiguity remains unresolved. This helps connect late-line combination therapy, partial IUS adoption, incretin-related GI complexity, younger CRC investigation, and cautious interest in microbiome therapeutics into one practice story.

SECTION 01

Combination IBD therapy is still treated mainly as a rescue strategy

CONTEXT
Combination biologic or biologic-plus-small-molecule therapy represents one of the clearest examples of the gap between potential efficacy and real-world comfort. It asks clinicians to accept greater therapeutic complexity in exchange for the possibility of deeper control.

DATA
53.1% reserve combination advanced therapy for multi-drug refractory cases facing imminent surgery, 25.0% use it frontline in highly aggressive disease, 15.6% remain interested but hesitant because of long-term safety, and 6.3% do not use it.

INSIGHT
The prevailing posture is not rejection. It is escalation under pressure, when the disease has already demonstrated that simpler sequences are insufficient.

WHY IT MATTERS
That late-line positioning can influence which patients accumulate irreversible disease burden before combination mechanisms are considered.

Clinical threshold for combination advanced IBD therapy
Percent of responding participants
Frontline for aggressive disease 25.0%
Last resort before surgery 53.1%
Interested but hesitant on long-term safety 15.6%
Do not prescribe combinations 6.3%

The survey's open-text responses reinforce the same concern: long-term safety, durable response, head-to-head comparisons, and real-world registry data are repeatedly named as evidence gaps. This makes the threshold understandable even in a rapidly advancing treatment landscape.

The pattern also cautions against assuming that more options automatically simplify IBD sequencing. Every new mechanism adds another branch to the decision tree, and the evidence needed to compare sequences may lag behind the availability of the drugs themselves.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Combination therapy has entered practice, but for most respondents it still sits late in the sequence rather than at the beginning. Long-term safety evidence, complexity of dual-pathway exposure, and the need to justify escalation may keep a high-efficacy strategy behind a higher clinical threshold. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 02

Treatment switching is being driven by both symptoms and objective healing

CONTEXT
Treat-to-target IBD care asks clinicians to reconcile symptoms with objective inflammation. The survey shows that switching class is often triggered by either side of that equation.

DATA
Persistent clinical symptoms or patient-reported outcomes lead at 35.5%, followed by incomplete mucosal or transmural healing at 32.3%, anti-drug antibody patterns at 19.4%, and persistent non-invasive inflammatory markers at 12.9%.

INSIGHT
The decision is distributed across patient experience, imaging, pharmacokinetics, and biomarkers. No single data stream owns the switch decision.

WHY IT MATTERS
Discordance between these signals can create exactly the kinds of difficult cases where optimization, switching, or combination therapy is hardest to sequence.

Strongest signal to switch therapeutic class rather than optimize dose
Percent of responding participants
Persistent symptoms or PROs 35.5%
Incomplete mucosal or transmural healing 32.3%
Low trough plus high ADAs 19.4%
Persistent calprotectin or CRP elevation 12.9%

For example, a patient can feel well while endoscopy shows residual disease, or remain symptomatic despite improving inflammatory markers. These are not equivalent treatment failures, even if they eventually lead to a class change.

The near-equal weight of symptoms and objective healing suggests that respondents are balancing lived disease burden with structural disease control rather than treating either as universally dominant.

The significance of this finding becomes clearer when it is read against the rest of the dataset. No single endpoint dominates. Patient experience and objective disease control are carrying nearly equal weight in class-switch decisions. Moderate-to-severe IBD can produce discordance between symptoms, endoscopy, drug exposure, and biomarkers, so the decision to switch often depends on which signal appears most credible in that patient. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 03

Intestinal ultrasound is sitting in a large adoption middle ground

CONTEXT
IUS offers a different model of disease monitoring: repeatable, non-invasive, and potentially available during the clinical visit. The technology therefore depends as much on implementation as on diagnostic performance.

DATA
19.4% report full integration, 35.5% partial integration, 38.7% planned adoption, and only 6.5% no integration interest.

INSIGHT
The technology has strong pull but incomplete operational maturity. The largest groups sit between interest and routine use.

WHY IT MATTERS
Training pathways, equipment costs, protected scanning time, documentation, and image storage can determine whether a clinically useful tool becomes scalable.

AGA guidance describes IUS as a valuable method for objective IBD assessment and treatment response. Recent professional discussion has also emphasized the training infrastructure needed to expand its use.

The survey fits that context closely: relatively few reject IUS outright, while many are still building the conditions required to make it routine.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Interest is substantially ahead of complete implementation. The technology appears to have crossed the relevance threshold but not the workflow threshold. Training, equipment, scheduling, competency, and image-storage requirements can slow implementation even when clinicians see clear clinical value. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 04

GLP-1 use is creating both symptom burden and diagnostic ambiguity

CONTEXT
The growth of GLP-1 and dual incretin therapy has created a new intersection between metabolic medicine and gastroenterology. Patients arrive with symptoms, procedural questions, or both.

DATA
Severe dysmotility and differentiating drug effects from disorders of gut-brain interaction each account for 29.0%. Post-treatment metabolic and weight-maintenance issues account for 25.8%, and pre-endoscopy withholding protocols for 16.1%.

INSIGHT
The burden is not concentrated in one complication. Gastroenterologists are being asked to interpret mechanism, symptoms, procedure safety, and treatment transitions.

WHY IT MATTERS
This can lengthen diagnostic workups because medication effects can mimic or amplify pre-existing GI disorders while the need for endoscopy adds another layer of risk assessment.

Most frequent GLP-1 or GIP/GLP-1 clinical dilemma in gastroenterology
Percent of responding participants
29.0%
16.1%
29.0%
25.8%
Severe GI dysmotility 29.0%
Pre-endoscopy withholding protocols 16.1%
Drug effect versus DGBI 29.0%
Metabolic shifts after stopping therapy 25.8%

Current multi-society procedural guidance has moved away from blanket cessation of GLP-1 therapy and toward individualized risk assessment. That evolution itself reflects how quickly the evidence and clinical workflow have been changing.

The survey's even split across several dilemmas suggests there is no single "GLP-1 problem" for GI practice. The challenge is the breadth of situations created by widespread exposure.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The burden is distributed across diagnosis, symptom management, procedures, and treatment transitions rather than clustering around one issue. Incretin therapy affects gastric and intestinal function while patients may already have functional GI symptoms, obesity-related disease, or procedural needs, creating overlapping explanations for the same complaint. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 05

Early-onset CRC concern is lowering the real-world diagnostic threshold

CONTEXT
Early-onset colorectal cancer sits outside the traditional expectation that malignancy risk rises primarily with older age. For clinicians, this changes the meaning of symptoms that might previously have been managed more conservatively.

DATA
45.2% report more diagnostic endoscopy for younger patients with minor lower-GI symptoms, 32.3% are pushing for lower informal thresholds in high-risk groups, 12.9% intensify family-history or genetic assessment, and 9.7% report no major practice shift.

INSIGHT
The survey shows a behavioral shift toward earlier investigation rather than a simple change in population screening.

WHY IT MATTERS
Endoscopic capacity and diagnostic workload can rise even without a formal change in screening age because symptomatic care follows a different risk calculation.

How rising early-onset CRC concern is changing practice
Percent of responding participants
More diagnostic endoscopy in young symptomatic patients 45.2%
Push lower informal thresholds in high-risk groups 32.3%
Intensify family history and genetic assessment 12.9%
No meaningful practice shift 9.7%

The finding also reveals why "screening" and "diagnosis" need to remain separate concepts in public discussion. A symptomatic younger adult is not the same scenario as an asymptomatic average-risk person entering a population screening program.

The clinicians in this cohort appear to be recalibrating the probability they are willing to tolerate before investigating, especially when bleeding or altered bowel habits are present.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The main change is not simply earlier population screening. It is a lower tolerance for watchful waiting when a younger patient has potentially relevant symptoms or risk markers. The consequences of a missed malignancy can make minor bleeding or altered bowel habits feel less safely attributable to benign disease in younger adults than they did previously. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 06

Microbiome therapeutics attract interest, but evidence remains the gatekeeper

CONTEXT
Microbiome-based prescription therapeutics promise a new category of intervention, but the field has a long history of broad claims that have not always translated into reproducible clinical effects.

DATA
67.7% are cautiously optimistic but want definitive phase III evidence, 22.6% are highly optimistic, and 9.7% are skeptical.

INSIGHT
Interest is high, but the adoption threshold remains conventionally evidence-driven.

WHY IT MATTERS
For a microbiome product to move from fascination to routine care, respondents appear to want evidence of clinically meaningful superiority, consistency, and durability.

This is an important contrast with consumer enthusiasm around the microbiome. Specialists are not equating mechanistic plausibility with proven therapeutic value.

The open-text responses around registry data and long-term outcomes reinforce the same orientation: real-world evidence is seen as essential for understanding how emerging advanced therapies perform beyond tightly controlled trials.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The field is open to microbiome therapeutics, but enthusiasm is being held behind a conventional evidence threshold. Microbiome interventions face questions about reproducibility, strain standardization, clinical endpoints, durability, and how they perform against established therapies. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

PRACTICE PATTERN

What may be sitting underneath the responses

These are interpretive patterns, not clinical recommendations. They describe the tensions that appear across the survey when individual findings are read together.

Open-text responses place long-term safety, head-to-head comparisons, durable response, hard clinical endpoints, phenotype-based treatment selection, objective healing, cost and access, and registry-quality real-world evidence among the most important remaining evidence gaps. The comments reinforce a specialty that is not asking for more novelty in isolation; it is asking for evidence that clarifies sequencing and durability.

Evidence maturity sets the pace
Sequencing pattern
New treatment mechanisms are entering practice, but late-line use and cautious optimism show that evidence depth still governs where they sit in the sequence.

Implementation is a clinical variable
Diagnostic pattern
IUS adoption depends on training, equipment, workflow, and documentation. Utility alone does not guarantee routine use.

Metabolic medicine is expanding the GI caseload
Cross-specialty pattern
GLP-1 related symptoms and procedural questions are creating new diagnostic work that does not fit neatly inside one disease category.

Risk tolerance is moving before policy
Cancer pattern
Concern about younger-onset CRC is already changing symptom-driven investigation even when formal population screening frameworks remain stable.

CLOSING PERSPECTIVE

The bottleneck is increasingly the transition from possibility to practice

Gastroenterology now has more therapeutic mechanisms, more non-invasive monitoring options, and more cross-specialty responsibilities than it did only a few years ago. The survey makes clear, however, that capability does not move into routine care automatically.

Combination advanced therapy remains mostly a rescue strategy. Intestinal ultrasound has strong interest but a large implementation middle ground. GLP-1 therapies are adding dysmotility and diagnostic ambiguity to daily GI work. Concern about early-onset colorectal cancer is lowering the threshold for symptom-driven investigation. Microbiome therapeutics attract optimism, but most clinicians still want phase III proof before they become routine.

These findings are different on the surface, yet they share one underlying mechanism: gastroenterologists are continuously translating emerging evidence into a setting constrained by training, workflow, safety, diagnostic uncertainty, and resource capacity.

The defining skill in the next phase of gastroenterology may therefore be less about adopting every new tool quickly and more about knowing when an innovation has enough evidence and enough infrastructure to change care without creating a new layer of uncertainty.

Questions professionals continue to ask
This topic remains dynamic. The questions below reflect common practical searches around the field rather than retrospective questions about this survey.

What is combination advanced therapy in inflammatory bowel disease?
Combination advanced therapy uses two targeted mechanisms, such as two biologics or a biologic plus a small molecule, in selected patients with difficult-to-control IBD. Evidence, safety, and sequencing continue to evolve.

What does intestinal ultrasound show in IBD?
Intestinal ultrasound can assess bowel-wall thickness, vascularity, and other features of active inflammation at the point of care. It can support repeated monitoring without ionizing radiation.

How do GLP-1 receptor agonists affect gastrointestinal symptoms?
They can slow gastric emptying and may be associated with nausea, vomiting, constipation, or other motility symptoms. The clinical challenge is distinguishing expected medication effects from underlying GI disease.

Do GLP-1 medicines always need to be stopped before endoscopy?
Current multi-society guidance favors individualized assessment rather than a universal stop rule. Symptoms, dose escalation, procedural risk, and local anesthesia protocols can influence the plan.

Why is colorectal cancer in younger adults changing gastroenterology practice?
Rising concern about early-onset colorectal cancer can lower the threshold for diagnostic evaluation when younger adults present with bleeding, altered bowel habits, anemia, family history, or other concerning features.

What are live biotherapeutic products for gastrointestinal disease?
Live biotherapeutic products are standardized microbial therapies designed to produce a clinical effect. Their future role in severe GI disease depends on trial evidence, product consistency, safety, and durable outcomes.

SELECTED EXTERNAL CONTEXT

1. American Gastroenterological Association, Intestinal Ultrasound for Inflammatory Bowel Disease
2. American Gastroenterological Association, Management of GLP-1 Receptor Agonists Prior to Endoscopy
3. Multi-society guidance on GLP-1 therapy before surgery and GI endoscopy

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