



# Executive Summary: Building Trust in Inflammatory Bowel Disease Care and Clinical Research Through a Culturally Informed Shared Decision-Making Lens



## Proceedings from the 2026 SAIA-AGA Clinical Research Roundtable

Chicago, IL USA



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## BACKGROUND AND RATIONALE

Inflammatory bowel disease (IBD) care requires complex, preference-sensitive shared decisions between healthcare professionals (HCPs) and patients and sometimes family members. Therapeutic choices extend beyond whether to initiate advanced therapy and include route of administration, treatment sequencing, surgery, dietary strategies, psychosocial factors, reproductive planning, cost, and participation in clinical research. High-quality IBD care depends on integrating clinical evidence with patient values, family context, cultural beliefs, and structural realities<sup>1-5</sup>.

Shared decision-making (SDM) must be focal to modern IBD care. Foundational SDM models underscore informing patients that a framework exists, comparing therapeutic options, eliciting patient preferences, and reaching a shared plan together<sup>6,7</sup>. IBD-SDM incorporates family dynamics, stigma, cultural beliefs, particularly within immigrant and collectivist communities<sup>8,9</sup>.

IBD-SDM cannot function effectively without trust. Trust influences whether patients feel comfortable divulging symptoms, discussing fears, considering advanced therapies or surgery, participating in clinical trials, and engaging in long-term care. Higher trust in HCPs is associated with improved outcomes<sup>10</sup>. Similarly, trust is shaped by interactions with HCPs and by broader systems. Patients may lose trust when symptoms are dismissed, visits feel rushed, or care becomes fragmented. Historical trauma, discrimination, language barriers, financial and accessibility concerns, and uncertainty surrounding AI health tools may further contribute to mistrust<sup>11-13</sup>.

In 2025, Strategic Alliance for Intercultural Advocacy in GI (SAIA) and American Gastroenterological Association (AGA)'s Clinical Research Roundtable (CRR) identified cultural, communication, logistical, and structural barriers impacting equitable IBD care delivery and inclusive clinical trial participation<sup>13</sup>. In 2026, SAIA-AGA's CRR aimed to brainstorm solutions focused on building trust and developing culturally sensitive SDM across clinical care and research settings.

To fulfill these goals, the CRR was grounded in intersectionality, emphasizing that experiences of IBD are shaped by overlapping identities including race, ethnicity, gender, sexual orientation, socioeconomic status, religion, colonialism, immigration history, and prior medical and nonmedical trauma<sup>14-16</sup>. Discussions extended beyond cultural competence to emphasize cultural humility, trauma-informed care, and psychological safety<sup>17</sup>. Finally, the CRR recognized clinical research participation as a preference-sensitive decision requiring transparent and culturally appropriate education and communication plus assurance that declining participation will not compromise clinical care<sup>18-20</sup>.



## MEETING DESIGN

SAIA and the AGA convened the 2026 SAIA-AGA CRR: Strategies to Build Trust on Saturday, May 2, 2026, during Digestive Disease Week in Chicago, Illinois. The meeting followed the format of the 2025 SAIA-AGA CRR where the focus was identifying barriers, but the 2026 roundtable intentionally shifted to developing actionable strategies for culturally informed IBD-SDM and trust-building in clinical care and research.

## PARTICIPANTS

Eleven patient advocates (including 3 from SAIA Leadership), 21 clinicians (including 11 from SAIA Leadership), 6 from AGA leadership, 3 care partners, and 46 industry and nonprofit partner observers participated. The meeting included two moderated sessions: 1) IBD-SDM in clinical care delivery and research, and 2) Building trust to advance culturally informed IBD-SDM. Patients and clinicians gave brief presentations followed by moderated multistakeholder discussions. Sponsors and partner organizations were invited to provide feedback throughout Roundtable discussions. Findings are presented below as clinician- and patient-informed priorities.



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

Key themes from the CRR are presented in Table 1.

### Theme 1. IBD-SDM should combine clinical evidence/expertise with patient values/goals.

Meaningful IBD-SDM should be a collaborative process that requires clinicians to explain therapeutic options, discuss benefits and risks in comprehensible terms, elicit patient goals, and arrive at a shared plan that can be revisited over time. Patients distinguished IBD-SDM from both paternalistic decision-making and informed decision-making alone. Patients should neither be told what to do nor asked to choose among complex options without guidance. Clinicians emphasized IBD-SDM should not be understood as “sharing the physician’s decision,” but as mutual deliberation during which patients participate at the level they prefer.

Patients and clinicians emphasized that clinical trials should be presented as a treatment option, not as a default decision, last resort, or recruitment opportunity. Patients should understand the purpose of the research, alternatives to participation, probability, and duration of being placed on placebo, visit and procedure burden, safety monitoring, potential costs, data use, and their right to decline without compromising clinical care.

### Theme 2. Family SDM: IBD-SDM must be grounded in the lived realities of patients and their families.

Patients emphasized that decisions are rarely made in isolation. Parents, partners, caregivers, extended family, chosen family, and faith communities may influence disease management decisions. Family involvement is a source of emotional, logistical, and interpretive support, but could also conflict with patient or clinician preferences. Patients emphasized that clinicians should ask why a patient or family is drawn to a particular approach, including complementary and alternative medicine (CAM) or diet-based strategies, rather than dismissing such preferences as irrational or nonadherent.

Language and health literacy were core to the discussion. One patient presented on “having to translate complex medical information as a newly diagnosed 11-year-old” for her Sikh Punjabi immigrant parents in the United Kingdom (UK). She described missed opportunities when interpreters, translated materials, visual aids, or age-appropriate explanations were not provided. She emphasized the burden of health literacy should not fall on patients and families; clinicians, research teams, and health systems must provide developmentally appropriate, culturally relevant, and language-concordant education that enables meaningful participation.



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

### Theme 3. Trust is a prerequisite for IBD-SDM...and it is fragile.

Trust in IBD care and research operates at interpersonal, institutional, and systemic levels. Trust was described as bidirectional: patients place trust in clinicians to listen without judgment, protect confidentiality, provide accurate information, and act in their best interests, while clinicians rely on patients to disclose symptoms, concerns, and barriers openly. Patients may trust their personal clinician while remaining wary of hospitals, insurers, pharmaceutical companies, research institutions, or broader health systems.

Everyday clinical behaviors are important elements of trust, including the amount of time spent with and attention paid to patients during clinical visits in addition to understanding of the patient's disease journey. Clinicians who actively listen, answer patient questions, and make empathic statements garner more trust. Clinicians recognized that the above activities to build trust are limited by short visit times, documentation burdens, and workforce shortages, curtailing opportunities to address the complexities of IBD in one encounter. Patients emphasized that clinicians should avoid assuming that one communication style, including non-verbal methods, is universally preferred, especially for patients who are neurodivergent or who come from cultural contexts in which direct eye contact may carry different meanings.

Patients described trust as fragile and easily eroded when symptoms are dismissed, minimized, or attributed to anxiety, depression, low pain tolerance, or seeking attention. Experiences that eroded trust included adverse events that occurred during childhood, during hospitalization, before or after surgery, or resulted in prolonged diagnostic uncertainty. Patients emphasized that medical invalidation did not only reduce confidence in clinicians; it could also undermine trust in their own bodies, delay seeking care, and influence whether family members believed their symptoms were real. In this way, dismissal resulted in downstream consequences for diagnosis, treatment acceptance, and long-term engagement in care.



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

### Theme 4: Psychological safety is imperative for trust and IBD-SDM

Psychological safety requires more than inclusive language; it requires clinicians to recognize power differentials, avoid assumptions, and create conditions where patients feel safe to disclose symptoms and concerns. The clinical environment was identified as a key element of psychological safety. Patients stated they feel vulnerable when multiple team members enter the room without permission, when intimate examinations are not explained, or when sensitive questions are asked without privacy. For colonoscopy, pelvic or perianal examination, ostomy-related concerns, and colorectal surgery, it is important to take into consideration modesty, gender preferences, religious concerns, prior trauma, and sexual history to ensure psychological safety.

One Muslim patient from the UK flagged “We don’t have intercourse before marriage. It would be helpful for clinicians to bring up sexual health discussions and advise on best practices for safe intercourse while living with fistulae.” Some patients described receiving dismissive or unhelpful responses when asking about sexual function after ostomy or surgery. Others emphasized discussing sexual health in front of family may be



culturally difficult, particularly for young adults, women, patients from conservative family systems, and sexual and gender minority patients. Clinicians acknowledged the need for greater training and evidence-based recommendations regarding sexual health in IBD and broader GI conditions.

Patients emphasized mental health and emotional distress are often inseparable from IBD care, particularly in the setting of repeated flares, diagnostic delays, hospitalizations, surgery, medication failure, medical trauma, or uncertainty about the future. Mental health should be factored into the equation of psychological safety as should modesty as it relates to medical trauma. For example, repeated use of colonoscopies, while necessary for endoscopic assessment during clinical trials, may induce unnecessary medical trauma and may be less acceptable in conservative cultures. In such cases, it is important to utilize non-invasive tools including intestinal ultrasound (IUS) and fecal calprotectin at certain intervals to reduce the extent of medical trauma and respect cultural preferences.



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

### Theme 5: IBD-SDM must be culturally informed and grounded in cultural humility.

Cultural humility emerged as a more appropriate framework than cultural competence. Rather than mastering a fixed set of facts about a cultural group, participants emphasized humility amongst clinicians as an ongoing practice of self-reflection, curiosity, recognition of power imbalance, and avoidance of stereotyping<sup>21</sup>. A patient of LGBTQIA+ identity from India said, “it was not necessary for clinicians to share the same identity as the patient;” she emphasized the need “to be respected, believed, and seen.” Identity concordance mattered less than the clinician’s willingness to listen, avoid assumptions, ask questions respectfully, and acknowledge when they did not know something.



Culture was especially visible in discussions of diet and CAM. Dietary advice is often generic and may not reflect culturally specific foods, religious observances, family cooking practices, food insecurity, or the emotional meaning of food within families. A patient whose family had lived through the Iraq War and settled in the U.S. as refugees was told she was “noncompliant” when following dietary therapies and CAM

specific to her culture. With significant mistrust at play, it would have been favorable for her background and upbringing to be understood in order to lead to mutually respectful SDM.

Preferences for pills, injections, infusions, or surgery may similarly reflect cultural beliefs. There was an expression of a preference towards pills, then injections, and later infusions. Oftentimes, injections and more so infusions are considered relevant treatments for cancer as a form of “chemotherapy” but there is a stigma attached to using injections and infusions particularly for immune-mediated inflammatory disorders (IMIDs). One South Asian American patient mentioned, “family often considers infusions as a form of chemotherapy with significant strength and absorption, yes, but also chock full of side effects.”



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

### Theme 6: IBD-SDM must be longitudinal and intersectional.

It is critical to introduce IBD-SDM early at every decision-making stage. Several patients described pediatric care in which decisions were made by parents and clinicians while the patient had limited understanding of their disease or its treatment. Some entered adult care without confidence to share symptoms or ask questions or advocate for escalation beyond repeated corticosteroid exposure. Patients described IBD-SDM as meaningful only once they understood their disease and what remission meant in order to connect treatment choices to life goals, underscoring the need to build autonomy gradually in their transition into adult care.

Patient experiences are shaped by overlapping dimensions of age, race, ethnicity, gender, sexual orientation, socioeconomic status, religion, immigration history, language, disability, geography, family structure, and prior medical trauma. These intersecting identities may influence whether symptoms are believed, patients feel safe asking questions, family members support or doubt them, and if sensitive concerns can be disclosed. Culturally informed care must therefore move beyond broad ethnic categories and recognize how multiple identities and structural conditions shape trust within each clinical encounter.

A Latina patient described a prolonged diagnostic journey marked by repeated reassurance that symptoms were insignificant, which contributed to loss of trust in clinicians, loss of trust in herself, and loss of trust from family members. Another described how being a South Asian queer woman shaped her interactions with health care, including heteronormative assumptions, misogyny, queerphobia, and the difficulty of discussing sexual orientation or intimacy in cultural settings where these topics may be stigmatized or unsafe.



## KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

### Theme 7: IBD-SDM is about more than biomarkers and symptom control.

Patients emphasized treatment decisions and clinical trial endpoints should account for quality of life (QoL), mental health, diet, education, employment, caregiving responsibilities, travel, fertility, sexual health, finances, and participation in family and community life. Rather than focusing only on symptoms, biomarkers, or endoscopic targets, patients wanted clinicians to ask what they hoped most to regain, including returning to school, work, caregiving, physical activity, or social functioning. Clinicians noted that patient-defined goals may differ from conventional endpoints and can clarify what a successful treatment plan means for each individual patient.

### Theme 8: IBD-SDM must recognize systemic influences and systemic mistrust.

Insurance requirements, cost, immigration concerns, travel, time off work, childcare, food access, medication availability, and local public health-system structure may determine whether IBD-SDM is possible. These barriers varied across the United States, United Kingdom, Canada, India, and other global contexts, where access to advanced therapies, specialist care, multidisciplinary support, or research participation may differ significantly. IBD-SDM depends on what is medically appropriate and what is accessible and sustainable.

Systemic mistrust is a barrier to IBD care delivery and research participation. As shown in the 2025 CRR, historical trauma, colonialism, racism, sexism, classism, financial incentives, insurance restrictions, fragmented care, and prior experiences of discrimination often shape whether patients perceive recommendations as trustworthy. In clinical research, these concerns may be amplified by



fear of experimentation, uncertainty about placebo exposure, lack of transparency about data use, and the burden of trial participation. Digital health and artificial intelligence (AI) were also raised as emerging areas where trust will depend on privacy protections and careful implementation. Patients and clinicians also identified transparency around data use and return of research findings as ways to understand if research is more a partnership or an extraction.



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### Conclusion

The 2026 SAIA-AGA CRR emphasized that culturally informed IBD-SDM requires partnership in understanding therapeutic options in addition to recognizing family and community context, supporting health literacy, acknowledging fear and practical barriers, and aligning care or research decisions with patient goals and lived circumstances. In both clinical care and research, IBD-SDM was viewed as a process that should begin early, evolve over time, and help patients and clinicians move toward an active partnership. The Roundtable emphasized that trust is essential to both IBD care and research. In clinical care, trust supports open communication, shared decision-making, and long-term engagement. In research, it enables active participation, engagement, and retention. Trust was viewed as relational and built over time; not through a single conversation or consent process, but through continuity, transparency, humility, privacy, and systems that help patients feel safe, heard, and respected.



# KEY THEMES & MEETING SUMMARY FROM THE SAIA-AGA CRR

**Table 1. Major Themes of the 2026 SAIA-AGA CRR**

IBD-SDM must integrate clinical evidence/expertise with patient values/goals.	IBD-SDM must be culturally informed and grounded in cultural humility.
IBD-SDM must be grounded in the lived realities of patients and their families.	IBD-SDM must be longitudinal and intersectional.
Trust is a fundamental prerequisite for IBD-SDM and it is fragile.	IBD-SDM must recognize systemic influences and systemic mistrust.
Psychological safety is imperative for trust and IBD-SDM.	IBD-SDM is about more than biomarkers and symptom control.

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## Roundtable Sponsors

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## REFERENCES

1. Sequier L, Caron B, Honap S, et al. Treatment sequencing in inflammatory bowel disease: Towards clinical precision medicine. *Best Pract Res Clin Gastroenterol*. 2025;77:101994. doi:10.1016/j.bpg.2025.101994
2. Agrawal M, Spencer EA, Colombel JF, Ungaro RC. Approach to the Management of Recently Diagnosed Inflammatory Bowel Disease Patients: A User's Guide for Adult and Pediatric Gastroenterologists. *Gastroenterology*. 2021;161(1):47-65. doi:10.1053/j.gastro.2021.04.063
3. Siegel CA. Shared decision making in inflammatory bowel disease: helping patients understand the tradeoffs between treatment options. *Gut*. 2012;61(3):459-465. doi:10.1136/gutjnl-2011-300988
4. Song K, Wu D. Shared decision-making in the management of patients with inflammatory bowel disease. *World J Gastroenterol*. 2022;28(26):3092-3100. doi:10.3748/wjg.v28.i26.3092
5. Siegel CA. Patient decision tools in inflammatory bowel disease. *Gastroenterol Hepatol*. 2013;9(9):585-587.
6. Elwyn G, Durand MA, Song J, et al. A three-talk model for shared decision making: multistage consultation process. *BMJ*. Published online November 6, 2017;j4891. doi:10.1136/bmj.j4891
7. Elwyn G, Frosch D, Thomson R, et al. Shared Decision Making: A Model for Clinical Practice. *J Gen Intern Med*. 2012;27(10):1361-1367. doi:10.1007/s11606-012-2077-6
8. Suryaprakash N, Ruzycki SM, Raman M, et al. A cultural lens on decision-making in treatment decisions about inflammatory bowel disease: a qualitative analysis with South Asian patients, caregivers and clinicians in Canada. *BMJ Open*. 2026;16(2):e113208. doi:10.1136/bmjopen-2025-113208
9. Youssef M, Tandon P, Jones T, Srikanth V, Targownik L. Key Themes in the Care of Inflammatory Bowel Diseases Among Immigrant Populations: A Systematic Review. *Dig Dis Sci*. 2025;70(3):1016-1033. doi:10.1007/s10620-024-08801-2
10. Birkhäuer J, Gaab J, Kossowsky J, et al. Trust in the health care professional and health outcome: A meta-analysis. Nater UM, ed. *PLOS ONE*. 2017;12(2):e0170988. doi:10.1371/journal.pone.0170988
11. Fuss A, Jagielski CH, Taft T. We didn't start the fire...or did we?—a narrative review of medical gaslighting and introduction to medical invalidation. *Transl Gastroenterol Hepatol*. 2024;9(0):0. doi:10.21037/tgh-24-26
12. Shukla M, Schilt-Solberg M, Gibson-Scipio W. Medical Mistrust: A Concept Analysis. *Nurs Rep*. 2025;15(3):103. doi:10.3390/nursrep15030103
13. Aswani-Omprakash T, Devi J, Balasubramaniam M, et al. Patient-Inclusive Recruitment in Inflammatory Bowel Disease Trials: Key Takeaways From the 2025 Strategic Alliance for Intercultural Advocacy in GI-American Gastroenterological Association Asian Clinical Research Roundtable. *Gastroenterology*. 2026;170(5):873-877. doi:10.1053/j.gastro.2026.03.001
14. Pérez-Stable EJ, Webb Hooper M. The Pillars of Health Disparities Science—Race, Ethnicity, and Socioeconomic Status. *JAMA Health Forum*. 2023;4(12):e234463. doi:10.1001/jamahealthforum.2023.4463
15. Newman KL, Wren PA, Long MD, Higgins PDR. Health Outcomes, Discrimination, and Stigma Among Sexual and Gender Minority People With Inflammatory Bowel Disease. *Inflamm Bowel Dis*. 2025;31(9):2429-2437. doi:10.1093/ibd/izaf054



## REFERENCES

16. Hawkins RL, Zia M, Hind D, Lobo AJ. Inequalities in Healthcare Access, Experience and Outcomes in Adults With Inflammatory Bowel Disease: A Scoping Review. *Inflamm Bowel Dis*. 2024;30(12):2486-2499. doi:10.1093/ibd/izae077
17. Raja S, Hasnain M, Hoersch M, Gove-Yin S, Rajagopalan C. Trauma Informed Care in Medicine: Current Knowledge and Future Research Directions. *Fam Community Health*. 2015;38(3):216-226. doi:10.1097/FCH.0000000000000071
18. Pathiyil MM, Jena A, Venkataramana Raju AK, Omprakash TA, Sharma V, Sebastian S. Representation and reporting of diverse groups in randomised controlled trials of pharmacological agents in inflammatory bowel disease: a systematic review. *Lancet Gastroenterol Hepatol*. 2023;8(12):1143-1151. doi:10.1016/S2468-1253(23)00193-0
19. Singh S, Allegretti J, Nersesova Y, Serra S, Kim A. Meeting Summary: AGA Roundtable on Clinical Trial Design in Inflammatory Bowel Disease. *Clin Gastroenterol Hepatol*. 2024;22(5):913-918. doi:10.1016/j.cgh.2023.12.005
20. Uzzan M, Bouhnik Y, Abreu M, et al. Declining Enrolment and Other Challenges in IBD Clinical Trials: Causes and Potential Solutions. *J Crohns Colitis*. 2023;17(7):1066-1078. doi:10.1093/ecco-jcc/jjad020
21. Pandit AU, Tomasino KN, Omprakash TA, Epstein DE. Cultural considerations in gastroenterology: barriers to care and a call for humility and action. *Transl Gastroenterol Hepatol*. 2024;9:74-74. doi:10.21037/tgh-24-17

