Bridge the GHAPP

Gastroenterology & Hepatology
Advanced Practice Providers

NEWSLETTER

VOLUME 16

Dear Reader,

Summer's end means fall's beginning is near, and with autumn leaves comes – you guessed it – conferences. AASLD, ACG, and of course, GHAPP National will be upon us in the blink of an eye. Year after year, GHAPP National Conference has had a stellar line up, and this year is no exception. Are you registered? There's still time to join us in Chula Vista, CA!

This edition of Bridge the GHAPP includes an article on liver disease, highlighting what providers should know and identifying knowledge gaps to be addressed, a very interesting case study of pelvic congestion, and reflection on mentorship. You'll also see more trivia questions, some shoutouts to our peers, and information about the upcoming conference.

If you're reading this at the national conference COME FIND ME and tell me what your favorite part of GHAPP so far has been! And then tell me your favorite TV show or book so far this year (are you a fellow Loon? A Crawler??), I want to hear your recs and meet our newsletter readers.

As always, we thank you for reading and your continued support of GHAPP, it would not be as great as it is without you. Looking forward to seeing you in October!

In Health,

Allysa Saggese, NP
Director of Newsletter

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Redefining Success in PBC: Why Normalization Is the New Goal

Oyin Penny, NP

Primary biliary cholangitis (PBC) management is changing rapidly, and advanced practice providers (APPs) are well-positioned to help lead this shift. Historically, treatment success in PBC was often measured by a percentage reduction in alkaline phosphatase (ALP), especially after 12 months of first-line therapy. However, with evolving treatment options and increasing focus on earlier assessment, the goal is moving toward full biochemical normalization. This includes normalizing ALP and improving long-term outcomes through proactive monitoring, timely escalation of therapy, symptom management, and clear documentation.

Diagnosis of PBC is often more straightforward than many clinicians assume. In most cases, liver biopsy is not required. Approximately 95% of patients are antimitochondrial antibody positive, and this finding, in the setting of cholestatic liver enzyme abnormalities, can support the diagnosis. Mildly elevated ALP should not be overlooked, as it may represent early cholestatic liver disease. The remaining 5% of patients who are AMA-negative may still meet diagnostic criteria and should not be missed. APPs should be comfortable interpreting abnormal liver enzymes and recognizing when additional evaluation is needed, particularly when autoimmune hepatitis overlap or metabolic dysfunction-associated steatotic liver disease overlap is possible.

First-line therapy for PBC remains ursodeoxycholic acid, or ursodiol. Weight-based dosing is important, typically 13–15 mg/kg/day, and dosing should be adjusted when weight changes, especially in patients using weight-loss medications. Treatment response should no longer be viewed as a passive 12-month waiting period. Increasingly, clinicians are assessing response at 6 months and considering escalation when ALP is not improving adequately or normalization is unlikely. Delayed escalation may leave patients exposed to ongoing disease activity.

Second-line therapies are now available for patients who have an incomplete response or intolerance to ursodiol. APPs need education on when to initiate these therapies, which patients are appropriate candidates, and which populations require caution. For example, PPAR agents are not appropriate for certain patients, including those with decompensated cirrhosis and pregnant patients. Women of childbearing potential should use contraception and have pregnancy testing prior to initiation. Newer agents, including IBAT inhibitors, are also important for APPs to understand as treatment options expand.

Pruritus and fatigue are common symptoms in PBC and can occur even when ALP values appear controlled. Normal laboratory results do not necessarily mean the patient is doing well. Symptom management should be recognized as a legitimate and independent treatment target. APPs should actively assess quality of life, itch severity, fatigue, and functional status during follow-up visits.

Strong documentation in the EHR/EMR is essential. APPs should clearly chart the diagnosis, treatment goals, maintenance laboratory plans, fibrosis monitoring, vitamin supplementation when indicated, and next steps if goals are not met. Documentation should also include use of noninvasive tests such as FibroScan and ELF score when available. Clear documentation improves continuity of care across referrals, covering providers, and transitions between hepatology, gastroenterology, and primary care.

Ultimately, PBC care has evolved faster than many referring providers realize. APPs who normalize treatment goals, escalate therapy proactively, manage symptoms, and document care plans thoroughly can improve patient outcomes and support a more consistent standard of care.

An Unusual Presentation of Pelvic Congestion Syndrome Due to Spontaneous Portosystemic Shunting in a Cirrhotic Patient (Presented at ACG 2025)

Allison Malick MD, Shannon Todd PA-C, Alomari A MD, Syed-Mohammed Jafri MD

Introduction:
We present a rare case of pelvic congestion syndrome (PCS) related to portosystemic shunting in a cirrhotic patient, highlighting an uncommon vascular cause of abdominal pain in advanced liver disease.

Case Description/Methods:
The patient is a 52-year-old female with a past medical history of hypertension, anemia, nephrolithiasis, and granulomatous hepatitis and non-alcoholic steatohepatitis (NASH)- related cirrhosis complicated by portal hypertension and encephalopathy, who presented with progressive pelvic pain. The patient had been previously listed for liver transplant, but due to recompensation, the patient was no longer in need of transplant at the time.

She reported persistent, cramping pelvic discomfort worsened by prolonged standing, sitting, or twisting, as well as pelvic pressure and pain with toileting and intercourse ongoing for several months. Vital signs were unremarkable. Physical examination revealed mild lower abdominal tenderness. Laboratory workup noted a total bilirubin of 1.1 mg/dL, ALP 144 U/L, ALT 22 U/L, AST 34 U/L, and WBC count of 6.4 $\times 10^9$/L. Contrast-enhanced CT of the abdomen and pelvis revealed dilated ovarian and uterine veins, including marked dilation and tortuosity of the right ovarian vein near the inferior vena cava (IVC), as well as enlargement of the right inferior mesenteric and splenic veins. The IVC was also dilated, measuring 4.7 cm. A portosystemic shunt venogram demonstrated retrograde flow into the pelvic ovarian veins, with a large ovarian vein–to–internal iliac vein shunt, consistent with PCS. Interventional Radiology performed coil embolization of two branches of the right ovarian vein, resulting in complete resolution of retrograde pelvic flow. Follow-up CT imaging demonstrated decreased caliber of the parauterine vessels. Clinically, the patient reported approximately 75% improvement in pelvic pain and pressure following the procedure.

Discussion:
PCS is generally caused by valvular incompetence or obstruction within the ovarian or uterine veins, leading to venous stasis, pelvic varices, and chronic pain. This case highlights a unique presentation of abdominal pain in a complex liver patient and underscores the importance of considering central venous hypertension as a mechanism of pelvic pain in cirrhotic individuals. It also demonstrates the value of multidisciplinary care in identifying nontraditional causes of PCS.

The Impact of Mentorship

Sarah Holbrooks Dawkins, FNP-C

Practicing in a subspecialty can be intimidating, and many Advanced Practice Providers don't receive formal training in these areas until they're already on the job, learning as they go. I experienced this firsthand. During those moments of uncertainty, I was fortunate to have Elizabeth Goacher as someone to lean on.

Elizabeth has been my sounding board, coach, and mentor, and she's the reason my career moved to the next level. She was my mentor through the AASLD Mid-Career Scholars Program, and the following year, she asked me to consider speaking at the GHAPP Annual Conference. Trying not to sweat, I told her, "While I'm honored you think I can do this, I don't think I'm ready for something that big." "Oh, Sarah," she said, "I don't think you're ready. I know you are. You can do this."

And so I did. I'm still working on my speaking style and my confidence in front of a crowd, but Elizabeth helped me see something in myself that I hadn't seen before. Today, I find so much fulfillment in teaching, speaking, and helping other APPs feel more confident in caring for patients with liver disease.

I watched what Elizabeth did for our APP team at Duke. She grew our group from 8 APPs to more than 20 during her nine years as APP Team Lead of the GI Division at Duke. She's been a pioneer for APPs at our institution, and now serves as the first APP in a Medical Director role within our GI Division.

When I followed her footsteps as APP Team Lead in 2023, Elizabeth was right there to guide me with institutional knowledge and the unwritten rules of leadership. She opened doors for me to grow professionally and now to lead others.

Whether it's grabbing dinner after work, hiking, or traveling to conferences together, Elizabeth has become far more than a mentor. She's a role model and close friend. She has made me a better clinician, a better leader, and happier in my workplace.

Now it's my turn to pay it forward, to be for someone else what Elizabeth has been for me: a person who sees the potential in you before you see it in yourself, and won't let you settle for less than what you're capable of. Every APP needs an Elizabeth.

"A mentor is someone who sees more talent and ability within you than you see in yourself, and helps bring it out of you."

- Bob Proctor

The GHAPP Peer Network is Now Live!

Connect. Collaborate. Advance.

The Peer Network is your space to:

- **Create Your Profile**
  Share your expertise and highlight your clinical focus.
- **Connect With Peers**
  Find and engage with GI & Hepatology APPS across the country.
- **Ask Questions**
  Get answers and insights from your peers.
- **Explore Resources**
  Access tools and content to support your practice.

Open the GHAPP ACE App and tap Peer Network to get started!

GHAPP

Sue Kim, RN, MSN, PhD candidate at UPenn and recipient of the AASLD Emerging Liver APP (ELAPP), for her article in the AASLD Liver Transplant Journal: Balancing abstinence and harm reduction across the continuum of care for liver transplantation in alcohol associated liver disease published 1 Dec 2025. She recently has had another publication in The American Journal of Gastroenterology: Barriers and Facilitators of Alcohol Use Disorder Treatment for Alcohol-Associated Liver Disease: A Systematic Review, published 1 Jun 2026.

Lindsay Yoder, PA-C, MPAS at IU Health Gastroenterology & Hepatology for her article recently published in Hepatology Communications: The Transitional Liver Clinic: Study protocol for a stepped-wedge cluster randomized trial, on 1 Jun 2026. Lindsay was also recently chosen as a 2026 Department of Medicine's Outstanding APP Award at Indiana University.

Angelina Collins, MSN, ANP-BC at UC San Diego Health was nominated as co-chair of the AGA 2026 Principles of GI for the NP and PA conference held 8/28 - 8/30 in Chicago, IL.

Trivia Questions

Here are a couple of trivia questions for you:

1

Which lab pattern is consistent with cholestatic injury

- A) Increased ALT/AST > increased Alk phos
- B. Increased Alk phos > increased ALT/AST
- C. Increased LDH
- D. Isolated increased Bilirubin

2

Most specific marker for alcohol use in the last 2-3 weeks:

- A) GGT
- C) Phosphatidylethanol (Peth)
- B) CDT
- D) MCV

3

Primary driver of ascites in cirrhosis:

- A) Low Oncotic pressure
- B) Increased hepatic lymph production
- C) Portal hypertension with splanchnic vasodilation
- D) High sodium intake

Answers are located on page 6!

9TH ANNUAL National Conference

What to Expect!

The annual GHAPP conference is just around the corner, starting October 1st! We look forward to engaging with everyone, especially new members and those coming for the first time. The GHAPP National Conference is more than outstanding education; it is an opportunity to connect, celebrate, and be part of a community that understands your journey.

This year, our expanded Boot Camp lineup offers even more opportunities to dive deeper into the topics shaping GI and hepatology practice over two days. Choose from IBD General and Advanced Boot Camps, the Inpatient Summit: GI & Hepatology, EoE Boot Camp, and four exciting new programs: the Cholestatic Boot Camp, Motility Boot Camp, IBS-C Boot Camp & the NIT Boot Camp, offering a hands-on training session & data synthesis roundtable & decision-making discussion.

The experience continues beyond the classroom with our dynamic Posters & Prosecco Session, exciting Welcome Reception, and IBD CME Symposium. Celebrate excellence as we honor two deserving colleagues in GI and Hepatology during the APP of the Year Award Presentation, and make time to explore the Exhibit Hall, connect with our valued sponsors, and discover the latest innovations and resources supporting GI and hepatology practice.

Don't forget to add **#GHAPP2026** to all your social media posts about the event. Share your insights, network with peers, and keep updated on conference happenings.

CONNECT ➤ LEARN ➤ INSPIRE ➤ LEAD

We can't wait to experience GHAPP National together!

Please note:
Some sessions have limited capacity and may fill quickly, or are currently at capacity.

Trivia Answers

Question 1: B)

Increased Alk phos > increased ALT/AST
Cholestasis causes a predominant elevation in alkaline phosphatase, often accompanied by elevated bilirubin.

Question 2: C)

Phosphatidylethanol (Peth)
This is a direct biomarker of alcohol consumption, highly specific and sensitive for recent use.

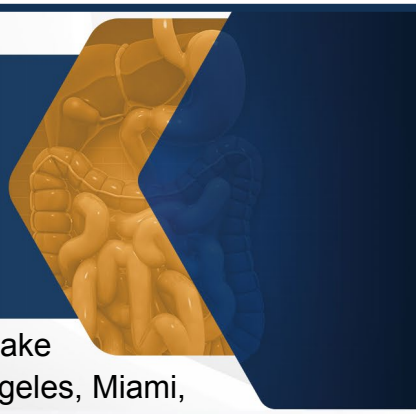
Question 3: C)

Portal hypertension with splanchnic vasodilation
lead to splanchnic vasodilation, RAAS activation, sodium retention and ascites formation.

Regional Conference Series

Earn up to a maximum or 2.0 AAPA Category 1 CME credits, or 2.0 ANCC nursing contact hours!

Hot Topics in Chronic Liver Disease and GI Disorders



We are pleased to announce the GHAPP Regional Conference series, which will take place in major cities such as Atlanta, Boston, Chicago, Cleveland, Denver, Los Angeles, Miami, New Orleans, New York, San Antonio, San Francisco & Scottsdale. These 3-hour CME-accredited dinner meetings will highlight "HOT" topics in chronic liver diseases and GI disorders, including IBD, MASH & PBC. Registration is open for these live events.

We hope to see you at the annual conference or one of our regional events for an enriching and educational experience!

REGISTER NOW!

www.ghapp.org/regionals

Upcoming dates & locations

Scottsdale, AZ – October 22, 2026
New York, NY – November 12, 2026
Miami, FL – November 19, 2026
New Orleans, LA – December 3, 2026

IBD Community Network

GHAPP
Gastroenterology & Hepatology Advanced Practice Providers

Mission of the IBD Community Network

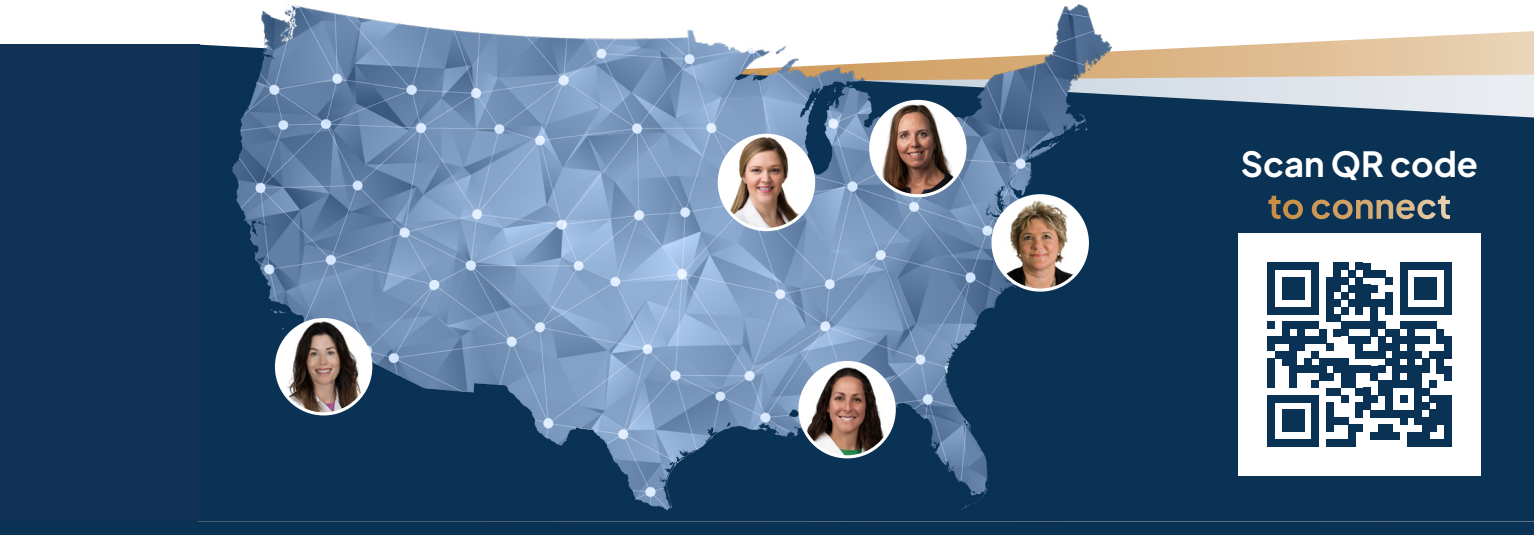
Fostering collaboration, advancing innovation, and improving outcomes for patients living with Inflammatory Bowel Disease.

Connect With Your Local IBD Expert

Partner with trusted IBD experts in your region to unlock your potential and achieve your goals.

Tailored Education

Join a regional network where learning reflects local needs. Collaborate with peers, and advance the quality of IBD care together.



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For more information, please visit:

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