are required to validate CLE diagnostically, harmonize response criteria, and clarify its role within personalized dietary management of refractory IBS.

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EUS-GUIDED COIL EMBOLIZATION FOR PRIMARY PROPHYLAXIS OF HIGH-RISK GASTRIC VARICES IN CIRRHOTIC PATIENTS: THE EXPERIENCE OF ANCONA (ITALY)

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Aims/Purpose: Gastric varices (GV) represent a severe complication of portal hypertension and carry a considerable risk of life-threatening bleeding. Conventional endoscopic treatments, such as cyanoacrylate injection, are often limited in feasibility and efficacy. Endoscopic ultrasound (EUS)-guided embolization has recently emerged as a promising alternative, enabling precise localization and targeted obliteration of feeding vessels. Evidence on its effectiveness, safety and long-term outcomes remains limited.
Methods: Four cirrhotic patients with isolated high-risk GV of the fundus, not eligible for liver transplantation or TIPS, underwent EUS-guided coil embolization over a time frame spanning from November 2024 to July 2025. The procedure was performed using a linear echoendoscope with colour-Doppler, 19G FNA-needles, and coils calibrated to vessel size (approximately 20% larger than the targeted vessel diameter). Real-time Doppler and fluoroscopic monitoring ensured complete obliteration. Follow-up endoscopy, EUS, and CT imaging were performed one month after the procedure.
Results: No major adverse events occurred, and all patients were discharged within three days. Complete obliteration was achieved in three of four patients after a single session, confirmed by absence of Doppler flow and by CT imaging. One patient showed clinical improvement in hepatic encephalopathy following embolization of a gastro-renal shunt. A case of coil extrusion was successfully managed endoscopically. One patient requires an additional embolization due to persistent fundal varices.
Conclusion: EUS-guided coil embolization appears to be a safe, technically feasible, and effective method for primary prophylaxis of high-risk GV in cirrhotic patients. Further prospective and randomized studies are necessary to support these preliminary findings.

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DOUBLE-BALLOON ENTEROSCOPY ASSISTED BY A THIRD MAGNETIC BALLOON ANCHORING SYSTEM: A PRELIMINARY CASE SERIES

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Aims/Purpose: Small bowel exploration in double-balloon enteroscopy is often limited by loop formation, which prevents deeper insertion. To overcome this setback, we employed a novel magnetic balloon anchoring system which had already proved its efficacy in difficult colonoscopies.
Methods: This system includes a through-the-scope balloon catheter filled with ferromagnetic fluid and an external permanent magnet. Upon loop formation, the balloon is inflated in conjuction with overtube and scope balloons and anchored through the external abdominal magnet. This triple balloon approach enables easier loop resolution through retraction and straightening. We employed this system in two patients after a failed standard technique attempt with a short enteroscope (155 cm length, 3.2 mm working channel).
Results: In a 69-year-old woman with recurrent gastrointestinal bleeding, this approach allowed deeper penetration and treatment of a 2 mm Yano-Yamamoto type 2b non-bleeding lesion of the mid-small bowel after a failed first attempt of standard anterograde double-balloon enteroscopy. In a 71-year-old man with a 15 mm ulcerative lesion of the proximal ileum, the triple balloon system allowed insertion approximately 100 cm deeper than in the previous standard procedure and biopsy of the lesion.
Conclusion: The double-balloon enteroscopy assisted by a magnetic balloon anchoring system - the "triple balloon enteroscopy" - might reduce the rate of incomplete procedures and enable deeper insertion when using a short enteroscope, which allows better manoeuvrability and stability and requires fewer medical and nursing staff. This could lead to better patient outcomes, optimization of procedure time and overall cost reduction.

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PREDICTORS OF SUBOPTIMAL BOWEL PREPARATION IN PATIENTS WITH INFLAMMATORY BOWEL DISEASES UNDERGOING COLONOSCOPY: PRELIMINARY RESULTS FROM THE NATIONAL MULTICENTRIC IBD-WIN-COLON STUDY

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Aims/Purpose: Colonoscopy quality in patients with inflammatory bowel disease (IBD) depends on adequate bowel preparation (BP). However, predictors of suboptimal BP in this population remain largely unclear.
Methods: IBD-WIN-COLON is a national, multicentric, cross-sectional study enrolling IBD patients undergoing colonoscopy for any indication. Demographic, clinical, endoscopic, and psychometric variables [including Beck Anxiety Inventory (BAI) and Beck Depression Inventory-II (BDI-II)] were collected. BP quality was assessed using the Boston Bowel Preparation Scale (BBPS). Suboptimal BP was defined as a BBPS score >6. Logistic regression