(15% of the cohort) were eligible for inclusion. Consequently, no patients with Child-Pugh C were enrolled or available for analysis. Although [^{18}F]fluorodeoxyglucose (FDG) and [^{18}F]fluorocholine (FCH) PET-CT might have potential use in patients with Child-Pugh C being considered for liver transplantation, we remain cautious regarding its impact. In our cohort, the combined use of these PET tracers did not significantly alter staging or management decisions for patients with Barcelona Clinic Liver Cancer stage A and Child-Pugh A or Child-Pugh B. It is, therefore, unclear as to why the imaging would detect significantly more additional hepatocellular carcinoma lesions in the context of Child-Pugh C. Nonetheless, one possible application of [^{18}F]FDG PET-CT could be in identifying patients at higher risk of recurrence, which might improve selection and prioritisation for liver transplantation in decompensated individuals.[2,3] Moreover, in France, more than 80% of patients diagnosed with hepatocellular carcinoma are male, thus, in our study, the gender distribution (90% of participants being male) is representative of the broader European population.[4,5] Additionally, our cohort primarily consisted of patients with chronic alcohol consumption and metabolic syndrome—both recognised as the leading risk factors for hepatocellular carcinoma in Europe. Further studies are warranted to evaluate the role of [^{18}F]FDG and [^{18}F]FCH PET-CT in patients with hepatocellular carcinoma linked to chronic hepatitis B, especially in Asian populations.

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During the preparation of this work the author used Chat-GPT 3.5 in order to improve the English of the manuscript. After using this tool, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

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Refining clinical success metrics in EUS-guided gastroenterostomy

We wish to express our appreciation for the DRA-GOO trial,[1] a pivotal study shedding light on the advantages of endoscopic ultrasonography-guided gastroenterostomy (EUS-GE) over duodenal stenting for malignant gastric outlet obstruction. This randomised, controlled, assessor-blinded trial provided compelling evidence of reduced reinterventions with EUS-GE, confirming data from previous non-randomised studies.

While acknowledging the commendable trial design, we would like to address a nuanced aspect regarding the definition of clinical success. The authors used a criterion of a 1-point improvement in the Gastric Outlet Obstruction Score (GOOS)[2] within 3 days. However, we believe this measure might inadvertently underestimate the true clinical impact of EUS-GE. Attaining even a modest improvement in the GOOS, such as transitioning from a no-oral-intake diet to a liquid-only diet, is to be considered a clinical success according to the former definition, while it fails to fully capture the breadth of patients' experiences and the clinical impact of the intervention.

Drawing from our group's retrospective[3,4] and prospective[5] experiences, we propose considering reaching a soft solid diet (GOOS ≥2) as the standard definition of clinical success, and even exploring the attainment of a full diet (GOOS ≥3) as a more clinically relevant endpoint. Our previous investigations revealed that EUS-GE might offer additional advantages beyond long-term patency, starting from the day after the procedure (clinical success of EUS-GE *vs* duodenal stenting of 100% *vs* 75%, p=0·006).[5] This evidence challenges the prevailing notion that EUS-GE should be reserved exclusively for patients with longer life expectancy. In our opinion, duodenal stents should be reserved only for patients for whom EUS-GE is considered unfeasible or dangerous. Notably, in the DRA-GOO trial, the 1-month GOOS was significantly higher (2·41 [SD 0·7] *vs* 1·9 [0·9], p=0·012) in the EUS-GE group, indicating a meaningful improvement in patient-reported eating habits.

While extending our congratulations to the authors for this eagerly awaited evidence, we propose that future trials comparing EUS-GE with duodenal stenting not only focus on reduced reintervention rates but also emphasise the enhanced eating experience with EUS-GE and several other clinically relevant endpoints (eg, chemotherapy tolerance or nutritional status). This shift will ensure that literature accurately reflects what is genuinely important for the patient. Furthermore, incorporating additional endpoints related to patients' reported outcomes

and experience would amplify the clinical relevance of the findings, aligning our understanding of success with the real-world experiences of individuals with malignant gastric outlet obstruction.

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India's continued response to tackling metabolic disorders and non-communicable diseases

In September, 2024, the Indian Ministry of Health and Family Welfare released two key policy instruments: revised operational guidelines for non-alcoholic fatty liver disease (NAFLD) and a national training module for primary care physicians.[1–3] These documents were preceded by a letter from the Union Minister of Health and Family Welfare to state health ministers that supported the early implementation of the NAFLD programme in their respective states. These developments reflect the Indian Government's expanded commitment to tackling NAFLD as part of a broader syndemic of metabolic conditions and mark notable progress in India's commitment to preventing NAFLD since our last updates in 2021 and 2023.[4,5]

The updated operational guidelines define a structured care pathway for NAFLD across health subcentres, primary and community health centres, and district hospitals. They recommend use of non-invasive tools (eg, the Fibrosis-4 Index) for risk stratification and referral, and formally position NAFLD within the continuum of non-communicable diseases alongside diabetes, hypertension, and cardiovascular diseases. This recognition represents a move away from siloed disease programmes towards integrated metabolic health management.

The updated guidelines align with national non-communicable disease strategies in India, which focus on the methodologies adopted by health-care workers at all levels, from villages up to community health centres and district hospitals. The assessment and reporting methods and care pathways for NAFLD have been well outlined in the new guidelines, which provide for early detection, risk stratification, and behavioural and lifestyle interventions.

The primary care physician training model forms the cornerstone of the bottom-up approach of India's NAFLD programme, empowering frontline workers to manage NAFLD. Some key components include training health-care providers to identify NAFLD with BMI, waist circumference measurements, family histories of metabolic illnesses, and non-invasive risk scores; equipping providers with practical diet-based and exercise-based interventions tailored for Indian populations; and strengthening advanced fibrosis and cirrhosis referral pathways to tertiary care centres, which are more likely to have the equipment needed to manage patients (eg, transient elastography machines).

In strategic consultation at the Institute of Liver and Biliary Sciences, officials from the Ministry of Health and Family Welfare convened on Oct 17, 2024, to discuss the National Fatty Liver Reduction Initiative as part of India's Vision 2047. The Vision 2047 document, which is currently under consideration by the Union Ministry of Health and Family Welfare, proposes a multisectoral strategy involving surveillance, awareness campaigns, interventions at schools and workplaces, food environment reforms, and improved access to diagnostics.

Building the capacity of India's health workforce through training and continuous education is crucial. This work will ensure health-care professionals are equipped to identify and manage NAFLD effectively. National webinars, the inclusion of NAFLD in national non-communicable disease consultative meetings, large-scale state-level training of medical officers, and the Ministry of Health and Family Welfare's recognition of obesity as a disease have collectively strengthened medical community