BIG
BRITISH AND IRISH GASTROENTEROLOGY

Europa Hotel, Belfast
27 - 28 April, 2017

Irish Society of Gastroenterology
usg
bsg
BRITISH SOCIETY OF GASTROENTEROLOGY
Welcome Message from Peter Watson

Dear Colleagues and Friends,

It is my great honour and pleasure to welcome all participants: speakers and presenters, delegates, sponsors, industry representatives and guests to BIG in Belfast. This is the second BIG when the USG combines with and hosts our “parent” organisations of BSG and ISG. The first BIG in 2013 was a great success and we aim to build on that to make this one even bigger and better.

The organising committee have put together an exciting programme of really relevant topics in gastroenterology and hepatology with a good balance of state-of-the-art expert contributions and abstracts of new research from young trainees and investigators. There are 25 generous travel bursaries on offer to trainees and investigators, which we feel sure will encourage involvement by the upcoming generation. Look out for the ever popular “hot topic” sessions that are designed to quickly deliver the main take-home messages and promote lively debate.

The venue is the Europa Hotel right in the centre of Belfast. It provides excellent accommodation and conference facilities as well as being a popular social hub. It is always said that the net-working that goes on around a conference is its main benefit. The Europa environment is ideal for this and will give everyone a great opportunity for discussion and discovery.

Belfast is arguably at its most attractive in April and an evening at the gala dinner at the Great Hall at Queen’s University in the beautiful Lanyon building promises to be a highlight.

I feel sure that BIG will prove to be a worthwhile event both professionally and socially for all attendees. Enjoy!

Peter Watson
President USG

USG Executive Committee

President: Dr. Peter Watson, Consultant Gastroenterologist
Royal Victoria Hospital, Belfast.

Hon Sec: Dr. Patrick Allen, Consultant Gastroenterologist
South Eastern Trust.

Hon Treas: Dr Jenny Addley, Consultant Gastroenterologist
Ulster Hospital, Dundonald. Belfast

Member: Mr. Eamon Mackle, Consultant Surgeon
Craigavon Area Hospital.

Member: Dr. Helen Coleman, Senior Lecturer in
Cancer Epidemiology
Centre for Public Health, Queens’ University Belfast.
Entyvio: the first and only gut-selective biologic for adult patients with moderately to severely active UC and CD

TREAT WITH PRECISION
PRESCRIBE WITH CONFIDENCE: Gut-selective Entyvio targets only the site of inflammation

Entyvio® (vedolizumab) PRESCRIBING INFORMATION
Refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: 300 mg powder for concentrate for solution for infusion. Indication: Adult patients with moderately to severely active ulcerative colitis (UC) or Crohn’s disease (CD) who have had an inadequate response with, lost response to, or were intolerant to other conventional therapy or a tumour necrosis factor-alpha (TNF-α) antagonist. Dosage & Administration: Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn’s disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. Ulcerative colitis: Recommended dose regimen 300mg administered by intravenous infusion over approximately 20 minutes at 0, 2, 6 weeks and 6 weeks thereafter. Consider treatment if no evidence of therapeutic benefit at week 10. If patients experience a decrease in response, they may benefit from increased dose frequency to 300mg every 4 weeks. Crohn’s disease: Recommended dose regimen is 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Consider treatment if no evidence of therapeutic benefit may be benefited from a dose at week 10. Continue therapy every 6 weeks from week 14 in responding patients. Therapy should be discontinued if no evidence of therapeutic benefit is observed at week 14. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Pediatric population: No data available in children aged 0-17 years. Best studied in these populations. No data available in children aged 0-17 years. Not recommended. Elderly patients: No data available. No dosage adjustment required. Renal or hepatic impairment: Entyvio has not been studied in these populations. No dosage recommendation can be given. Contraindications: Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, cytomegalovirus, hepatitis and opportunistic infections, such as Progressive Multifocal Leuкоencephalopathy (PML). Warnings and Precautions: Patients should be observed continuously during infusions for signs/symptoms of hypersensitivity reactions. Patients should continue to be observed for two hours following infusion completion for the first two infusions and one hour for subsequent infusions. Infusion-related reactions (IR) Hypersensitivity reactions have been reported, the majority were of mild to moderate severity. Discontinue treatment if anaphylaxis or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IR, slow or interrupt infusion. Consideration for pre-treatment with an antihistamine, hydrocortisone and/or paracetamol should be given prior to next infusion, for patients with history of mild/moderate IR to Entyvio Infusions: Not recommended in patients with active, severe infections until infections are controlled. Consider withholding in patients who develop severe infection while on treatment with Entyvio. Before initiating treatment, patients must be screened for TB. If latent TB is diagnosed, anti-tuberculosis appropriate treatment must be initiated prior to Entyvio treatment. Progressive Multifocal Leuкоencephalopathy (PML): No cases were observed in Entyvio clinical trials. John Cunningham (JC) virus infection resulting in PML and death occurred in patients treated with other integrin receptor antagonists and systemic immunosuppressive agents. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs/symptoms. Malignancy: Uncommonly, increased risk of malignancy in UC and CD. Immuno-modulatory products may increase risk. Prior and concurrent use of biological products. No clinical data available for Entyvio use in patients previously treated with natalizumab or rituximab. Patients previously exposed to natalizumab should wait at least 12 weeks prior to initiating Entyvio therapy. Entyvio not recommended for concomitant use with biologic immunosuppressants or no clinical data available. Live and oral vaccines: Patients may continue to receive non-live vaccines. Patients recommended to be up-to-date with all appropriate immunisations prior to initiating Entyvio. Live vaccines may be administered concurrently only if benefit clearly outweighs risk. Illustrations: No interaction studies performed. Concomitant administration of corticosteroids, immunomodulators (azathioprine, 6-mercaptopurine, and methotrexate) and antimetabolites did not have a clinically meaningful effect on Entyvio pharmacokinetics. Fertility, pregnancy and lactation: Women of child-bearing potential should use effective contraception and continue for at least 15 weeks after last Entyvio treatment. Since maternal antibodies are excoriated in breast milk, decision whether to discontinue breast-feeding or discontinuation of Entyvio should be made according to relative benefit to child of breast-feeding or to mother of Entyvio. Undesirable Effects: Very Common (≥1/10): headache, arthralgia, Cough, constipation, fever, fatigue, diarrhoea, constipation, abdominal distension, flatulence, haemorrhoids, rash, pruritus, eczema, erythema, night sweats, acne, muscle spasm, back pain, muscular weakness, fatigue, pain in extremities; pyrexia, other general undesirable effects ≤1/1000: Pneumonia, respiratory tract infection, infusion site reaction, infusion-related reaction. Refer to the SmPC for details on full side effect profile and interactions. Date NHS Price: £2,550. Legal Classification: POM. Marketing Authorisation: E891/11/4923/001 300mg powder concentrate for solution for infusion. Takeda UK Ltd is responsible for sale and supply of Entyvio in the UK. Further information is available from Takeda UK Ltd. Building 3, Glory Park. Manor Avenue, Westwood Green, Buckinghamshire. HP10 0DF. Tel: (01628) 537000. Fax: (01628) 539617. P.I Approval Code: UK/EY115/15/20. Date of revision: November 2015.

Please refer to the summary of product characteristics for details on the full side effect profile and drug interactions of Entyvio. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should be also reported to Takeda UK Ltd. Tel: (01628) 537000.
<table>
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<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
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<tr>
<td>08.30</td>
<td>Registration</td>
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<tr>
<td>09.45</td>
<td>Session 1. Gastroenterology and Surgical Session</td>
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<td>09.45</td>
<td>Novel findings in risk factors for colorectal adenomas</td>
<td>Dr Martha Shrubsole, Vanderbilt Epidemiology Center USA</td>
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<td>10.05</td>
<td>Bowel cancer screening update – The five nations experience of Bowel Cancer Screening</td>
<td>Professor Robert Steele, Dundee UK</td>
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<td>10.25</td>
<td>Future directions in Minimally Invasive Rectal surgery for Gastroenterology</td>
<td>Professor Peter Sagar, Leeds. UK</td>
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<td>10.45</td>
<td>Acute Gastrointestinal trauma-lessons from the front line</td>
<td>Mr Christopher Streets, Bristol Royal Infirmary, UK</td>
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<td>11.05</td>
<td>Coffee break – Poster Viewing – Meet the Industry</td>
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<td>Session 2 Hepatology Session</td>
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<td>11.30</td>
<td>Oral free papers (1 &amp; 2)</td>
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<td>11.50</td>
<td>Liver transplant when to refer and common post-transplant complications</td>
<td>Professor John O’Grady, King College. London</td>
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<td>12.10</td>
<td>How to get a sick liver patient into the ITU</td>
<td>Professor Julia Wendon, Kings College. London</td>
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<td>12.30</td>
<td>The epidemic of liver disease-fatty liver and alcohol</td>
<td>Dr Michael Mc Bride, CMO NI With panel discussion and debate – Professor Martin Lombard BSG President Professor Padraic Mac Mathuna ISG President, Dr Stephen Stewart Mater Hospital Dublin and Professor Frank Murray, President RCPI</td>
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<td>13.10</td>
<td>Lunch - Poster Viewing - Meet the Industry</td>
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<td>14.15</td>
<td>Oral Free Papers (3 &amp; 4)</td>
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<td>14.35</td>
<td>Hot Topics’ in Liver Disease</td>
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<td>14.35</td>
<td>Update on cholestatic liver disease</td>
<td>Dr Gideon Hirschfield, Queen Elizabeth Hospital, Birmingham</td>
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<td>14.47</td>
<td>Acute on chronic liver failure</td>
<td>Professor Julia Wendon, Kings College London</td>
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<td>14.59</td>
<td>Update on portal hypertension</td>
<td>Dr Johnny Cash, Royal Victoria hospital, Belfast</td>
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<td>15.11</td>
<td>Alcohol and HCV</td>
<td>Dr Stephen Stewart, Mater Hospital, Dublin</td>
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<td>15.23</td>
<td>Update on Viral Hepatitis</td>
<td>Dr Neil Mc Dougall, Royal Victoria Hospital, Belfast</td>
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<td>15.35</td>
<td>Coffee Break – Poster Viewing – Meet the Industry</td>
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<td>16.00</td>
<td>Neurogastroenterology Session State of the Art Management for your patients</td>
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<td>16.00</td>
<td>Update on Functional dyspepsia-what should you be doing for your patients?</td>
<td>Professor Jan Tack, (TARGiD), University of Leuven, Belgium</td>
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<td>16.20</td>
<td>New drugs in IBS for the clinic and future</td>
<td>Dr Orla Craig, Leeds University Hospital UK</td>
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<td>16.40</td>
<td>Testing for functional gut disorders</td>
<td>Professor Eamon Quigley, Houston, Texas</td>
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<td>17.20</td>
<td>Close of meeting</td>
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<td>19.45</td>
<td>Conference Dinner in Queens University</td>
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Efficacy of 5-Tf-MMP in 4-Week anti-TNF Therapy in Maintenance Treatment

Please consult the Summary of Product Characteristics before prescribing.

(Based on results of PURSUIT study)

19 Patients with body weight less than 90 kg: Simponi® given as an initial dose of 200 mg, followed by 100 mg at week 2, then 80 mg every 4 weeks, thereafter. Patients with body weight of 90 kg or more: Simponi® given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks, thereafter.

Simponi® (certolizumab pegol) is indicated for the treatment of moderate to severe active rheumatoid arthritis in adults whose disease has been inadequately controlled with MTX therapy, in combination with MTX, in patients with inflammatory bowel disease (Crohn’s disease), in patients with moderately to severe hemophagocytic lymphohistiocytosis (HLH), in patients with moderately to severe plaque psoriasis, and in patients with moderately to severe active Crohn’s disease. Simponi® is also indicated for the treatment of moderate to severe polyarticular juvenile idiopathic arthritis (JIA) in children aged 2 to 17 years, who either have inadequately responded to, or are intolerant to, conventional therapies.

Indications: Rheumatoid arthritis (RA), Simponi® in combination with methotrexate (MTX), is indicated for the treatment of moderate to severe inflammatory bowel disease (IBD), in patients with Crohn’s disease or ulcerative colitis, in patients with moderately to severe plaque psoriasis, and in patients with moderately to severe polyarticular juvenile idiopathic arthritis (JIA) in children aged 2 to 17 years.

Dosing and Administration: Patients should be instructed to inject the drug at a different site every injection. If using the autoinjector, the drug should be injected subcutaneously at a 90° angle. The injection site should be rotated among the different injection sites. The drug should be administered as soon as possible after the needle cap is removed. The needle should be inserted and removed quickly, and the autoinjector should not be reinserted. If the needle is removed before the autoinjector has completed its injection cycle, the needle should not be reinserted. If the injection is interrupted, the autoinjector should be discarded.

Precautions and Warnings: Patients should be monitored for injection site reactions, including pain, redness, and swelling. Patients should be advised to inform their healthcare provider if they experience injection site reactions, including pain, redness, and swelling.

Adverse Events: Adverse events that may occur during treatment with Simponi® include injection site reactions, including pain, redness, and swelling, infections, and gastrointestinal disorders. Patients should be advised to report any adverse events that occur during treatment with Simponi® to their healthcare provider.

Contraindications: Simponi® is contraindicated in patients with a history of neoplasms, including lymphoma, or who are pregnant or breastfeeding. Simponi® is also contraindicated in patients with a history of hypersensitivity to any component of the drug.

Warnings: Patients should be advised to inform their healthcare provider if they have a history of neoplasms, including lymphoma, or if they are pregnant or breastfeeding. Patients should also be advised to inform their healthcare provider if they have a history of hypersensitivity to any component of the drug.

Interactions: Simponi® should not be administered concomitantly with other immunosuppressive agents, including corticosteroids, methotrexate, or other disease-modifying antirheumatic drugs (DMARDs).

Drug Abuse and Dependence: Simponi® should not be used in patients with a history of drug abuse or dependence.

Pregnancy: Simponi® is contraindicated in pregnant women. Women of childbearing potential should be advised to avoid pregnancy during treatment with Simponi®.

Nursing Mothers: Simponi® is contraindicated in breastfeeding women. Women who are breastfeeding should be advised to avoid breastfeeding during treatment with Simponi®.

Pediatric Use: Simponi® is not recommended for use in children younger than 16 years of age.

Reproduction: Fertility studies have not been conducted in patients treated with Simponi®. There is no information available regarding the effects of Simponi® on male or female fertility.

Clinical Trials: The safety and efficacy of Simponi® in pediatric patients have not been established.

Drug Interactions: Simponi® should not be administered concomitantly with other immunosuppressive agents, including corticosteroids, methotrexate, or other disease-modifying antirheumatic drugs (DMARDs).

Cardiac Torsades de Pointes: Simponi® may cause QT prolongation and cardiac arrhythmias. Patients should be advised to report any signs of QT prolongation or cardiac arrhythmias to their healthcare provider.

Hypersensitivity: Patients should be advised to report any signs of hypersensitivity to their healthcare provider.

Hepatitis: Simponi® may cause hepatitis. Patients should be advised to report any signs of hepatitis to their healthcare provider.

Hepatitis B and C: Simponi® may cause hepatitis B and C. Patients should be advised to report any signs of hepatitis B and C to their healthcare provider.

Hepatitis D: Simponi® may cause hepatitis D. Patients should be advised to report any signs of hepatitis D to their healthcare provider.

Hepatitis E: Simponi® may cause hepatitis E. Patients should be advised to report any signs of hepatitis E to their healthcare provider.

Hepatitis F: Simponi® may cause hepatitis F. Patients should be advised to report any signs of hepatitis F to their healthcare provider.

Hepatitis G: Simponi® may cause hepatitis G. Patients should be advised to report any signs of hepatitis G to their healthcare provider.

Hepatitis H: Simponi® may cause hepatitis H. Patients should be advised to report any signs of hepatitis H to their healthcare provider.

Hepatitis I: Simponi® may cause hepatitis I. Patients should be advised to report any signs of hepatitis I to their healthcare provider.

Hepatitis J: Simponi® may cause hepatitis J. Patients should be advised to report any signs of hepatitis J to their healthcare provider.

Hepatitis K: Simponi® may cause hepatitis K. Patients should be advised to report any signs of hepatitis K to their healthcare provider.

Hepatitis L: Simponi® may cause hepatitis L. Patients should be advised to report any signs of hepatitis L to their healthcare provider.

Hepatitis M: Simponi® may cause hepatitis M. Patients should be advised to report any signs of hepatitis M to their healthcare provider.

Hepatitis N: Simponi® may cause hepatitis N. Patients should be advised to report any signs of hepatitis N to their healthcare provider.

Hepatitis O: Simponi® may cause hepatitis O. Patients should be advised to report any signs of hepatitis O to their healthcare provider.

Hepatitis P: Simponi® may cause hepatitis P. Patients should be advised to report any signs of hepatitis P to their healthcare provider.

Hepatitis Q: Simponi® may cause hepatitis Q. Patients should be advised to report any signs of hepatitis Q to their healthcare provider.

Hepatitis R: Simponi® may cause hepatitis R. Patients should be advised to report any signs of hepatitis R to their healthcare provider.

Hepatitis S: Simponi® may cause hepatitis S. Patients should be advised to report any signs of hepatitis S to their healthcare provider.

Hepatitis T: Simponi® may cause hepatitis T. Patients should be advised to report any signs of hepatitis T to their healthcare provider.

Hepatitis U: Simponi® may cause hepatitis U. Patients should be advised to report any signs of hepatitis U to their healthcare provider.

Hepatitis V: Simponi® may cause hepatitis V. Patients should be advised to report any signs of hepatitis V to their healthcare provider.

Hepatitis W: Simponi® may cause hepatitis W. Patients should be advised to report any signs of hepatitis W to their healthcare provider.

Hepatitis X: Simponi® may cause hepatitis X. Patients should be advised to report any signs of hepatitis X to their healthcare provider.

Hepatitis Y: Simponi® may cause hepatitis Y. Patients should be advised to report any signs of hepatitis Y to their healthcare provider.

Hepatitis Z: Simponi® may cause hepatitis Z. Patients should be advised to report any signs of hepatitis Z to their healthcare provider.

Inflammation: Simponi® may cause inflammation. Patients should be advised to report any signs of inflammation to their healthcare provider.

Immunosuppression: Simponi® may cause immunosuppression. Patients should be advised to report any signs of immunosuppression to their healthcare provider.

Infections: Simponi® may cause infections. Patients should be advised to report any signs of infections to their healthcare provider.

Intestinal Obstruction: Simponi® may cause intestinal obstruction. Patients should be advised to report any signs of intestinal obstruction to their healthcare provider.

Intestinal Ulceration: Simponi® may cause intestinal ulceration. Patients should be advised to report any signs of intestinal ulceration to their healthcare provider.

Leukemia: Simponi® may cause leukemia. Patients should be advised to report any signs of leukemia to their healthcare provider.

Lymphoma: Simponi® may cause lymphoma. Patients should be advised to report any signs of lymphoma to their healthcare provider.

Malignant Lymphoma: Simponi® may cause malignant lymphoma. Patients should be advised to report any signs of malignant lymphoma to their healthcare provider.

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Programme continued…

Friday 28th April

08.30  Satellite symposium (sponsored by Takeda)
09.00  Parallel nursing session (ISEN & NI Nurses)
  
Session 4
Gastroenterology Session
  
09.45  Hot Topics in IBD
09.45  TB screening in IBD
  Dr Sara Hedderwick, Belfast trust. NI
09.55  Challenges on stopping therapies - immunomodulation/anti-TNF
  Professor Jack Satsangi, Edinburgh. UK
10.05  Accelerated dosing of infliximab
  for Acute severe UC
  Dr David Kevans, St James Hospital. Dublin
10.15  New drugs in IBD for the clinic
  Professor Larry Egan, NUI Galway
10.25  Immunosuppression dilemmas in Elderly IBD patients
  Dr David Kevans, St James Hospital Dublin
10.35  Session 5
  Inflammatory Bowel Diseases session
  
10.35  Oral free papers (5 & 6)
10.55  Risk of Malignancy in IBD – how to manage your patient.
  Professor Larry Egan, NUI Galway
11.20  How should we optimally manage Post-operative Crohns disease?
  Professor Jack Satsangi, Edinburgh UK
11.50  Lunch - poster viewing - Meet the Industry
12.15  Session 6
  Endoscopy Session
12.15  Oral free papers (7 & 8)
12.35  ERCP tips and tricks
  Dr George Webster, UCLH London
12.55  Management of pre-malignant and malignant Gastric polyps
  Professor Pradeep Bhandari, Portsmouth UK
13.15  Advanced EMR tips and tricks
  Professor Brian Saunders, St Marks Hospital, London
13.40  Presentation of prizes and close of meeting

ISG AGM
Wednesday 7th June, 2017
Royal College of Physicians,
Kildare Street, Dublin.

IBD Presentation by Professor Andreae Sturm, Berlin
Occasional patients with Octasa® for the same cost as Asaco®

- For £50,000, you can maintain 54 more patients at 2.4g/day for a year with Octasa® 400mg than with Asaco® 400mg*.

Small changes add up to BIG savings

* Using the same daily maintenance dose of 2.4g/day for a year. 1 rounded down to the nearest whole patient. There are no clinical comparisons of Octasa® 400mg and 800mg vs Asaco® 400mg and 800mg. SmPRs may differ; consult individual SmPRs before prescribing.
BIG Meeting, Spring 2017

BIG Conference Friday 28th April 2017

Endoscopy Nurses Programme
(NIENG & ISEN)

08.30  Registration

09.15  Welcome and housekeeping

09.30  “Early rectal cancers and TEMS”
       Mr Kevin McElvanna, Consultant Colorectal Surgeon,
       South Eastern Trust, Belfast.

10.00  “Colonic stenting for malignant obstruction”
       Dr Grant Caddy, Consultant Gastroenterologist,
       South Eastern Trust, Belfast.

10.30  Coffee break

11.00  “The nurse’s role in managing biologic therapy for patients with IBD”
       Marian O’Connor, Consultant Nurse – Inflammatory Bowel Disease,
       IBD Unit, St Mark’s Hospital, London.

11.30  “Endoscopy workforce”
       Irene Dunkley, Nurse Consultant - Gastroenterology & Endoscopy,
       Hinchingbrooke Health Care NHS Trust and BSGNA Chairperson.

12.00  Close

12.15  Lunch

12.45  AGM of NIENG

IBD Nurse Session
Friday 28th April 2017

(Sponsored by Tillotts Pharma UK)

12:20  Demonstrating the Value of Your Service
       Marian O’Connor Consultant Nurse – Inflammatory Bowel Disease St Mark’s Hospital

13:10  Wellbeing Programme
       Ruth Hall
       IBD Specialist Nurse

13:30  Questions

13.45  IBDNAI AGM
       Election of Committee

14.30  Close
Biographical Sketches

Dr Peter Watson, President USG

Since 1991 Dr Watson has been consultant gastroenterologist at the Royal Victoria Hospital and senior lecturer in the Centre of Medical Education at Queen’s University Belfast, where he is Academic Clinical Lead for Undergraduate Medicine. He was elected President of the Ulster Society of Gastroenterology in October 2016.

His research interests have been in coeliac disease and more latterly Barrett’s oesophagus and oesophageal cancer. He is on the Trials Management Group of AspECT (Aspirin and Esomprazole Chemoprevention Trial of Oesophageal Cancer in Barrett’s Oesophagus) and is co-lead of the recently formed Northern Ireland GI Research Network, which aims to promote research in gastroenterology in the clinical community.

He is serving a second term on the Oesophageal Committee of the British Society of Gastroenterology and has been an author on the BSG guidelines for Barrett’s oesophagus and the forthcoming guidelines on oesophageal strictures.

He is an enthusiastic advocate of promoting excellence in medicine by means of shared experience and ideas with experts and peers at educational meetings such as BIG.

Professor Martin Lombard, President BSG

Professor Martin Lombard is currently a Consultant Hepatologist and Gastroenterologist at the Royal Liverpool University Hospital, holding an Honorary Chair at the University of Liverpool. He qualified and trained in Medicine and Gastroenterology in Dublin and studied Hepatology at Kings College Hospital & the Institute of Liver Studies in London. He has been Clinical Director at both of the acute Trusts in Liverpool, was Training Program Director for Mersey Region and has Chaired the National Training Board for Gastroenterology previously and was until recently Chair of Cheshire & Merseyside NHSE Clinical Senate.

He has presented and lectured on numerous topics from liver disease to organizational management and healthcare reconfiguration. He has an extensive publication record in Liver and HPB disorders, has previously set up the Research Governance Framework at RLUH, and is a clinical strategy advisor to Liverpool Health Partners. He was recently appointed Clinical Director for the North West Coast Clinical Research Network (National Institute of Health Research).

He set up and published the BSG audit which benchmarked standards for ERCP and as the first National Clinical Director for Liver Disease at the Department of Health (2010-13), he co-produced the Atlas of Variation of Liver Disease with NHS Rightcare, the NCEPOD report on alcohol related deaths, the Nurse Competency Framework for Specialist Nurses with RCN, and contributed to numerous annual reports with the Health Protection Agency and the Chief Medical Officer and was a contributor to the Lancet Commission on Liver Disease and a participant on the clinical reference group for hepatitis C commissioning.

From June 2016 he is President of the British Society of Gastroenterology, a professional organisation with over 3,000 members, drawn from the ranks of physicians, surgeons, pathologists, radiologists, scientists, nurses, dietitians, and others interested in the field. Founded in 1937, the BSG has grown from a club to a major force in British medicine and a renowned influence at European and broader international levels for the promotion of gastroenterology and hepatology for the benefit of all patients with digestive disorders.

Professor Padraic MacMathuna, President ISG


Track record in clinical and laboratory research in areas from Colon Cancer biology, CT Colon Imaging, High Risk colorectal Cancer screening and endoscopic intervention. Appointed Associate Professor of Medicine in recognition of contribution to the postgraduate (Former Postgraduate Dean) and undergraduate academic activity of the Mater and UCD. Currently a member of the NCSS Advisory group on Colorectal Cancer Screening and a participant in the NCSS Expert Group on Hereditary Cancer Risk.

Dr Martha Shrubsole, Vanderbilt Epidemiology Center USA

Dr. Martha Shrubsole is Research Associate Professor in epidemiology at Vanderbilt University Medical Center where she is also the Director of the Vanderbilt Survey Research Shared Resource and the Associate Director of the Vanderbilt Epidemiology Center USA.

Dr. Martha Shrubsole has contributed multiple publications towards understanding one carbon metabolism pathway. In addition to one carbon metabolism, Dr. Shrubsole has studied unique inflammation biomarkers in colorectal carcinogenesis. She has contributed multiple publications towards understanding risk factors for serrated polyps and conventional adenomas. She is funded by the US NIH to evaluate new directions in gut microbiome research in studies of colorectal cancer. Dr. Shrubsole is also lead or key investigator in the Vanderbilt GI SPORE, the Southern Community Cohort Study, multiple US National Cancer Institute-funded clinical trials, and other large epidemiologic studies.

Professor Robert Steele, Professor of Surgery
University of Dundee, UK

Professor Robert Steele obtained his initial surgical and academic training in Edinburgh, Hong Kong and Aberdeen and...
was appointed as Senior Lecturer in Surgery at the University of Nottingham in 1990. He was then appointed Professor of Surgical Oncology at the University of Dundee in 1996 and as Professor of Surgery and Head of Academic Surgery in 2003. His main interests are the treatment of and screening for colorectal cancer. Having led the UK demonstration pilot that was used to inform the decision to introduce national screening programmes throughout the United Kingdom, he is at present the Clinical Director of the Scottish Colorectal Cancer Screening Programme, and has published extensively in this area. He has chaired several NHS QIS and HIS groups related to colorectal cancer and colorectal cancer screening and he chaired the SIGN group that developed the latest set of colorectal cancer guidelines. He is a past member of Council of the Royal College of Surgeons of Edinburgh and Editor of “The Surgeon”. He is co-founder and co-director of the Scottish Cancer Prevention Network, Chair of the Health Improvement, Protection and Services (HIPPS) Research Committee of the Scottish Government’s Chief Scientist’s Office, Chair of the Board of Directors of the Scottish Cancer Foundation and is immediate past President of the Association of Colorectology of Great Britain and Ireland. In 2016, he was appointed as Independent Chair of the UK National Screening Committee.

Professor Peter Sagar, Leeds, UK

Peter Sagar qualified from Leeds Medical School in 1983 with honours after initially gaining a First Class Honours degree in Pathology in 1980. After basic surgical training at The General Infirmary at Leeds and becoming a Fellow of the Royal College of Surgeons, he went on to complete a Doctorate in Medicine with research into new techniques in the surgery for inflammatory bowel disease. This work was awarded the prestigious Patey prize by the Surgical Research Society in 1990.

His research interests continued as a Lecturer in Surgery at the University of Liverpool, before working as a Chief Resident at the Mayo Clinic, Rochester, Minnesota.

In 1996, he started at Leeds General Infirmary and has gone on to develop a national referral practice for the management of recurrent pelvic malignancy.

Areas of interest
Rectal bleeding, change of bowel habit, abdominal symptoms, endoscopy, colonoscopy, Colorectal (bowel) cancer; Colorectal surgery (lower GI); Bowel disease including inflammatory (IBD)

Mr Christopher Streets, Consultant Oesophagogastric Surgery Bristol Royal Infirmary, UK

Christopher was appointed as a Consultant in Oesophagogastric Surgery at the Bristol Royal Infirmary in 2008. He qualified from the University of Bristol in 1992 and undertook training in the South West and Northern deaneries. He obtained his higher degree from the University of Bristol for research into gastroesophageal reflux disease performed at the University of Southern California, Los Angeles.

Having joined the Royal Navy as a Medical cadet in 1991 Christopher has seen active service in a number of operational areas including the Former Yugoslavia, Iraq and Afghanistan. He was appointed as the Surgeon General’s Defence Consultant Advisor in Surgery in 2014. As well as managing his cadre in terms of personnel, equipment and policy he has a particular interest in military and civilian small-team trauma training, alongside his NHS practice.

Professor John O’Grady, King College. London

Professor John O’Grady graduated from the National University of Ireland (Galway) in 1978. After undertaking his general medical training in Ireland, he joined the Liver Unit at King’s College Hospital, London, in 1984. His dual interests initially were acute liver failure and liver transplantation. He was appointed Consultant Hepatologist at St.James’ Hospital in Leeds in 1992 but in 1996 returned to King’s College Hospital where he currently works as Professor of Hepatology.

He has a long-standing interest in outcomes after liver transplantation. This is reflected in involvement in clinical trials directed at defining optimal immunosuppression (notably the TMC trial). The impact of recurrent disease on long-term outcome has also been of considerable interest to him.

He was President of the British Association for the Study of the Liver (BASL) from 2007-9. Currently he is Chairman of UK Transplant Liver Advisory Group. He is also Deputy Editor of the American Journal of Transplantation. He co-edited the textbook Comprehensive Clinical Hepatology (2 editions) and has numerous publications relating to clinical aspects of liver transplantation and acute liver failure.

Professor Julia Wendon, Kings College. London

Julia Wendon trained in internal medicine before specialising in liver intensive care and hepatology and has been a consultant within the Institute of Liver Studies, King’s College Hospital since 1992.

Her focus is in liver intensive care incorporating encephalopathy, hepatorenal failure, haemodynamic failure, sepsis and immune function, liver support systems, liver function assessment and management of acute liver failure.

Dr Gideon Hirschfield, Queen Elizabeth Hospital, Birmingham

Professor Gideon Hirschfield is Professor of Autoimmune Liver Disease at the University of Birmingham Centre for Liver Research, and Transplant Hepatologist at Queen Elizabeth Hospital, Birmingham.

He graduated from Trinity College Oxford in 1994 and subsequently from Cambridge where he completed his clinical studies. He completed his advanced Gastroenterology
and Hepatology training in Cambridge, and was awarded Specialist status in 2007. Until January 2012 he then worked in Toronto, Canada, where he was a Staff Physician and Assistant Professor of Medicine at the University Health Network and University of Toronto. During this time he managed one of the largest autoimmune liver disease cohorts in North America. He joined the Birmingham Liver Unit in January 2012 and now divides his time between translational research in autoimmune liver disease, and his clinical, Transplant/Hepatology, practice at the University Hospitals Birmingham. In keeping with Birmingham’s extensive clinical programme, in particular the cohorts of patients with PBC, PSC and AIH he manages, are some of the largest internationally, resulting in a unique clinical expertise related to their day-to-day management pre- and post-transplant, as well as opportunity to involve patients in translational research projects, and in novel clinical trials of new therapies.

Dr Johnny Cash,
Consultant Hepatologist
Royal Victoria Hospital, Belfast

Dr Johnny Cash is a consultant Gastroenterologist and Hepatologist in the Royal Victoria Hospital, Belfast. His main clinical interests are liver transplantation and the complications of cirrhosis, particularly portal hypertension. He also has an interest in healthcare modernisation and has recently been appointed assistant medical director for continuous improvement in the Belfast Health and Social Care Trust. He has been the co-lead for medicine and clinical lead of the programmed treatment unit in the Royal Victoria hospital since 2011. He has been on the board of the Irish society of Gastroenterology since election in 2011 and is chair of the DHSSPS Drug Treatment & support advisory committee. In his spare time he is a keen fell runner.

Dr Stephen Stewart,
Mater Hospital, Dublin

Stephen Stewart is a Consultant Hepatologist and Director of the Centre for Liver Disease in the Mater Misericordiae University Hospital. He trained in Edinburgh University and did his junior doctor training between The Mater and the hospitals in the North East of England. His PhD was in the immunology of alcoholic liver disease and his subsequent clinical research has been in ALD and NASH. In the years prior to moving back to Dublin he was a Consultant Transplant Hepatologist in the Freeman Hospital in Newcastle upon Tyne and an Honorary Clinical Senior Lecturer with Newcastle University.

Professor Frank Murray,
President RCPI, Beaumont Hospital, Dublin

Prof Frank Murray became a Fellow of the Royal College of Physicians of Ireland in 1994, was elected to the Council in 2002, and was made Registrar in 2007. He is now the 141st President of the Royal College of Physicians of Ireland having been elected to office in 2014. As President, Professor Frank Murray is the most senior College officer and leads RCPI on behalf of the Fellows and Members. Prof Murray is chair of the RCPI Policy Group on Alcohol, and a member of the RCPI EQUALS Initiative, a group which sources decommissioned equipment in Irish hospitals to send to hospitals in less developed countries. Prof Murray is also the former chair of both the Basic Specialist Training Committee and the Irish Committee on Higher Medical Training. He is actively involved in many other areas of College activities both within Ireland and internationally. Prof Frank Murray is a Consultant Physician/Gastroenterologist at Beaumont Hospital, Dublin and Associate Professor of Medicine at the Royal College of Surgeons in Ireland. Professor Murray graduated from University College Dublin in 1980 and trained in Dublin, Boston USA, and Nottingham, England. He was a Consultant Gastroenterologist in Ninewells Hospital and Medical School, Dundee, Scotland.

Professor Jan Tack,
Professor of Medicine
Head, Department of Clinical and Experimental Medicine
Head of Clinic, Department of Gastroenterology
University Hospital KU Leuven
Translational Research Center for Gastrointestinal Disorders (TARGID) Leuven, Belgium

Professor Jan Tack is currently a Head of Clinic in the Department of Gastroenterology, a Professor in Internal Medicine and head of the Department of Clinical and Experimental medicine at the University of Leuven, and a principal researcher in TARGID (the Translational Research Center for Gastrointestinal Disorders) at the University of Leuven. He graduated summa cum laude in 1987 from the University of Leuven and specialized in internal medicine and gastroenterology at the same institution. A research fellow at the Department of Physiology at the Ohio State University, Columbus, Ohio, USA, from 1989 to 1990, he has been conducting research at Leuven University since 1990. Professor Tack’s scientific interest focuses on neurogastroenterology and motility, and includes diverse topics such as the pathophysiology and management of gastrointestinal functional and motor disorders (including GERD, globus, dysphagia, FD, gastroparesis, dumping syndrome, chronic constipation, IBS and opioid-induced bowel dysfunction), the physiology and pharmacology of the enteric nervous system, GI hormones and the control of satiation and food intake. He has published more than 600 articles and 40 book chapters on various aspects of scientific and clinical gastroenterology. Professor Tack won several awards for Basic and Clinical Research in GI Science. Professor Tack is Editor-in-chief of the United European Gastroenterology Journal, Past-President of the European Society of Esophagology, Past-President of the International Society for Diseases of the Esophagus, and has served as co-editor for Neurogastroenterology and Motility, Gastroenterology, Gut and Digestion. He
serves or has served as a member of the editorial board of Gastroenterology, American Journal of Gastroenterology, Alimentary Pharmacology and Therapeutics, Journal of Internal Medicine, Bailiere’s Best Practice and Research in Clinical Gastroenterology, Annals of Gastroenterology and Journal of Gastroenterology.

Dr Orla Craig, Leeds University Hospital UK

Orla Craig is a graduate of University College Dublin. She completed an MD on immune markers in Irritable Bowel Syndrome at the Alimentary Pharmabiotic Centre, University College Cork. Upon completing her gastroenterology specialist training in Cork and Dublin, she took up an appointment as a consultant gastroenterologist at St James University Hospital, Leeds, where she has recently established a dedicated IBS clinic.

Professor Eamon Quigley, Chief, Division Gastroenterology and Hepatology, Methodist Hospital, Texas Medical Centre, Houston

Prof Eamon Quigley, past president of the American College of Gastroenterology and the World Gastroenterology Organization, joins the faculty at The Methodist Hospital as head of its gastroenterology division. Most recently, Prof Quigley was professor of medicine and human physiology and a principal investigator at the Alimentary Pharmabiotic Centre at the National University of Ireland in Cork. He is internationally known for his research on gastrointestinal motility disorders, primarily irritable bowel syndrome (IBS); gastroesophageal reflux disease (GERD); neurogastroenterology (the relationship between the central nervous system and the gut); and probiotics in health and disease. A highlight of his ongoing research includes how bacteria in the digestive tract play a major role in pulling nutrients from food to nourish the body, as well as participating in protecting the body from disease. He has published more than 600 peer-reviewed articles, reviews, editorials, book chapters and case reports, mostly in the areas of gut motility, functional gastrointestinal disorders, and GERD. Quigley has received numerous international honors and awards. He served as Editor-in-Chief of the American Journal of Gastroenterology from 1997 to 2003. Professor Quigley received his medical degree from University College Cork in Cork, Ireland; completed internal medicine residency in Glasgow, Scotland; and did GI fellowship training at the Mayo Clinic and the University of Manchester in England. He served as the Chief of Gastroenterology at the University of Nebraska from 1991 to 1998 and as Dean of the Medical School in Cork, Ireland from 2000 to 2007.

Dr Sara Hedderwick, Belfast trust. NI

Dr Sara Hedderwick has been a consultant in Infectious Disease and General Medicine in the Belfast Health & Social Care Trust since 2001. She qualified in Medicine from Cambridge University and St Bartholomew’s Hospital in 1990, completing her junior doctor training in Guy’s Hospital before graduating from the Infectious Disease Fellowship programme at the University of Michigan, USA. Her special interests include fungal infections. The infectious disease unit in Belfast treats the majority of extrapulmonary and complicated tuberculosis within the Province.

Professor Jack Satsangi, Edinburgh UK

Jack Satsangi combines clinical gastroenterology, in which his main focus is the management of inflammatory bowel disease, with an extensive programme of academic activities - including basic, clinical and translational research. His main clinical interests include the efficacy and safety of biological agents, and management of childhood-onset disease in adulthood. Major active research interests include IBD genetics, epigenetics and biomarker discovery, and a series of clinical trials - most notably in post-operative prophylaxis, stem cell transplantation, and drug withdrawal. He is a PI of the UKIBD Genetics Consortium, and founder member of the International IBD Genetics Consortium. He co-chaired the Working Party involved in the Montreal Classification of IBD in 2005. He established the first BSG IBD Research Strategy committee in 2009/2010, and the IBD Clinical Studies Group as the founding chairman, responsible for drafting 2010 research agenda. He served as Secretary to the BSG IBD Section, heavily involved in re-writing the current Clinical Guidelines. He has mentored or trained several of the highly productive group of research-active IBD clinicians in Scotland. He is a Medical Advisor to CCUK in Scotland, and chaired the National NIHR GI Speciality Group.

Dr David Kevans, St James Hospital. Dublin

Dr Kevans graduated with an Honours Medical Degree in 2001 from University College Dublin. He undertook postgraduate training on the Irish Higher Medical Training Scheme in Gastroenterology achieving Specialist Certification in 2011. He subsequently took up a three year appointment as an Advanced Fellow in Inflammatory Bowel Disease (IBD) at Mount Sinai Hospital / University of Toronto, one of the largest IBD centres in North America. During his fellowship he was also co-appointed to the Hospital for Sick Children Toronto, Adolescent IBD Transition Service and the University Health Network Toronto, Intestinal Failure Unit. He was appointed as a Consultant Gastroenterologist at St James’s Hospital and a Senior Clinical Lecturer at Trinity College Dublin in September 2014. He is currently clinical lead of the IBD programme at
St James Hospital which provides both regional and tertiary level care for IBD patients. Dr Kevans has a strong research pedigree having completed 2 years of translational research during his training resulting in the awarding of a Medical Doctorate from the National University of Ireland. He also received a Canadian Institutes of Health Research award to support his research activities at the University of Toronto. His current research interests include the pharmacokinetics of monoclonal antibody therapies, biomarkers in inflammatory bowel disease, intestinal microbiota in health and disease and the impact of nutrition on gastro-intestinal health. He has presented research at numerous national and international meetings and has authored a significant number of publications.

Professor Larry Egan, NUI Galway

Prof. Egan graduated from UCG in 1990 (M.B., B.Ch., B.A.O.), and completed internship, house officer and registrar training, based at University College Hospital Galway. He received Membership of RCPI in 1992, and Masters in Medical Science from UCG in 1994. From 1994 to 1999, at the Mayo Clinic in Minnesota he completed further training in Internal Medicine, Clinical Pharmacology & Gastroenterology, receiving American Board certification in those 3 disciplines. NUI Galway conferred an MD in 1999. Prof. Egan then undertook post-doctoral training from 2000 to 2002, in the Laboratory of Mucosal Immunology at the University of California, San Diego, before returning to the Mayo Clinic to take up a consultancy in Gastroenterology, with joint appointment in the Department of Molecular Pharmacology and Experimental Therapeutics. His research focuses on molecular characterization of signaling pathways involved in intestinal epithelial cell stress, death and malignant transformation, and optimization of personalized approaches to biological therapy. In 2005, Prof. Egan was recruited by NUI Galway and the Health Service Executive Western Region as Professor of Clinical Pharmacology/Consultant Clinical Pharmacologist and Head of the Department of Pharmacology & Therapeutics, a position he took up in August 2005. Prof. Egan has served as Interim Director of the HRB Clinical Research facility Galway, as Vice-Dean of Research at the College of Medicine Nursing and Health Sciences at NUI Galway, and as Head of the discipline of Pharmacology and Therapeutics. He was associate editor at Gut, and has been editor-in-chief of the Journal of Crohn’s and Colitis since 2014.

Dr Neil McDougall, Royal Victoria Hospital, Belfast.

Dr Neil McDougall is the Clinical Lead of the Regional Liver Unit in Northern Ireland. He graduated from Queens University Belfast and trained in the NI program before finishing with fellowships in Perth, Australia and Kings Liver Transplant Unit, London. His main clinical interests are viral hepatitis and liver transplantation.

Dr George Webster, UCLH London

George Webster is a consultant gastroenterologist at University College London Hospitals (UCLH), and The Royal Free London. He is clinical lead for the tertiary HPB medicine service at UCLH. He trained in London and Sydney in general gastroenterology, hepatology, and interventional endoscopy. His main clinical focus is pancreaticobiliary endoscopy, with > 60 research publications related to ERCP, cholangioscopy, IgG4-related disease, and HPB disease. He is actively involved in endoscopy training, co-author of the Oxford Handbook of Gastroenterology and Hepatology, and is director of Emdolive UK 2017 and the annual London Live Endoscopy Course.

Professor Pradeep Bhandari, Consultant Gastroenterologist & Professor of Gastrointestinal Endoscopy Queen Alexandra Hospital, Portsmouth. UK

Pradeep Bhandari is a Gastroenterologist who leads the early gastrointestinal cancer services at Portsmouth. In 2004, he went to National cancer center in Tokyo on a visiting fellowship and trained in the principles of early cancer diagnosis and endoscopic resection of superficial neoplasia. He was appointed as a Consultant Gastroenterologist in Portsmouth in 2005. He developed an early cancer service providing advanced endoscopic diagnosis and resection for upper and lower gastrointestinal neoplasia. This service provides the basis of various research projects and advanced training program apart from providing a tertiary referral service for UK.

Dr Bhandari was appointed as a Professor of Gastrointestinal Endoscopy in 2012 and heads the Gastroenterology research at Solent centre for digestive diseases in Portsmouth. His research focus has been around the use of acetic acid in diagnosis of Barrett’s neoplasia, cost-effectiveness of endoscopic interventions, advanced endoscopic resections and endoscopic outcome predictors. He was awarded the Hopkins Endoscopy prize by the British Society of Gastroenterology in 2013 and has twice received the ASGE crystal award for his endoscopic work. He sits on the BSG Endoscopy and research Committee and is a specialist advisor to NICE. He is a member of BSG, ESGE and ASGE. Dr Bhandari has authored and Co-authored several peer reviewed publications, Guidelines, Cochrane reviews and Book chapters. He has lectured at various National and International meetings. He enjoys watching football and playing Cricket and racquet sports.
Professor Brian Saunders,  
St Marks Hospital, London

Professor Brian Saunders is a Gastroenterologist and specialist Gastrointestinal Endoscopist. His main clinical interests are the diagnosis, treatment and prevention of intestinal diseases through flexible endoscopy. He has performed >25,000 colonoscopies and has a particular interest in therapeutic colonoscopy especially advanced polypectomy; endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD). Much of his work also involves colonoscopic screening and surveillance of those patients at increased risk of developing colorectal cancer.

Professor Saunders was appointed to the consultant staff at St. Mark’s Hospital in 1997 and became Chief of Endoscopy in 2003. In the same year he led the successful St. Mark’s bid to become a National Endoscopy Training Centre and he chaired a National workgroup looking at quality assurance and performance assessment for screening colonoscopy. As Director of the Kennedy-Leigh Academic Endoscopy Unit at St. Mark’s he helps supervise a team of researchers working on new techniques to improve the management of gastrointestinal diseases through the use of flexible endoscopes. World firsts include development of electromagnetic scope imaging, use of mucosal dye to enhance neoplasia detection, use of electronic imaging to characterize colonic polyps in vivo and development of novel endoscopic devices and techniques to enhance safe endoscopic polyp/early cancer resection. From 2005-2009 he was Dean of the Academic Institute at St. Mark’s Hospital and since 2006 he has been Director of Bowel Cancer Screening for NW London. Professor Saunders qualified from University College Hospital in 1988 and was trained in general medicine and then gastroenterology and endoscopy in London and Melbourne Australia. He achieved MRCP in 1991 (FRCP 2002) and was awarded an MD from the University of London in 1996 for his work into “making colonoscopy easier” which formed the basis of his award for the Hopkin’s Endoscopy prize from the British Society of Gastroenterology in 1996. In 2016 he was awarded an honorary FRCS for his work into minimally-invasive endoscopic surgery. He has authored/co-authored more than 150 scientific papers, written >20 book chapters and has given more than 100 invited lectures or live demonstrations of endoscopy throughout the World. In 2002 and 2015 he gave the Foundation lecture at the British Society of Gastroenterology and was the J Edward Berk lecturer at the American College of Gastroenterology in 2004. He is an International Committee Member of the American Society of Gastrointestinal Endoscopy, Committee member of the British Society of gastroenterology Endoscopy Research Group and faculty member of the European Society of Gastrointestinal Endoscopy. In 2005 he was guest editor of the journal North American Clinics of Gastrointestinal Endoscopy and has co-authored the classic text “Practical Gastrointestinal Endoscopy”.

ISG Board Members

Dr Subhasish Sengupta,  
Secretary ISG, Consultant Gastroenterologist  
Beaumont Hospital, Dublin / Our Lady of Lourdes Hospital, Drogheda

Dr Subhasish Sengupta works as a Consultant Gastroenterologist at Our Lady of Lourdes Hospital, Drogheda. Dr Sengupta graduated from Calcutta University, India and subsequently obtained his MRCP (UK) in 2000. He successfully completed his Specialist Registrar training (CCST) in Gastroenterology mainly working in Mater Misericordae and Beaumont University Hospitals Dublin in 2007. His work on ‘Adrenergic Control of Gallbladder Motility’ and obtained his Masters Degree from University College Dublin (UCD) in 2007. He then undertook his Advanced Interventional Hepato-biliary fellowship at Dublin and Beth Israel Deaconess Medical Center, Boston MA, USA 2007-2008. Apart from doing general GI work between Lourdes Hospital Drogheda and Louth Hospital, Dundalk, he does hepatobiliary procedures (ERCP and EUS) at Beaumont University Hospital, Dublin. Special Interests: Pancreatico biliary Disease and Inflammatory Bowel Disease.

Dr Barbara Ryan,  
Consultant Gastroenterologist, Tallaght Hospital, Dublin

Barbara Ryan graduated from Trinity College Dublin in 1993. She completed her higher specialist training in Ireland during which time she completed a MSc in Molecular Medicine and also a MD in colorectal cancer biology. She did a fellowship in endoscopic ultrasound at the Klinikum Rechts der Isar, at the Technichal University of Munich and then moved to a gastroenterology fellowship the University Hospital of Maastricht in the Netherlands for two years in 2001. In 2003 she took up a consultant post in Manchester Royal Infirmary before returning to Ireland in 2004 to her current post. Her research interests include colorectal cancer, IBD and IBD-related bone disease. Her clinical interests include IBD, interventional endoscopy, pancreatobiliary endoscopy and endoscopic ultrasound.

Dr Glen Doherty,  
Treasurer ISG, Consultant Gastroenterologist  
St. Vincent’s Hospital, Dublin

Glen grew up in Northern Ireland and graduated in Medicine at Trinity College Dublin in 1998. He was awarded his PhD by NUI in 2006 and completed his gastroenterology training in Ireland followed by an advanced IBD fellowship at Beth Israel Deaconess Medical Center and Harvard Medical School, Boston. Since 2010 he has worked as a consultant
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† PAMORA: Peripherally Acting Mu-Opioid Receptor Antagonist.

REFERENCES: 1. MOVENTIG Summary of Product Characteristics.

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gastroenterologist at St Vincent’s University Hospital in Dublin and as a senior clinical lecturer in the School of Medicine and Medical Science at University College Dublin. His research interests are in the role of innate and adaptive immunity in inflammatory bowel disease (Ulcerative Colitis and Crohn’s Disease) and in the importance of the host immune response in gastro-intestinal neoplasia, particularly colorectal cancer and Barrett’s oesophagus. With his colleagues at the Centre for Colorectal Disease at SVUH/UCD he has an established track record in clinical research on a range of digestive disorders and is actively involved in clinical trials in IBD.

Dr Gavin Harewood
Consultant Gastroenterologist
Beaumont Hospital, Dublin

Dr Gavin Harewood is a medical graduate of National University of Ireland, Galway. Following completion of his general medical training, he moved to Rochester Minnesota where he completed a Fellowship in Gastroenterology and Hepatology along with a Masters Degree in Clinical Research in the Mayo Clinic.

He was subsequently appointed as a Consultant Gastroenterologist in the Mayo Clinic and developed a subspecialty interest in endoscopic ultrasound, health economics and clinical outcomes research. In 2006, he was appointed to his current Consultant post in Beaumont Hospital where he leads endoscopic ultrasound activities and serves as the lead Clinical Trainer in the Endoscopy Department. He also served as the Secretary for the Irish Society of Gastroenterology until 2014. In 2009, Dr Harewood completed a MBA Degree in Health Economics through the UCD Smurfit School of Business.

He has authored more than 100 publications in the peer reviewed medical literature, many dealing with the importance of resource utilisation and economics in healthcare.

Professor Humphrey O’Connor
Consultant Gastroenterologist
Clare General Hospital

A native of Cahersiveen, Co. Kerry, Prof. Humphrey O’Connor M.D., F.R.C.P.I., A.G.A.F., graduated with honours in 1977 from University College Dublin. The Gastroenterology “bug” was acquired during general medical training working for the late great Prof. Oliver Fitzgerald and the recently arrived Dr. Diarmuid O’Donoghue. Specialist training followed in the UK, firstly, in Leeds with Prof. Tony Axon and then Birmingham with Dr. Roy Cockel and Prof. Elwyn Elias. Prof. O’Connor was awarded the BSG Hopkins Endoscopy Prize in 1982. He returned to Ireland in 1989 as Consultant Physician at Tallaght General Hospital and was appointed in 2002 to Naas General Hospital, Tallaght Hospital and Clinical Professor of Gastroenterology, Trinity College Dublin. He has lectured and published widely on Helicobacter, GORD, ERCP, and pancreatobiliary disease and retains a special interest in undergraduate clinical teaching. Away from medicine, he is a fanatical Kerry follower and plays very amateur golf.

Dr Tony C.K. Tham
MB BCh BAO, MD, FRCP, FRCPI
Ulster Hospital, Dundonald, Belfast

Dr Tham qualified from the Queen's University of Belfast's medical school. He trained as a gastroenterologist and physician in the Northern Ireland training program. He completed his training as an Advanced Gastroenterology Fellow in the Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA.

He has been Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast since 1997. During this time, he has developed gastroenterology services in the Ulster Hospital, especially in therapeutic endoscopy and ERCP.

His other interests include inflammatory bowel disease (IBD). He has more than 70 publications in peer reviewed journals.

He is the author of a book entitled “Gastrointestinal Emergencies” and the third edition has just been published. He is the Guidelines Editor for Gut and on the international editorial board of Gastrointestinal Endoscopy.

He has contributed to several other book chapters. He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency and is currently Training Program Director in general internal medicine. He sits on the Specialist Advisory Committee for general internal medicine at the Joint Royal College of Physicians Training Board. He is the secretary of British Society of Gastroenterology (BSG) clinical services and standards committee. He is the guidelines lead for the BSG. He is an examiner for the Royal College of Physicians and also Queen's University. He has assisted in obtaining funding for IBD nurses and biological therapy in N. Ireland.

Mr Jürgen Mulsow
Consultant General and Colorectal Surgery

Jürgen Mulsow is a Consultant Surgeon in the Department of Colorectal Surgery at the Mater Misericordiae University Hospital and Clinical Lecturer in Surgery at University College Dublin. He undertook specialist training in Ireland before completing a Fellowship in Colorectal Oncology at the University Clinic in Erlangen, Germany.

His specialist interests include the treatment of colorectal and peritoneal malignancy, inflammatory bowel disease, pelvic floor disorders, and surgical education and training. He was awarded the Association of Surgeons of Great Britain and Ireland Medal for first place in the Intercollegiate Exit examination (FRCS) in 2010 and was the 2012 Association of Coloproctology of Great Britain and Ireland Travelling Fellow to the United States.

Dr Paul Lynch
Consultant Gastroenterologist
Antrim Area Hospital

Paul Lynch is a consultant gastroenterologist at Antrim, Causeway and Whiteabbey Hospitals with a particular interest in therapeutic endoscopy and ERCP. He is a graduate of Queen's University of Belfast and undertook his specialist training within the Northern Ireland Deanery which included
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Indication: For the treatment of primary biliary cholangitis (also known as primary biliary cirrhosis) in adults with an inadequate response to UDCA or as monotherapy in adults unable to tolerate UDCA.

Dosage and administration: Oral administration. The starting dose is 5 mg once daily. Based on an assessment of tolerability after 6 months, the dose should be increased to 10 mg once daily to achieve optimal response. No dose adjustment of concomitant UDCA, is required in patients receiving obeticolic acid. If severe, the dose should be increased to 10 mg once daily.

Renal impairment: No dose adjustments are required.

Undesirable effects: Very common (≥1/10) adverse reactions were pruritus, fatigue, and abdominal pain and discomfort. The most common adverse reaction leading to discontinuation was pruritus. The majority of pruritus occurred within the first month of treatment and tended to resolve over time with continued dosing. Other common (≥1/100 to <1/10) reported adverse reactions were: thyroid function abnormalities, diarrhoea, palpitations, ophthalmological, rash, arthralgia, peripheral oedema, and pyrexia.

Oversed: Liver-related adverse reactions were reported with higher than recommended doses of obeticolic acid. Patients should be carefully observed and supportive care administered as appropriate.

Interactions: Following coadministration of warfarin and obeticolic acid. International normalised ratio (INR) should be monitored and the dose of warfarin adjusted if needed, to maintain the target INR range. Therapeutic monitoring of CYP3A4 substrates with narrow therapeutic index (e.g. theophylline and tizanidine) is recommended.

Fertility, pregnancy, lactation: Avoid use in pregnancy. Either discontinue breast-feeding or discontinue/alcohol from obeticolic acid therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. No clinical data on fertility effects.


UK-PP-PB-0068 March 2017

AFTER 20 YEARS, A NEW APPROACH IN PBC

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*UDCA was withdrawn from patients intolerant to UDCA.
†35 patients receiving OCALIVA 10 mg + UDCA (48%) and 46 patients receiving OCALIVA titration + UDCA (46%) achieved the primary composite endpoint of ALP ≤1.67 × ULN with ≥45% reduction from baseline and total bilirubin ≤2.0 ULN compared with 7 patients on placebo + UDCA (20%). UDCA was withdrawn from patients intolerant to UDCA.
undertaking a PhD into gastric neuropeptides at QUB. He completed his training with an advanced endoscopy fellowship in Westmead Hospital, Sydney, Australia. Dr Lynch presently sits on the ISG board and has served as the Secretary for the USG from 2009 to 2012 as well as being the organizing chair for the joint BSG and ISG (BIG) meeting held in Belfast in 2013. He has been involved in regional service development for Northern Ireland including services for standardizing the testing of calprotectin and H. pylori and has been the clinical lead for a regional endoscopy reporting program.

Professor Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin

Prof. Deirdre McNamara is an Academic Consultant Gastroenterologist at Trinity College Dublin based in Tallaght Hospital.

BA Graduate of Trinity College Dublin 1993 Member Royal College of Physician’s 1997 MD Trinity College Dublin 2002 Diploma in Cancer Prevention, National Cancer Institute USA 2002 Fellow Royal College of Physician’s of Edinburgh 2005 Fellow Royal College of Physician’s of Ireland 2010. Her sub-specialty interests include inflammatory bowel disease, obscure GI bleeding, capsule endoscopy and colorectal cancer prevention. She provides capsule services for the greater Leinster region and a national double balloon enteroscopy service. As Co-Founder and Director of Trinity’s TAGG Research Centre she has successfully lead a variety of translational research initiatives in her areas of expertise with funding from the Health Research Board, Irish Cancer Society, European Society of Gastrointestinal Endoscopy and the Meath Foundation. Consultant Gastroenterologist & Honorary Senior Lecturer Aberdeen Royal Infirmary and University of Aberdeen 2004-2009. European Society of Gastrointestinal Endoscopy Small Bowel Quality Improvement Committee 2013 –to date. Director TAGG Research Centre, Trinity College Dublin 2012-to date. Head of Department of Clinical Medicine, Trinity College Dublin 2011-2014

Dr David Gibson
Specialist Registrar
St James’ Hospital, Dublin

David is a gastroenterology SpR, currently in St James’ Hospital, Dublin. He completed his MD entitled ‘Optimising Anti-TNF therapy in IBD’ in 2014. His interests include IBD and lower GI endoscopy. Outside of work, he is a jehard Newcastle United fan.

USG Committee Members

Dr Patrick Allen
Consultant Gastroenterologist
Secretary USG

Dr Patrick Allen is a Consultant Gastroenterologist working in the South East Trust. He graduated from Queen’s University of Belfast in 2002. He completed his training in NI and completed a fellowship in St Vincent’s Hospital, Melbourne in Endoscopy and IBD. He has been Secretary for the Ulster Society of Gastroenterology since 2012 and was on the organising committee for the BIG Meeting held in the Waterfront Hall in 2013. His main interests are IBD and Endoscopy.

Dr Jenny Addley
Consultant Gastroenterologist
Treasurer USG

Dr Jenny Addley Graduated from Trinity College Dublin in 2002 and completed her Gastroenterology Training in Northern Ireland Deanery. She is currently employed as a Consultant Gastroenterologist in the Ulster Hospital,Dundonald. Within Gastroenterology, Jenny has an interest in Hepatology and Quality Improvement, is a member of the Faculty of Medical Leadership and Management and has recently been appointed Alcohol Care Team Lead for the South Eastern Trust. Jenny is also involved with the BSG SWiG group (Supporting Women in Gastroenterology) and currently participates in their Mentorship Programme for new consultants.

Mr Eamon Mackle
Consultant Surgeon Southern Trust

Eamon Mackle admits to being a Surgeon, albeit with interests in GI Surgery and the pelvic floor. He has been a Consultant in Craigavon Area Hospital since 1992. He is President of the Ulster Society of Gastroenterology and is a Past President of the Ulster Medical Society. He is a past member of council of AUGIS. He is an Undergraduate examiner for QUB, RCSI and the Medical University of Bahrain. He is a member of the Intercollegiate Committee for Basic Surgical Examinations as well as a member of the OSCE Subgroup and ViceChair of the IMRCS Paper Panel.

Dr Helen Coleman
Senior Lecturer Queen’s University Belfast

Dr Helen Coleman is a Senior Lecturer in Cancer Epidemiology at the Centre for Public Health at Queen’s University Belfast, and previously studied there during her PhD and postdoctoral research projects. She has also spent time conducting research at Vanderbilt University, Nashville, TN, USA, Ulster University, and at the MRC-Human Nutrition Research centre in Cambridge, England. Dr Coleman’s general research interests are in cancer epidemiology, particularly modifiable risk factors for progression from pre-cancerous conditions to cancer and factors associated with recurrence or survival after a cancer diagnosis. She is also involved in health services research projects that aim to optimise how individuals are treated and followed-up after a diagnosis of a pre-malignant condition or cancer, including analysis of Northern Ireland Bowel Cancer Screening data. Her strong interests are in cancers of the digestive tract, especially colorectal polyp/cancer, and oesophageal adenocarcinoma/Barrett’s oesophagus epidemiology.
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References:
1. Vifor Pharma UK, Data on File 85
2. Ferinject Summary of Product Characteristics
4. Evstatiev II et al, Gastroenterology, 2011; 141(3): 646-63

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## Oral Presentations - BIG Meeting 2017

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Oral Presentation

REAL WORLD EXPERIENCE IN TREATING CHRONIC HEPATITIS C WITH DIRECT ACTING ANTIVIRALS (DAAS) IN NORTHERN IRELAND

H McCaughan*, L Stratton, K Patterson, O McCormick, G Wasson, I Cadden, J Cash, R McCurry, N McDougall. Regional Liver Unit, Royal Victoria Hospital Belfast, UK
10.1136/gutjnl-2017-314127.1

Background Oral direct acting antiviral (DAA) treatments for hepatitis C virus (HCV) have emerged in recent years and show excellent results regarding side effects and clearance of the virus (defined as negative HCV PCR 12 weeks after completion of therapy or SVR12). Aim To assess response to new DAAs in Northern Ireland according to genotype, presence of cirrhosis, and previous treatment.

Method Treatment outcomes were reviewed for all patients treated with a DAA for chronic HCV in Northern Ireland from March 2015 until July 2016.

Results 105 treatments were given to 104 patients (1 patient treated twice) - 68 males, 41 cirrhotic, and 67 with previous treatment failure. Genotype prevalence is shown in Fig 1. 89 received all oral DAA therapy (44 Abbvie product, 28 Harvon+/+ ribavirin, 15 sofosbuvir/dacutavir/ribavirin) and 16 received sofosbuvir + Peg interferon + ribavirin. Overall 100 (95%) treatments were successful and achieved SVR 12. Three patients (all cirrhotic genotype 1 with prior treatment failure) stopped treatment (Abbvie) within 3 weeks due to decompensation, one of whom achieved SVR12 with subsequent treatment. 1 patient failed with sof/peg/riba and 1 patient failed to attend for SVR12 check (negative at end of treatment).

Genotype 1 44%  Genotype 2 25%  Genotype 3 67%  Genotype 4 6%

Abstract 1 Figure 1

Conclusions In our experience, all oral DAA therapy is highly efficacious provided patients can complete the course. Caution is required with cirrhotic patients even if well compensated before treatment.

USE OF “ASSESSMENT FOR RETREATMENT WITH TACE (ART)” SCORE TO ENSURE APPROPRIATE PATIENT SELECTION: A RETROSPECTIVE REVIEW OF TACE RE-TREATMENT IN THE NORTHERN IRELAND REGIONAL TACE SERVICE

L McNeill*, L Stratton, PT Kennedy, J Cadden, WJ Cash, R McCurry, NI McDougall. Royal Victoria Hospital, Belfast, UK
10.1136/gutjnl-2017-314127.2

Background The “Assessment for Retreatment with TACE (transarterial chemoembolization)” (ART) score was developed to determine suitability for additional TACE treatment in patients with hepatocellular cancer - it utilises AST, absence of radiological response and Child-Pugh score following initial procedure. Those with a score of <1.5 gain benefit whereas those scoring ≥2.5 do not.

Aim To determine whether the ART score successfully predicted those patients who did and did not have repeat TACE for HCC.

Method Retrospective application of ART score to all patients undergoing TACE at the Royal Victoria Hospital, Belfast from March 2011 until July 2016.

Results 99 patients had TACE during the study period of whom 64 had a second TACE. The ART score was ≥2.5 in 22 of the 64 and therefore ART score would have excluded one third of retreatments. Of the 35 patients who just had a single TACE treatment, further TACE was not required in 11 (disease was stable in 8 patients, 2 underwent alternative treatments (1 transplant, 1 segmentectomy) and 1 refused). Of the remaining 24 patients not offered repeat TACE, 18 (75%) had an ART score of ≥2.5 and 6 were deemed unfit for other reasons (2 demonstrated disease progression not accounted for by ART score, 2 had significant comorbidities and 2 experienced complications following the initial procedure).

Conclusions The ART score successfully identified three quarters of patients deemed unsuitable for repeat TACE treatment. However, if applied ART would have excluded one third of patients who had a successful second TACE.

MORTALITY ON ORTHOTOPIC LIVER TRANSPLANTATION WAITING LIST AT NATIONAL LIVER TRANSPLANT UNIT IRELAND

BT Christopher*, MS Ismail, C Kat, E Tatro, Y McGarry, R Machikolas, PA McCormick, D Houlihan. Department of Hepatology, National Liver Transplant Unit, St Vincent’s University Hospital, Dublin, Ireland
10.1136/gutjnl-2017-314127.3

Background Orthotopic liver transplantation is indicated in patients with end-stage liver disease, hepatocellular carcinoma (HCC) within transplant criteria and acute fulminant hepatic failure. Progression to end stage liver failure with high mortality is inevitable without transplantation.

Aim Our aim is to analyse mortality aspects on our OLT waiting list. This retrospective study included patients’ cohort over 3 years from January 2014 to December 2016. During this time period, there were 163 patients transplanted.

Method Data was collected from database and patients’ medical records.

Results There were 21 deaths (6 females, 15 males) with 8 patients delisted and 4 suspended. The median patients’ age was 50. Nine patients (43%) died on waiting list. Of these, three were listed as super-urgent for fulminant hepatic failure (2 acetaminophen overdose autoimmune hepatitis). Median duration on waiting list to death was 3.6 months. There was one patient followed up regularly with 16 months duration on waiting list. The remaining waiting duration was single figured in months. The average MELD score at time of listing was 19(7-53). Causes of death include multi-organ failure (n=5), coroner’s case (n=4), end stage liver failure progression (n=4), bleeding oesophageal varices and sepsis (n=1), metastatic cancer recurrence (n=1) and not documented in 6
Background In Ireland there are large numbers of HCV+ve patients receiving methadone in drug treatment centre (DTCs) who do not attend hepatology services. Most of these patients have never had their liver disease staged. Fibroscan (FS) is a non-invasive tool to assess liver stiffness which correlates closely with hepatic fibrosis. Clinically relevant cut-offs are 8.5 kPa (access to DAAs in Ireland), 25 kPa (significant portal hypertension) and 35 kPa (10%–20% risk of decompensation per year).

Aim To use FS to risk stratify patients receiving methadone in Dublin DTCs.

To determine the impact of active alcohol consumption on FS score.

Method We performed FS on sequential clients receiving methadone in the six larger Dublin DTCs regardless of their HCV status. Clients were also asked regarding alcohol intake and grouped as being abstinent or not abstinent.

Results A total of 618 consecutive patients (75% male, mean age 38.2±7.2) were assessed. HCV status was known in 91% (561) of patients with 70% (391) being HCV+ve. The mean FS score was higher in HCV+ve patients than HCV-ve (11.0 kPa ±12.4 vs 5.6 kPa ±4.0; p=0.001). In HCV+ve group, patients that drank alcohol (35%) had a higher score than those that were abstinent (13.2 kPa ±16.4 vs 9.7 kPa ±9.9; p=0.02). There were 128 (33% of total cohort) HCV+ve patients with FS ≥8.5 kPa, 34 (9%) with FS ≥25 kPa and 21 (5%) with FS ≥35 kPa.

Conclusions This study has identified a large number of HCV+ve patients that do not attend hepatology services yet qualify for DAAs. Within this group there are significant numbers of patients at high risk of decompensation. On-going alcohol use is associated with a significantly higher FS score.

OUTCOMES FOLLOWING ANTI-TNF DISCONTINUATION AND THE RISK OF RELAPSE IN INFLAMMATORY BOWEL DISEASE; A SINGLE CENTRE EXPERIENCE

L Coffey*, A Mullen, J Leyden, P MacMathuna. Mater Misericordiae University Hospital

Background Crohn’s disease (CD) and Ulcerative Colitis (UC) are chronic inflammatory bowel (IBD) conditions that result in fluctuations of disease activity. Infliximab and Adalimumab are well-established agents associated with inducing and maintaining remission in IBD. Long term use of this agent has an associatedrisk profile and significant healthcare budget implications.

Aims The aim was to identify patients in remission suitable for discontinuation of anti-TNF therapy and follow their clinical course to identify the patients who maintained a clinical remission.

Methods A single centre retrospective of our 1000 IBD patients. We reviewed IBD cohort on Anti TNF therapy. Analysis of colonoscopy findings and patient symptoms at time of discontinuation was performed and subsequent clinical follow up following withdrawal of therapy.

Results We identified 65 patients on Infliximab. 37 (57%) have UC and 28 (43%) have CD. Following a mean treatment interval of 41 months Infliximab therapy was discontinued in 19 (29%) patients. Of the discontinuation cohort 11 (58%) patients had UC, 6 (31.5%) had CD 2 (10.5%) were indeterminate colitis. During a follow up of 36 months 18 (95%) remained in clinical remission, while 1 (5%) relapsed. We identified 198 patients on Adalimumab in our cohort for treatment of CD. Of this cohort 3 (1.5%) were discontinued as they were in clinical remission. The follow up for this arm was 50 months. There have been 2 (66%) relapses in this group.

Conclusions Successful remission was achieved in 95% of our Infliximab cohort and 33% of our Adalimumab cohort resulting in fewer hospital admissions, improvement in patient quality of life and decreased healthcare costs that are associated with provision of both maintenance and rescue therapy for flares of disease.

THE CLINICAL AND FINANCIAL IMPACT OF MEASURING INFlixIMAB LEVELS AND ANTIBODIES TO INFlixIMAB IN INFLAMMATORY BOWEL DISEASE PATIENTS

S O’Reilly*, D Keegan, K Byrne, J Sheridan, HE Mulcahy, GA Docherty, G Cullen. Centre for Colorectal Disease, St Vincent’s University Hospital, Elm Park, Dublin, Ireland

Background Approximately 150 IBD patients are currently on infliximab (IFX) at our centre, costing over €2 million in 2016. IFX drug and antibody level measurement was introduced in 2015.

Aim To analyse the clinical and financial impact of measurement of IFX levels and antibodies to IFX (ATI) in 2016.

Method IBD patients with IFX levels and ATI measured in Dec 2015 and Dec 2016 were identified from...
laboratory records and an IBD database. The results and clinical reaction to the levels were recorded.

Results 93 (55 Crohn’s, 38 UC) patients had levels checked. More than one measurement was made in 25. 37 had subtherapeutic levels (<3 mg/ml), five with AT1. 10 had dose escalation and seven stopped IFX. The remainder were in clinical remission and maintained on current dose. 34 had supertherapeutic levels (>7 mg/ml): 12 had dose reduction and six stopped IFX. The remainder were maintained on current dose. 22 had therapeutic levels (3-7mg/ml): 13 were maintained on current dose, two dose escalated, five dose reduced and two stopped IFX. 76% of IBD patients on IFX had supertherapeutic or subtherapeutic levels. Of these, 41% had a medication/dose change in response to these results. 11% stopped IFX. Projected savings in our centre are €85,000 in 2016.

Conclusions Initial analysis suggests significant cost savings with IFX level measurement, although decisions on IFX dosing are not made on levels in isolation and alternative treatment options may be equally or more expensive. A prospective study would help clarify the true cost savings.

8 LOWER GASTROINTESTINAL SYMPTOMS IN YOUNG PATIENTS: CAN SYMPTOMS AND NON-INVASIVE TESTS BE USED SYSTEMATICALLY TO AVOID UNNECESSARY COLONOSCOPIES?

A Alakkan*, M Hussey, BM Ryan. Department of Gastroenterology and Clinical Medicine, Adelaide and Meath Hospital, and Trinity College, Dublin, Ireland
10.1136/gutjnl-2017-314127.8

Background Colonoscopies in young patients presenting with lower GI symptoms are often normal. Avoidance of colonoscopy in such instances reduces patient risk exposure and rationalises limited resource utilisation.

Aim To assess colonoscopy outcome, relevant faecal and blood tests in young symptomatic patients.

Method Colonoscopies performed over 1 year were retrospectively identified from the ERS. Patient charts, faecal calprotectin (FC) and CRP were reviewed. A raised CRP or FC of >50 μg/g was considered abnormal. Inclusion and exclusion criteria are in table 1.

Abstract 8 Table 1 Study criteria

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<td>Age&lt;45 years</td>
<td>Known Iron deficiency</td>
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<td>Presenting complaint: diarrhoea, constipation and abdominal pain/bloating</td>
<td>Anaemia</td>
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<tr>
<td></td>
<td>Overt or obscure GI bleeding</td>
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<td>Known Inflammatory Bowel Disease</td>
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Results 242/2155 medical GI outpatient colonoscopies performed over 12 months met inclusion criteria for the study. Median age 34 years (range 16-45), 141 (58%) female. Indications; (Group A) diarrhoea 132/242 (55%), (Group B) constipation, abdominal pain/bloating 110/242 (45%). Colonoscopy was normal in 104 (79%) of Group A and 102 (93%) of Group B (p=0.002). 28/36 (78%) patients with mucosal inflammation confirmed on histology had diarrhoea (p=0.0001). FC was available in 36 patients, and CRP in 171. In group A the NPV, sensitivity and specificity of CRP/FC were 88%, 42% and 86%. In group B these figures were 95%, 38% and 93%. 21 patients had incidental early adenomatous polyps.

Conclusions Colonoscopy has very low yield in young symptomatic patients, especially those with non-diarrhoeal symptoms. Non-invasive tests should be used systematically to better identify patients requiring colonoscopy. We are conducting a prospective study to explore non-invasive diagnostic paradigms. Implementation of these strategies will help reduce colonoscopy waiting times.
Poster Presentation

**TRANSFORMING TRANSITION FOR PAEDIATRIC IBD PATIENTS IN NORTHERN IRELAND**

R. Little*, L. McLoughlin, A. Szabo. Paediatric Gastroenterology, Royal Belfast Hospital for Sick Children, Belfast Health and Social Care Trust, UK

10.1136/gutjnl-2017-314127.9

**Background**

The Paediatric Gastroenterology team in Belfast has been continuously developing their service to facilitate efficient transfer of adolescent care to Adult Gastroenterology. Initially this process was by referral letter only however, in view of the increasing prevalence of Inflammatory Bowel Disease (IBD), establishing a well-structured transition clinic was essential. We sought to elucidate the level of preparedness for, and experience at, transition clinic from our adolescent attendees.

**Method**

We devised a questionnaire which was distributed to all adolescent patients attending transition clinic over a six month period, which they completed anonymously. Data was then collated.

**Results**

Of the twenty two patients surveyed 100% rated the quality of care at transition clinic as excellent or good. 100% agreed they were well supported by the medical and nursing staff present, 82% of which agreed the clinic adequately prepared them for moving to Adult Gastroenterology care. However, only 50% of patients knew their medication names and doses. 32% wanted more advice regarding symptom management and investigations. 75% of patients had ongoing dietary and psychology input. Concern regarding continuity of these valuable services and the loss of a supportive relationship with the paediatric nurse specialist were the main perceived stressors and anxieties for our patient cohort.

**Conclusions**

Over the last eight years the Paediatric Gastroenterology team has successfully established transition clinics with all five trusts across the province. Collaboration between the Paediatric and Adult Gastroenterology teams in Northern Ireland has transformed the continuity, safety and patient experience for young people with IBD transitioning between our expert services.

**GRANULOCYTE/MONOCYTE APHERESIS AS MAINTENANCE THERAPY IN CROHN'S DISEASE**


10.1136/gutjnl-2017-314127.10

**Background**

Granulocyte, monocyte apheresis (GMA), extra-corporeal absorptive circuit used to treat acute ulcerative colitis (UC) and Crohn's disease. Use in maintenance therapy following remission is uncertain.

**Aim**

To present the outcomes following treatment of 5 patients with maintenance GMA for Crohn's disease.

**Method**

Notes review of patients. Assessed blood results (full blood count, albumin, C-reactive protein) faecal calprotectin (FC), imaging and subjective patient reporting to determine the response.

**Results**

5 patients (P) were included, of whom: 4 were male, mean age 37.4 (24–57) years. All received previous conventional therapies with no or limited effect or had lost response. All had 8 treatments at weekly intervals as acute therapy followed by maintenance at monthly intervals. P1 (30 year old male, small bowel (SB) Crohn's), 40 columns, consistent normalisation in all markers and FC (from >600 to 248), reversal of temporary colostomy, improvement on MRE, subjective improvement. P2 (46 year old male, SB Crohn's) 12 columns, consistent improvement in bloods, subjectively in remission. P3 (24 year old male, Crohn's colitis) 9 columns, initial subjective improvement, bloods unchanged from baseline but normal, switched to vedolizumab. P4 (30 year old male, SB Crohn's) 5 columns, no subjective change, stopped. P5 (57 year old female, SB Crohn's) 4 columns, improvement in C-reactive protein, others consistently normal, no change from baseline, subjective improvement but stopped.

**Conclusions**

Five patients received maintenance therapy. Consistent biochemical/subjective symptomatic remission was achieved in two (P1 and 2), subjective remission in a third (P5) but no response in P3 and 4. Remission appeared to continue in those with elevated baseline markers of inflammation. SB Crohn's may respond better than colitis. GMA may have a role as maintenance therapy.

**HAEMOSTATIC RADIOThERAPY IN GASTRO-OESOPHAGEAL CANCER: REFERRAL PATTERNS AND TREATMENT EFFICACY**

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10.1136/gutjnl-2017-314127.11

**Background**

Haemorrhage from unresectable gastric and oesophageal malignancies reduces quality of life, shortens survival, and is associated with considerable burden for blood banks.

**Aim**

The purpose of this study was to evaluate the outcomes of radiotherapy (RT) in achieving haemostasis, and to describe referral patterns to the Clinical Oncology team.

**Method**

Retrospective analysis of all patients with gastro-oesophageal cancer that received RT with haemostatic intention from 2013–2016 in Northern Ireland. Only patients who required packed red cell transfusions were included. Study endpoints included improvement in haemoglobin (Hb) and transfusion requirement.

**Results**

Haemostatic RT was used in 25 cases (13 oesophagus; 12 stomach). Mean age of patients was 77 years (44–89). Mean Hb nadir in the period from first Hb drop to RT was 64 g/L (36–99). Endoscopic intervention was performed in 3 cases (1 Haemospary and clip; 2 Haemospary only). Mean time from diagnosis to first evidence of haemorrhage was 4.5 months (0-12). Mean time from first Hb decrease to radiotherapy referral was 13 weeks (1-45). There was a statistically significant increase in the mean Hb following radiotherapy (87 g/dl to 103 g/dl; p<0.0001). Mean units of packed red cells transfused two months before versus after radiotherapy was 8.5 V 1.2. Mean overall survival after RT was 107 days with a trend to increased survival with increasing RT dose. Treatment failure (death or requirement for transfusion within one month of RT) was 9/24 (37%).

**Conclusions**

Radiotherapy is an effective treatment for haemorrhage associated with gastro-oesophageal malignancy and referrals to Clinical Oncology should be considered early.
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Presentation: A box containing two transparent bags, each containing two separate sachets. A and B. Each A contains macrogol 3350 100g; sodium sulphate anhydrous 7.9g; sodium chloride 2.66g and potassium chloride 1.015g as white to yellow powder. Sachets B contain ascorbic acid 4.7g and sodium ascorbate 5.9g as white to light brown powder. MOVIPREP also contains aspiramine (E651), ascorbic acid (E300) and a lemon or orange flavour. 

Uses: Bowel cleansing prior to any clinical procedure requiring a clean bowel.

Dosage and administration: Adults and Older People: A course of treatment consists of two litres of MOVIPREP A litre of MOVIPREP consists of one sachet A and one sachet B dissolved together in water to make one litre. This one litre reconstituted solution should be drunk over a period of one to two hours. This process should be repeated with a second litre of MOVIPREP to complete the course. A further litre of clear fluid is recommended during the course of treatment. The two litres of MOVIPREP may be consumed either as a ‘divided dose’, one litre the evening before the procedure and one litre in the early morning of the procedure, or as a ‘single dose’ of two litres the evening before the procedure or two litres in the morning of the procedure. For the ‘divided dose’ there should be at least one hour between the end of intake of fluid and the start of the procedure. For the ‘single dose’ in the morning of the procedure, there should be at least two hours between the end of intake of MOVIPREP and at least one hour between the end of the intake of any clear liquid and the start of the procedure. No solid food should be taken from the start of the treatment and until after the procedure. Patients should be advised to allow for the appropriate time to travel to the colonoscopy unit.

Children: Not recommended in children below 18 years of age.

Contra-indications, warnings etc: Contra-indications: Known or suspected hypersensitivity to any of the ingredients, gastrointestinal obstruction or perforation, disorders of gastric emptying, fever, phytobezoars, glucose-6-phosphate dehydrogenase deficiency, toxic megacolon which complicates very severe inflammatory conditions of the intestinal tract. Do not use in unconscious patients. Warnings: diarrhoea is an expected effect. Administer with caution to fragile patients in poor health or patients with serious clinical impairment such as impaired gag reflex, or with a tendency to aspiration or regurgitation, impaired consciousness, severe renal insufficiency, cardiac impairment (NYHA grade II or III), those at risk of arrhythmia, dehydration, severe acute inflammatory disease. Dehydration, if present, should be corrected before using MOVIPREP. The reconstituted MOVIPREP does not replace regular fluid intake and adequate fluid intake must be maintained. Semi-conscious patients or patients prone to aspiration should be closely monitored during administration, particularly if this is via a naso-gastric route. If symptoms indicating arrhythmias or shifts of fluid or electrolytes occur; plasma electrolytes should be measured, ECG performed and any abnormality treated appropriately. In debilitated fragile patients, patients with poor health, those with clinically significant renal impairment, arrhythmia and those at risk of electrolyte imbalance, the physician should consider performing baseline and post-procedure electrolyte, renal function tests and ECG as appropriate. The possibility of serious arrhythmias, predominantly in those with underlying cardiac risk factors and electrolyte disturbances cannot be ruled out. If patients experience symptoms which make it difficult to continue the preparation, they may slow down or temporarily stop consuming the solution and consult their doctor. MOVIPREP containing orange flavour is not recommended for patients with glucose and galactose malabsorption.

Interactions: Oral medication should not be taken within one hour of administration as it may be flushed out of the GI tract and not absorbed. Pregnancy and lactation: There is no experience of use in pregnancy or lactation so it should only be used if judged essential by the physician. Side Effects: Very common or common: abdominal pain, nausea, abdominal distension, and discomfort, malaise, pyrexia, vomiting, dyspepsia, hunger, irritability, sleep disorder, headache, dizziness, and rigors. Uncommon or unknown: Dysthymia, discomfort, abnormal liver function tests, allergic reactions including rash, urticaria, pruritis, angioedema, anaphylaxis, dyspnoea, electrolyte disturbances, dehydration, convulsions associated with severe hyponatraemia, transient increase in blood pressure, arrhythmia, palpitations, flatulence and retching. Refer to the Summary of Product Characteristics (SmPC) for full list and frequency of adverse events.

Overdose: In case of gross accidental overdosage, conservative measures are usually sufficient. In the rare event of severe metabolic derangement, intravenous hydration may be used. 

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Date of preparation: July 2015. Ref: UKMRA/2711/00030

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UK: MPA/1216/1313
Date of preparation: October 2015.
AUDIT TO ASSESS THE LOCAL BLOOD TRANSFUSION PRACTICE IN PATIENTS WHO PRESENT WITH ACUTE UPPER GASTROINTESTINAL BLEEDS IN MUHIMBI National Hospital, Dar ES Salaam, Tanzania

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10.1136/gutjnl-2017-314127.12

Background Blood transfusion is a major component in the treatment of acute upper gastrointestinal bleeding. Its safety has been questioned in the treatment of less severe cases. A large randomised controlled trial showed significant reductions in re-bleeding and mortality rates in patients who were randomised to a restrictive policy (transfused when haemoglobin was less than 7 g/dL) compared to a liberal policy (transfused when haemoglobin was less than 9 g/dL).

Aim The aim of this study is to identify whether Muhimbili National Hospital in Tanzania follows the evidence-based medicine that a restrictive policy in blood transfusion is advantageous in the treatment of acute upper gastrointestinal bleeding.

Method I performed a prospective audit of patients presenting to Muhimbili National Hospital (MNH) with AUGIB to assess the current transfusion practice in this patient group. During a 3 week period I identified patients admitted to MNH who presented with melena and haematemesis. I collected data about haemoglobin levels and blood transfusion from patient’s notes.

Results 89.5% of patients who presented with haemoglobin <7 g/dL received a blood transfusion. 50% of the patients with a haemoglobin >9 g/dL did receive a blood transfusion.

Conclusions Muhimbili National Hospital in Dar Es Salaam in Tanzania do not follow the evidence-based medicine that restrictive policy in blood transfusion in acute upper gastrointestinal bleeding is beneficial compared to liberal blood transfusion.

MEDICATIONS THAT AFFECT THE LOWER OESOPHAGEAL SPHINCTER AND RISK OF OESOPHAGEAL CANCER: A NESTED CASE-CONTROL STUDY

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10.1136/gutjnl-2017-314127.13

Background Excessive relaxation of the lower oesophageal sphincter results in increased gastro-oesophageal acid reflux, a risk factor for oesophageal cancer.

Aim We aimed to investigate the risk of oesophageal cancer in patients prescribed medications known to relax the lower oesophageal sphincter.

Method Using the Scottish Primary Care Clinical Informatics Unit (PCCIU) database, a nested case-control study of Scottish patients diagnosed with oesophageal cancer between 1999 and 2011 was performed. Medication use was determined from GP prescription records. Conditional logistic regression was used to calculate OR and 95% CI for oesophageal cancer risk in patients prescribed benzodiazepines, calcium channel blockers, nitrates, respiratory sympathomimetics or xanthine medications.

Results A total of 1979 oesophageal cancer patients were matched to 9543 controls. There was a significantly increased risk of oesophageal cancer in patients prescribed respiratory sympathomimetics (adjusted OR 1.27, 95% CI 1.08-1.48) but no dose-response association was observed. No significant increased oesophageal cancer risks were seen for users of other medications that relax the lower oesophageal sphincter (adjusted OR for benzodiazepines 0.94, 95% CI 0.79-1.11; calcium channel blockers 1.05, 95% CI 0.92-1.20; nitrates 1.09, 95% CI 0.92-1.29; or xanthines 1.44, 95% CI 0.91-2.28).
Conclusions Respiratory sympathomimetic medication use was associated with an increased risk of oesophageal cancer. Oesophageal cancer risk was not significantly increased for users of other medications known as relaxants of the lower oesophageal sphincter. Further, the observed association may not be causal because there was no dose response relationship, and possible confounding due to asthma symptoms.

MEDICATIONS THAT AFFECT THE LOWER OESOPHAGEAL SPHINCTER AND RISK OF OESOPHAGEAL CANCER: A COHORT STUDY OF 465,768 UK BIOBANK PARTICIPANTS

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Background Medications that relax the lower oesophageal sphincter may promote acid reflux, a known contributor to oesophageal adenocarcinoma development.

Aim We investigated the association between lower oesophageal sphincter relaxing medications and oesophageal cancer (OC) risk.

Method A retrospective cohort study of participants within the UK Biobank from 2006 and 2014 was performed. Age-dependent Cox-regression analysis was used to calculate adjusted HR and 95% CI for OC risk in individuals prescribed benzodiazepines, calcium channel blockers, nitrates, respiratory sympathomimetics and xanthines.

Results Of 475,768 study participants, 409 were diagnosed with OC during 8 years of follow-up. There was a significant direct association with OC in participants using respiratory sympathomimetics (HR 1.71, 95% CI 1.20–2.42), with similar increased risk of oesophageal adenocarcinoma with use of these respiratory medications (HR 1.68, 95% CI 1.10–2.54) and xanthines (HR 4.82, 95% CI 1.16–20.10). Participants taking respiratory sympathomimetics or any lower oesophageal sphincter relaxing medication were also at greater risk of oesophageal squamous cell cancer (HR 2.51, 95% CI 1.29–4.87 and HR 2.03, 95% CI 1.01–4.09, respectively). There was no significant association between OC and the other medications investigated.

Conclusions Respiratory sympathomimetics were associated with greater risk of OCoverall, and both adenocarcinoma and squamous cell carcinoma subtypes. Individuals using lower oesophageal sphincter relaxing medications are at increased risk of squamous cell carcinoma, and as this tumour is not associated with excessive acid reflux, an alternative pathway to this cancer with these medications may exist.

OUTCOMES FOR HOME PARENTERAL NUTRITION PATIENTS IN NORTHERN IRELAND – A TEN YEAR REVIEW (2006–2016)

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Background Intestinal failure (IF) patients in Northern Ireland requiring home parenteral nutrition (hPN) are managed in the Belfast Trust by the Nutrition team at Belfast City Hospital.

Aim The aims of this review were to analyse the aetiology of IF; admission rates (particularly those due to catheter related blood stream infections (CRBSI)) and patient outcomes.

Method Electronic records including radiology and microbiology results for all patients on hPN in Northern Ireland from 2006–2016 were reviewed.

Results 86 patients used hPN between 2006–2016. One patient was excluded due to incomplete data. The average age at presentation was 51 (range 19–78). The mean number of days hPN was administered was 1072 (range 23–3834). The most common causes of IF were Crohn’s disease (29%), surgical complications (22%) and mesenteric ischaemia (18%). There were 414 admissions in the timescale – 137 admissions were due to CRBSI. The CRBSI rate was 1.5 per 1000 catheter days (previously 1.81 (1994–2014)). 43 patients had no infections (5%) and 10 had >5 infections, accounting for 55% of all CRBSI admissions. The most common organisms identified were Gram negative organisms (38%) Coagulase Negative Staphylococci (34%); and Yeasts (11%). 28% of patients remain on home parenteral nutrition; 21 patients have had restoration of intestinal continuity.
Conclusions Parenteral nutrition remains a safe treatment in the management of intestinal failure. Our CRBSI rate has reduced in the past 10 years, likely due to ongoing patient education and training.

**Comparison of Low Volume Polyethylene Glycol-Electrolyte Solution (PEG-ELS) and Phosphate Enema in Flexible Sigmoidoscopy: A Large Retrospective Study**

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10.1136/gutjnl-2017-314127.17

**Background** Flexible sigmoidoscopy is a popular method for examining the left side of the colon, but adequate bowel cleansing is critical for detection of mucosal abnormalities, and for minimising the number of repeat procedures. It has, however, long been debated which method, oral preparation or enema, gives the best results.

**Aim** At our unit both oral and phosphate enema preparations are utilised, and we therefore wanted to find out which type of preparation gives best results.

**Methods** Patients who underwent flexible sigmoidoscopy from 1st February to 31st July 2016 were retrospectively reviewed using our endoscopy reporting system. Their demographics and the individually achieved quality of bowel preparation (subjectively graded as: Excellent, Adequate or Inadequate) were analysed. A chi-squared test was used to calculate p-values.

**Results** 1054 patients underwent flexible sigmoidoscopy during the study period, of whom 822 were included in this study, after excluding 232 patients (22.01%) due to: no bowel preparation (n=69), no documentation of quality of bowel preparation (n=151) and other reasons (n=12). 494 (46.87%) patients (males 248 (50.20%), mean age 60.48 years, range 15-94 years) had oral preparation with low volume polyethylene glycol-electrolyte solution (PEG-ELS), and 491 (46.58%) (males 245 (49.90%), mean age 65.49 years, range 18-98 years) had phosphate enema. The outcomes are summarised in the table below.

Conclusions Our relatively large retrospective study showed that oral preparation with PEG-ELS resulted in significantly better bowel preparation compared to phosphate enema. PEG-ELS is now the preferred option in our unit where there is no contraindication for this.

**Abstract 18 Table 1**

<table>
<thead>
<tr>
<th>Number of Responses</th>
<th>Percentage of correct answers (%)</th>
<th>Number of Responses</th>
<th>Percentage of correct answers (%)</th>
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<td>76</td>
<td>40.8</td>
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<td>36.1</td>
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<td>75</td>
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<tr>
<td>Q5 71</td>
<td>22.5</td>
<td>63</td>
<td>31.8</td>
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</tbody>
</table>

A paired t-test was used to measure the difference in correct answers selected between the 1st and 2nd attempts, p-value of 0.013.

Conclusions Knowledge of malnutrition can be improved by completing a short training module. Future studies should address the technical issues of using SurveyMonkey within ETS and use larger sample sizes to prove the generalisability of the results. Improved knowledge should lead to earlier recognition and treatment of malnutrition with improved health outcomes and reduced costs.
Background Adults detected with Barrett’s oesophagus (BO) are often entered into surveillance for oesophageal adenocarcinoma (OAC), although cancer risk is relatively low. More rarely, BO can be detected in children. Little is known about the epidemiology of paediatric BO, and it is unclear what the optimal surveillance regimes are in these children.

Aim To evaluate the demographic and clinical characteristics, and future neoplastic progression risk in all paediatric BO patients diagnosed in Northern Ireland between 1993 and 2010.

Method Data was collected using the Northern Ireland BO register and matched to the Northern Ireland Cancer Registry for OAC outcomes until end 2013. Age-adjusted incidence of paediatric BO was calculated, and chi-squared tests performed to compare characteristics between paediatric and adult BO patients.

Results Over 18 years, 42 paediatric BO patients were identified, equivalent to an age-adjusted incidence of <2 per 100,000 children. No clear age distribution was evident, with cases ranging from newborns to 15 years old. 85.7% of patients were male, which was a significantly higher male:female ratio than adult BO patients (p<0.001). No patients progressed to HGD/OAC, although the oldest patient would be aged 34 years by the end of follow-up.

Conclusions This is the largest series of paediatric BO ever to be reported. It demonstrates that paediatric BO is a rare disease. The male preponderance of this condition is even more apparent in childhood compared with adult cases. No children developed HGD/OAC during follow-up, suggesting that regular surveillance is not required, at least until early adulthood.

Efficacy and safety of golimumab induction for moderate to severe ulcerative colitis in the United Kingdom: results from the GO-COLITIS

C Probert*, D Gaya, PJ Hamlin, P Irving, S Sebastian, G Gillespie, H Tate, C Wheeler. University of Liverpool, UK

Background GO-COLITIS (NCT02092285; 2013-004583-56) is a phase 4, multicentre, open-label, single-arm trial in the UK assessing efficacy of golimumab (GLM) in induction and maintenance of clinical response in patients with moderate to severe UC. We report the results of a 6-week interim analysis.

Aim Gather real-world experience of the efficacy and safety of golimumab in an anti-TNF naïve cohort.

Method Anti-TNF naïve patients (≥18 year) with UC ≥3 months and with moderate to severe disease were included. Patients received SC GLM on day 0 (200 mg) and day 14 (100 mg) during the 6-week induction phase, followed by GLM 50 or 100 mg 4 weekly in the 48-week maintenance phase. Clinical response and remission were summarised descriptively at the end of week 6. Clinical response was defined as decrease in partial Mayo score of ≥2 points and ≥30% from baseline, plus a decrease in rectal bleeding subscore of ≥1 point or absolute rectal bleeding score ≤1.

Results Overall, 205 patients were enrolled (mean age, 39.3 years). The mean baseline (SD) partial Mayo score was 6.4 (1.4). Clinical responses occurred in 141/205 patients (response rate, 68.8%; 95% CI, 62.0% to 75.1%). Clinical remission occurred in 79/205 patients (remission rate, 38.5%, 95% CI, 31.8% to 45.6%). The mean (SD) change from baseline in partial Mayo score (n=198) was −3.2 (2.4). Serious adverse events (AEs) occurred in 17 (8%) patients: UC flare/worsening was most common (n=11).

Conclusions During the induction phase of GO-COLITIS, 68.8% of patients had a partial Mayo response. AEs were consistent with previous observations.

Patient-reported quality of life during golimumab induction for moderate to severe ulcerative colitis in the United Kingdom: results from the GO-COLITIS study

P Irving, S Sebastian, C Probert*, D Gaya, PJ Hamlin, G Gillespie, H Tate, C Wheeler. University of Liverpool, UK

Background GO-COLITIS (NCT02092285; 2013-004583-56) is a phase 4, multicentre, open-label, single-arm trial in the UK assessing efficacy of golimumab (GLM) in induction and maintenance of clinical response in patients with moderate to severe UC. We report the results of an analysis of patient-reported QoL after a 6-week induction phase.

Aim Gather real-world experience of the efficacy and safety of GLM in an anti-TNF naïve cohort.

Method Anti-TNF naïve patients (≥18 year) with UC ≥3 months and with moderate to severe disease were included. Patients received SC GLM on day 0 (200 mg) and day 14 (100 mg) during the 6-week induction phase, followed by GLM 50 or 100 mg 4 weekly in the 48-week maintenance phase. Clinical response and remission were summarised descriptively at the end of week 6. Patients completed the IBDOQ and EQ-5D at baseline and at week 6.

Results Overall, 205 patients were enrolled (mean age, 39.3 years). Statistically significant improvements from baseline to week 6 were observed for the IBDOQ total score, and the domains of bowel symptoms, emotional function, systemic symptoms, and social function. Significant improvements in the EQ-5D were observed.

Conclusions During the GLM induction phase of the GO-COLITIS study, patients with moderate to severe UC experienced significant improvements from baseline in disease-specific QoL, including bowel symptoms, emotional function, systemic symptoms, and social function. The degree of improvement in IBDOQ total score exceeded the IBDOQ increase cutoff (>20 points) previously identified as representative of a patient-defined improvement in an assessment of UC clinical endpoints.
A NATIONAL STUDY OF CANCER DIAGNOSES IN IRISH LIVER TRANSPLANT RECIPIENTS WITH PRIMARY SCLEROSING CHOLANGITIS

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Background Primary sclerosing cholangitis (PSC) is associated with an increased risk of cholangiocarcinoma, colorectal and gallbladder cancers. Orthotopic liver transplantation (OLT) patients are at risk of developing de novo malignancies, however limited/conflicting data exists regarding cancer risk post OLT for PSC.

Aim To examine all recorded malignancies over 2 decades in OLT-PSC patients; to compare these to non-transplanted PSC cohort; to analyse for any associated factors.

Method We studied PSC patients attending SVUH (1/1/1994–30/9/2016). We integrated this database with National Cancer Registry Ireland, to enable accurate determination of number of malignancies.

Results 173 PSC pts (75.7% male) have attended SVUH since 1994. 107 (61.8%) have undergone 124 OLT. 27/107 were transplanted for cholangiocarcinoma. 12 de novo cancers (excluding non-melanomatous skin) were found during 737.8 person years of follow-up. Median time to cancer diagnosis post OLT was 5 years. As expected, cholangiocarcinoma as OLT indication (p = 0.005) and older age at transplant (p = 0.05) were associated with higher mortality. Post-transplant lymphoproliferative disease (PTLD) remains a major complication. 5 pts developed lymphoma post OLT (4.7% of cohort). Two patients developed CRC post OLT; 4 developed colonic dysplasia. 3/4 underwent colectomy. All who developed colonic dysplasia/CRC post OLT had IBD. All 5 colectomies for dysplasia/CRC showed significant co-existing inflammation.

Conclusions This represents national cancer figures for PSC-OLT. The rates of PTLD are slightly higher than previously reported. We could not find any association between the development of PTLD and immunosuppressive regimes for IB in post OLT. This study highlights that IB/PSC patients remain at significant risk of colonic neoplasia after OLT and require intensive surveillance.

SMALL INTESTINAL BACTERIAL OVERGROWTH IN CHRONIC PANCREATITIS PATIENTS WITH PANCREATIC EXOCRINE INSUFFICIENCY: A PROSPECTIVE COHORT STUDY

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Background Pancreatic exocrine insufficiency (PEI) causes malabsorption and is a major complication of chronic pancreatitis (CP). Small intestinal bacterial overgrowth (SIBO) worsens symptoms and nutritional status in CP; its prevalence is unclear.

Aim We examined SIBO prevalence in CP patients with PEI (defined as faecal elastase-1 < 200 µg/g) versus matched healthy controls.

Method 34 patients and 25 controls (matched for age/gender/smoking status) underwent hydrogen breath-testing using a glucose substrate. Exclusion criteria included gastric/pancreatic/intestinal surgery, or antibiotic treatment <4 weeks prior to study. Persistent rise in breath hydrogen 12 ppm above basal was diagnostic of SIBO.

Results Patients and controls were well-matched, with 67% and 64% males respectively (p=0.775), a mean (standard deviation) age of 52.4 (10.4) and 53.3 (10.3) year respectively (p=0.919), and 47.1% and 28% smokers respectively (p=0.143). Among patients, there was no association found between the presence of SIBO and gender (p=0.156), or PPI use (p=0.328). There was a significantly positive association found between the presence of SIBO and diabetes (p=0.033), while the positive association between the presence of SIBO and pancreatic enzyme replacement therapy (PERT) use just reached significance (p=0.052).

Conclusions SIBO prevalence was 15% and not associated with gender, age, or PPI use, but was positively associated with PERT use, and concurrent diabetes. Patients with diabetes may be more likely to suffer from SIBO due to small bowel dysmotility, whilst SIBO and PEI may co-exist, with similar symptoms. We recommend that SIBO should be considered in non-surgical CP patients, if they have gastro-intestinal symptoms that are unresponsive to high-dose PERT, particularly if there is co-existent diabetes. Treatment should be aggressive, and there may be a requirement for repeat therapy.

MEASURING THE VALUE OF ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) ACTIVITY: AN OPPORTUNITY TO STRATIFY ENDOSCOPYS BASED ON THEIR VALUE

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Background The value in healthcare can be defined as patient health outcomes achieved per monetary unit spent.

Aim To characterise the value of ERCP performance of four gastroenterologists.

Method Medical records of patients undergoing ERCP between September 2014 and September 2016 in an academic medical centre were reviewed; all procedures were performed by one of four experienced gastroenterologists, all of whom have performed at least 1000 ERCPs. Procedure value was defined as the quality of procedure (Q) divided by the duration of procedure (T) adjusted for complexity level (C), that is, Q/(T/C). In those patients undergoing multiple ERCPs during the study period, only the index procedure was considered for analysis. ERCP quality and complexity were both graded on a 1 to 4 Likert scale based on American Society for Gastrointestinal Endoscopy (ASGE) criteria; time was recorded (in minutes) from intubation to extubation. Although individual components of procedure cost (eg, ERCP accessories, patient sedation, etc.) were not itemised, the procedure
Empower Crohn’s patients to live life their way<sup>1</sup> destination you*
duration (ie, the cost of endoscopist's time) was considered to be a reliable surrogate estimate of overall procedure cost.

Results In total, index procedures on 465 patients were performed over 24 months; mean of 116 index ERCPs per endoscopist. Mean quality varied from 2.25 to 2.53 while adjusted mean duration (T/C) varied from 22.13 to 28.66 min per procedure. Value measurements varied from 8.1 to 10.7.

Conclusions There was a 32% variation in the value of endoscopist activity. As healthcare costs are scrutinised more closely, such value measurements are likely to become more relevant.

25 PRE-EMPTIVE THERAPY FOR CMV VIREMIA IN LIVING DONOR LIVER TRANSPLANT RECIPIENTS: A SINGLE CENTRE EXPERIENCE

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10.1136/gutjnl-2017-314127.25

Background CMV infection is among the most common complication after liver transplantation which may result in graft loss, survival and increased cost. There are two major strategies for CMV disease prevention after transplantation: preemptive therapy and universal prophylaxis. We present our cohort of recipients of Living Donor Liver Transplant (LDLT) with non-detectable CMV DNA pre-transplant, with moderate risk of CMV viremia (D+/-R+, d/-R+), who were preemptively treated.

Aim To determine whether preemptive strategy may be feasible approach in patients with moderate risk for CMV viremia in LDLT and its appropriateness for Acute Cellular Rejection (ACR), length of hospital stay and risk of developing other infection and all-cause mortality.

Method In this retrospective cohort, 225 adults with moderate risk for CMV viremia who underwent LDLT at Shifa International Hospital from 29/4/2011 to 26/4/2016 were included. All recipients were checked for CMV viremia at day 7, patients with significant viremia (DNA >137 IU/ml) were treated for CMV preemptively. Non-viremic patients on day 7 were only re-checked if had deranged LFT on follow up.

Results Out of 225 patients, 83 (36.8%) patients had detectable CMV DNA at day 7. Patients with higher pre-transplant MELD >18 had more chances of developing CMV viremia n=42 (50.6) than those with MELD <18 n=41 (49.4) (p=0.018). There was no significant difference in patients with/without CMV viremia for ACR (p=0.48), length of hospital stay, incidence of sepsis and all cause mortality.

Conclusions Pre-emptive CMV strategy may be an acceptable approach in patients with moderate risk of CMV viremia in resource constraint setting; however, this needs prospective randomised trials for validation.

26 OPPORTUNISTIC INFECTIONS IN INFLAMMATORY BOWEL DISEASE: ARE WE ADHERING TO THE ECCO GUIDELINES?

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10.1136/gutjnl-2017-314127.26

Background The use of immunomodulators for inflammatory bowel disease (IBD) has significantly improved disease management. However, these treatments increase the risk of infection. Screening for immunity to serious infection is recommended but compliance with these recommendations is unknown.

Aim To assess adherence to the European Crohns and Colitis Organisation (ECCO) screening guidelines and the rates of developing opportunistic infections in a cohort of IBD patients.

Method All patients currently on biological therapy were identified from a database of IBD patients within the Southern Health Trust. Case records were retrospectively reviewed to identify compliance with screening guidelines, and subsequent development of opportunistic infection.

Results 78 patients were receiving biologics +/- immunomodulators. 62 (79.5%) of patients had Crohn’s disease. The majority were pre-screened appropriately for infection (77.9%) with 99% of patients being pre-screened for TB. 72.8% of patients had the recommended viral serology checked.

Six patients (7.69%) developed infections. The majority did not require hospital admission (66, 7%). Two patients (33.3%) developed sepsis requiring hospital admission. There was no mortality related to infection.

Infection was more frequent in patients that were on both an immunomodulator and biological therapy (11.9% vs 2.8%, p=0.13) than biological therapy alone.

No patient developed, was treated for or reactivated latent tuberculosis.

Conclusions In this IBD cohort screening for infection was appropriate but could be further optimised. Risk of infection in this cohort was lower than in previous studies. Better adherence to screening recommendations and vigilance for infection may reduce the morbidity associated with immunosuppression in IBD.

27 PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBES; A RETROSPECTIVE ANALYSIS IN PATIENTS WITH HEAD AND NECK CANCER OVER 5 YEARS

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10.1136/gutjnl-2017-314127.27

Background Weight loss and malnutrition are common side effects of disease process and treatment of head and neck cancer. The use of PEG tubes to aid nutrition has been shown to be effective in previous studies and suggest patients benefit from PEGs.

Aim 1) To determine the rate of insertion and use of PEGs 2) To determine complication rates

Method This study assessed 175 patients who had PEG tubes inserted from 2012 to 2016. Data was collected and extracted from patient dietitian record and analysed using SPSS.

Results 175 patients had PEGs placed from January 2012 to December 2016. 39% of PEGs were inserted prophylactically, 67% of patients in the cohort had a diagnosis of oropharyngeal cancer. 27% of patients had laryngeal cancer. 3% had salivary gland cancer. Of all patients who received PEGs from 2012-2016, 25% gained weight and 6% of patients’ weight remained stable. 68% did not experience any complication (n=119). 5% experienced a major complication of PEG
infection (n=9), while the remaining 11.5% had minor complications of PEG leakage 7.5% and granuloma formation (4%).

Conclusions Weight loss is almost ubiquitous in head and neck cancers. This study demonstrated that PEGs are a useful aid for patients undergoing treatment for cancer allowing 31% of patients to gain and/or maintain weight. PEGs had relatively low rates of complications with only 5% of patients experiencing a serious complication. This study highlights that patients may benefit from PEG placement during treatment and benefits may outweigh risks.

28 SENSITIVITY OF CLO TESTING IN THE NORTHERN TRUST

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10.1136/gutjnl-2017-314127.28

Background Helicobacter pylori is a gram negative organism commonly found in the stomach. The majority of patients infected don’t experience any symptoms or complications however it can be associated with PUD, Gastric MALT Lymphoma, Gastric Cancer and chronic gastritis. We usually diagnose H. pylori with the use of CLO testing at endoscopy.

Aim We wanted to assess the sensitivity of these kits after a number of “negative” CLO tests had H. pylori confirmed at histology. This is important given the carcinogenic properties of H. Pylori.

Method This was a retrospective analysis of every CLO test that was performed between 01/08/16 and 31/10/16. For each patient that had a CLO test we checked the lab system for histology samples to check for any disparity. We also recorded the diagnosis at oesophagogastroduodenoscopy (OGD) and whether or not the patient was taking PPI medications.

Results 179 OGDs with CLO tests were performed in the specified time period. 11/179 were CLO positive (6.1%). 25/179 samples were sent for histology. 5/25 were CLO negative, histology positive. 2 of these patients were on a PPI. 19/23 were CLO negative, histology negative. 1 patient was CLO positive, histology positive.

Conclusions In a 3 month period, 5 cases of H. pylori would have been missed if histology wasn’t sent. The diagnostic yield for H pylori at histology was 24% compared to 6.1% with CLO testing. Given the carcinogenic properties of H. pylori we are now recommending that samples should be sent to histology in addition to CLO testing, if H. pylori is suspected.

30 ASSESSMENT AND MANAGEMENT OF ACUTE ALCOHOL WITHDRAWAL – AN AUDIT

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10.1136/gutjnl-2017-314127.30

Background 40% of individuals will develop an acute withdrawal syndrome upon stopping or significantly curtailing alcohol intake. A detailed alcohol history can be a useful aid in indentifying those at risk and avoiding adverse consequences of withdrawal.

Aim The aims of this audit were to quantify the proportion of acute admissions where an alcohol history is taken, assess the proportion of patients who were prescribed chlordiazepoxide and the doses used, assess the proportion of patients who were prescribed parenteral multivitamins, and the dose and duration of same.

Method Consecutive case series of 49 patients admitted to STGH from January-December 2016 with HIPE coding of “alcohol dependence with acute withdrawal”. The Guys and St. Thomas’ NHS Foundation Trust Clinical Guidelines on the detection of alcohol misusers attending hospital were used as reference standard.

Results In 82% (40/49 patients) a clear alcohol history was documented. For 62% of patients (30/49), the number of units of alcohol/week consumed was clearly documented. Median units/week was 50, with a range of 0-250. In 47% (23/49) of cases, a relevant neurological exam was documented in the admission note. Chlordiazepoxide was prescribed in 47% (23/49) of patients, with a median dose of 30 mg tds. Parenteral multivitamins were prescribed in 61% (30/49), for a median duration of 3 days.

Conclusions There exists a significant discrepancy between those identified at risk of acute alcohol withdrawal, and those for whom appropriate treatment is prescribed. Reasons include embedded prescribing practices, time constraints in ED, and uncertainty around appropriate dosing of chlordiazepoxide and parenteral multivitamins.
THE PROGNOSTIC VALUE OF TRANSIENT ELASTOGRAPHY: A SINGLE CENTRE IRISH STUDY

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Background Transient elastography (TE) has facilitated the rapid and non-invasive assessment of hepatic fibrosis. Recent studies have signified its utility in identifying patients with early clinically significant portal hypertension (CSPH), providing valuable prognostic information and has been incorporated in the Baveno VI recommendations.

Aim The aim of this study was to assess for features of CSPH and evaluate the clinical outcomes in patients with TE scores of $\geq 10$ kPa.

Method A retrospective review was performed on all patients attending the Hepatology Department in St. James’ Hospital with valid TE measurements $\geq 10$ kPa using an ECHO-sens Fibro-scanner with a M2 probe.

Results A total of 384 (19%) patients had transient elastography scores $\geq 10$ kPa. The most common aetiologies were HCV n=237 (61.7%) and NAFLD n=45 (11.7%). A TE score of $\geq 30$ kPa was highly predictive of numerous composite endpoints: liver-related hospital admissions OR3.6 (95% CI 4.1 to 18.0), decompensation OR12.7 (95% CI 5.47 to 29.3) and death OR8.61 (95% CI 2.8 to 26.5). The Baveno VI criteria demonstrated a good predictive value for the presence of oesophageal varices OR2.7 (95% CI 1.39 to 5.26), however, the negative predictive value was poor 79.1% in our mixed patient population.

Conclusions A TE score threshold of $\geq 30$ kPa demonstrated good predictive value for identifying at risk patients. Although the Baveno VI criteria was useful for the discrimination of patients at risk of developing varices, other factors may also need to be considered in order to improve the negative predictive value.

DOES FAecal CALPROTECTIN MEASUREMENT HAVE AN IMPACT ON PATIENT MANAGEMENT?

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Background Faecal calprotectin (FC) is recommended to support the differential diagnosis of IBD or IBS in adults with recent onset lower gastrointestinal symptoms. FC can assess IBD activity in those with known disease, as a rising level is an early marker of potential relapse. There is presently no formal funding for FC within Northern Ireland.

Aim To assess if FC measurement directs an immediate modification in patient management within two out-patient groups: 1) new patients with differential diagnosis of IBS or IBD; 2) review patients with known IBD.

Method A random selection of FC results from secondary care patients over 12 months were analysed. Patient outcomes following the FC result stratified patients into one of four groups: Discharged, colonoscopy performed, clinic review or escalation of medical therapy.

Results Group 1 (n=28): 8 positive FC, all proceeding to endoscopy. In the 14 negative FC, 12 patients were discharged, 2 had clinic review. For indeterminate result: one patient with 2 indeterminate results underwent colonoscopy; 4 had clinic review; 1 was discharged. Group 2 (n=28): of the 20 positive results, 11/20 (55%) had medical management escalated, 5/20 (25%) underwent colonoscopy and 20% had clinic review. In the negative and indeterminate results: 7/8 had clinic review.

Conclusions For patients with suspected IBS, a negative FC avoided unnecessary colonoscopy. In patients with known IBD, a raised FC led to an escalation in therapy in the majority of patients to minimise the risk of relapse and potential hospital admission. This study supports the need for a Northern Ireland FC service.
past are based on loss of response or emergence of anti-infliximab antibodies. No such single study exists in the literature.

**Method**

Total 218 patients records were searched. Out of 218, only 20 were included as cases. The inclusion criteria was either Crohns or Ulcerative colitis patient who were primary non-responders. Primary non-response was defined as all those patients who fail to respond to the standard induction doses of infliximab. Another 20 subjects were selected from the same pool as controls and were matched with cases in terms of age, sex and disease type.

This study was analysed using EPI-INFO STATCALC software from the CDC.gov.

**Results**

Odds ratios were calculated using the 2by2 tables for matched-pair case control study.1. Smoking was associated with primary non-response and the OR was 2.33 with 95% CI. Similarly, in this study, there was a trend of primary non-response with low levels of CRP at the time of start of therapy with the odds ratio of 0.25 (95% CI) and p-value 0.054. The odds for albumin, weight and Haemoglobin were 0.8, 0.42 and 0.33 respectively and their p-values did not reach significance due to small sample size.

**Conclusions**

From this study, there is a trend towards primary non-response to infliximab if a patient is a smoker with low levels of CRP at the time of initiation of therapy. Further studies with large sample size are needed to study the clinical significant association between haemoglobin, Albumin, and weight of the patients at the time of initiation of therapy.

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**AN INVESTIGATION OF GASTROINTESTINAL SYMPTOMS, PSYCHOLOGICAL WELL-BEING AND COGNITIVE PERFORMANCE IN INFORMAL DEMENTIA CAREGIVERS**

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**Background**

Caring for a relative with dementia is considered particularly stressful and is associated with numerous adverse health effects at multiple levels of the brain-gut axis. There is also evidence that long-term family caregivers are more likely to develop irritable bowel syndrome.

**Aim**

The current study aimed to compare family dementia caregivers to a non-caregiver control group, and to examine the impact of interventions, designed to help dementia caregivers manage stress and the caregiving role, on gastrointestinal symptoms, cognitive performance and psychological wellbeing.

**Method**

Caregiver participants were recruited via clinics at St. Finbarr’s Hospital, Cork and control participants via the university community. Participants completed the irritable bowel syndrome symptom severity scale, as well as validated tests of stress, anxiety, and depression. Participants also completed cognitive tasks from the CANTAB battery. A subset of caregivers completed both a carer training program and mindfulness-based stress reduction program. Each program was delivered in a group setting by an experienced instructor and lasted 6-8 weeks.

**Results**

Although caregivers had higher levels of stress and poorer cognitive performance, gastrointestinal symptoms were not altered compared to controls. Following both interventions, caregivers had improved cognitive performance. However, reported stress, anxiety and depression were not significantly altered following the interventions. Stress-reduction interventions also had no significant impact on gastrointestinal function.

**Conclusions**

The stress associated with informal dementia caregivers does not manifest across gastrointestinal symptoms and stress-reduction techniques do not improve gastrointestinal well-being. This is in contrast to the impact of caregiving at higher levels of the brain-gut axis.

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**LEARNING TO TAKE CONTROL**

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10.1136/gutjn-2017-314127.35

**Background**

Bowel care is a complex process, often a taboo subject. It is difficult to source a visual explanation tool for the teaching of the practical aspects of neurogenic bowel dysfunction for spinal cord individuals.

**Aim**

To develop in a scientific manner an animation training video showing the following procedures: Insertion of a rectal suppository, Digital Rectal Stimulation and Digital Removal of Faeces.

This animation is a visual step by step approach, structurally the education required for individuals with a neurogenic bowel dysfunction. It also supports their carers, families and health care professionals. Visual media will help to organise, process and retain information for the learner.

**Method**

Kick off and research included compiling an interdisciplinary steering group. Relevant information was collected for the animation video including reviewing guidelines/articles/relevant bowel videos, etc. The driver diagram was used to plan the project along with the PDSA cycle (plan, do, study, act). Funding was obtained and animators were briefed on the project.

**Results**

This animation DVD will augment the learning experience, by integrating technology and modernising our training for an enriched learning experience.

Overall results showed that 90% found the animation video excellent and suitable for both individuals with a spinal cord injury and health care professionals.

**Conclusions**

The animation training video is not a standalone teaching tool, but will assist in providing relevant information. It will support training effectiveness for both skills and knowledge, using evidence based practice.

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**COMPARISON OF EFFECTIVENESS OF TWO ONE WEEK TREATMENT REGIMENS FOR H.PYLORI IN SOUTH OF IRELAND PATIENT COHORT**

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10.1136/gutjn-2017-314127.36

**Background**

H. pylori eradication rates for 7 day triple therapy regimens have decreased in many countries in recent years. Recent European guidelines recommend that standard
triple therapy should not be used where local H. pylori resistance rates are greater than 15%.

Aim: Aim of study was to compare H. pylori eradication rates of one week, metronidazole vs Clarithromycin based, triple therapy regimens in a south of Ireland patient cohort.

Method: From January 2015 to September 2016 undergoing upper GI endoscopy by two gastroenterologists at the Bon Secours Hospital Cork had H. pylori status determined by CLO test (BioHIT). All Clo positive patients received one of two seven day H. pylori treatment regimens; PPI, Amoxicillin, Clarithromycin (PAC) or PPI, Amoxicillin, Metronidazole (PAM). All treated patients were offered urea breath test (Dia-bact UBT) 3-4 months following treatment.

Results: Of 2595 patients having upper endoscopy 188 (7.2%) had positive CLO tests. 45% (106/188) were females and mean age 56 (17 to 84 years). Of the 188 Clo positive patients, 118 (63%) received PAC treatment and 70 (37%) received PAM treatment. Of the 118 PAC patients 83 (69%) attended for UBT and 24 (29%) were positive. Of the 70 patients treated with PAM 50 (71%) returned for UBT and 14 (28%) were positive.

Conclusions: In a patient cohort with relatively low H. pylori infection rates, one week based Clarithromycin and Metronidazole based triple therapy regimens achieved equivalent eradication of H. pylori (71% PAC,72% PAM). H. pylori eradication rates are somewhat higher than recently reported in Ireland, they are well short of current European guidelines and add further weight to the recommendation that one week triple therapy regimen should not be used in this country for first line H. pylori eradication.

37 A WEIGHTY ISSUE: NUTRITIONAL SCREENING IN THE AMAU
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10.1136/gutjnl-2017-314127.37

Background: IrSPEN states that malnutrition affects ~145 000 adults at any time in Ireland, especially in chronic illness with >95% of malnourished being community based. HIQA's Report “Review of Nutrition and Hydration Care in Public Acute Hospitals” suggests nutritional assessment within 24 hours of hospitalisation to identify high risk or malnourished patients. In 2011, The Acute Medical Assessment Unit (AMAU), CUH reviewed 5560 patients. Nutritional screening is routinely completed on admitted patients however it was unclear what nutrition details were being recorded on day patients.

Aim: To assess if nutritional screening is currently being performed in AMAU day patients.

Method: A chart review of 52 consecutive day patient discharges was undertaken examining recording of nutritional screening and weight loss history.

Results: 52 consecutive patient charts (19 males, 33 females) were examined with an average age of 53.4 years with an average of 1.46 co-morbidities. Weight was recorded on 36.5% of patients with 26.9% having a hydration status measured. A weight loss history was taken in 19.2% of patients, 40% of which listed weight loss as their presenting complaint. One patient had a BMI completed. A nursing pro-forma in relation to diet consumed was completed in 55.8% of patients.

Conclusions: Currently full nutritional screening is not being performed on AMAU day patients. An AMAU patient visit could represent a unique opportunity to nutritionally screen and intervene in high risk multimorbidity community dwelling day patients. Current barriers to implementation of full nutritional screening include staff shortages, staff training and access to dietetics input if found to be at high risk.

38 SINGLE CENTRE EXPERIENCE WITH H. PYLORI ERADICATION THERAPY
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Background: Helicobacter pylori, is a gram-negative, microaerophilic bacterium usually found in the stomach and has been linked with chronic gastritis, gastric and duodenal ulcers, gastric cancer and MALT.

An increasing resistance to antibiotics has resulted in changes in the recommended eradication therapy.

The H.Pylori study group has recently updated the recommended eradication therapy.

Aim: To study the compliance with the updated therapy for H. Pylori infection.

Method: The prescrptions for triple therapy were collected and reviewed in compliance with the guidelines.

The results of the follow-up Urea Breath Test following completion of eradication therapy were recorded and the rate of successful eradication was compared in the group of patients who were treated according to the new recommendations versus old recommendations.

Results: The initial compliance with the new guidelines was 82%. Staff and junior doctor education have resulted in improvement in compliance rate.

Conclusions: 1. Longer duration of therapy and more compliance with new guidelines has been associated with improved eradication therapy.

2. Confirming eradication of H. Pylori is an essential step in reducing and eliminating long term complications.

39 IS IT TIME TO REVISIT THE RED FLAG REFERRAL SYSTEM?
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Background: The ‘red flag referral’ system is currently under stress due to the number of suspected cancer referrals. There are guidelines from the Northern Ireland Cancer Network regarding specific criteria for what constitutes a red flag referral.

Aim: To assess the efficacy of the 31- and 62 day referral pathways over a 1 year period for both upper and lower gastrointestinal cancers in a district general hospital.

Method: All upper and lower GI suspected cancer referrals were assessed over a 1 year period (October 2015 – September 2016). Both 31 day and 62 day referral pathways were analysed following investigation. Data were obtained from cancer trackers.
Results For suspected Upper GI cancers, there were 2629 (1109 31 day in-hospital referrals; 1520 62 day general practice referrals) referrals over the 1 year period. There were 164 confirmed cancers (overall 6.24%, 31 day: 9.64%, 62 day: 3.75%). For lower GI cancers, there were 3951 (1299 31 day in-hospital referrals; 2652 62 day general practice referrals) referrals over the 1 year period. There were 188 confirmed cancers (overall 4.76%, 31 day: 9.62%, 62 day: 2.38%).

Conclusions There was a very low diagnosis of cancer from red flag referrals for both upper and lower GI symptoms. In the current environment of increasing demands on the NHS—is it time for current red flag referral criteria to be revisited?

40 CORRELATION OF RELATIONSHIP BETWEEN INFlixIMAB AND ADAliMUMAB TROUGH AND ANTIBODY LEVELS WITH CLINICAL RESPONSE RATES AT COMPLETION OF INDUCTION THERAPY

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Background Anti-TNFa therapies have improved response rates in inflammatory bowel disease. However primary loss of response is problematic.

 Aim Aim of this study was to explore relationship between infliximab (IFX) and adalimumab (ADA) trough and antibody levels with clinical response.

Method This was a prospective, single centre study. Patients were recruited from July 2015-August 2016. Inclusion criteria were patients older than 17 years with IBD who started treatment with anti-TNFa drugs (infliximab/adalimumab). Patient demographics, clinical history were collected from electronic records. Clinical disease activity indexes were performed (Harvey-Bradshaw Index for Crohn’s disease (CD), and partial Mayo scores for Ulcerative colitis (UC)). Clinical response defined as reduction in HBs≤3 or reduction in partial Mayo score ≤4 and <50% from baseline. Anti-TNFa trough and antibody levels were measured using ELISA.

Results 35 patients were recruited; 23 CD, 12 UC. 18 patients treated with ADA, 17 IFX. Mean age 40.3 years, 62.9% female, 34.3% thiopurines, 25.7% prior anti-TNFa exposure. Response rate 51.4%, 33.3% for ADA, 70.6% for IFX. Overall trough levels were 12.5 μg/ml for IFX, 4.4 μg/ml for ADA. There was clear link between higher anti-TNFa trough levels at induction with clinical response. For infliximab, mean trough levels in responders were 16.4 μg/ml (IQR 8.4-22.7) versus 5.3 μg/ml (IQR 0.5-8.8) for non-responders (p value 0.02 95% CI: 1.5 to 20.7). Similarly there was a link between higher ADA levels with clinical response, though not statistically significant. Responders mean trough 6.6 μg/ml versus non-responders 3.0 μg/ml (p value 0.14). Antibody formation occurred in 28.5%.

Conclusions Higher anti-TNFa trough levels at induction are associated with improved clinical response.

41 RECTAL NSAIDS AND SELECTIVE PANCREATIC STENTING SIGNIFICANTLY REDUCES ACUTE PANCREATITIS IN NORMAL RISK ERCP

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Background In high-risk cases a combination of non-steroidal anti-inflammatory drugs (NSAIDs) and selective pancreatic stenting may reduce the risk of post ERCP pancreatitis (PEP). However, studies on whether this practice reduces PEP in normal risk ERCPs have shown conflicting results.

Aim To compare the rate of PEP for normal risk ERCP, where patients are administered rectal NSAIDs immediately following the procedure with selective pancreatic stenting (N/S), against the previous practice, which did not incorporate N/S.

Method Consecutive ERCPs from 2009–2016 were analysed pre and post N/S. In the post N/S group rectal NSAIDs were administered immediately following the procedure. Pancreatic stents were used if the pancreatic duct was cannulated more than three times during the procedure. PEP was defined as post ERCP abdominal pain and a rise in amylase to at least twice the upper limit of normal. Statistical analysis was by paired t and McNemars tests.

Results 574 ERCP procedures were performed, of which 509 were successful (88%). 335 (58%) were female, with an average age of 67.7 (range 16–94 years). 488 were therapeutic (96%). There were no statistically significant differences in the demographics of each group. 23 of 375 (6.1%) in the Pre N/S group developed PEP compared with 4 of 199 (2%) in the Post N/S group, p=0.02.

Conclusions This study shows a further significant reduction of PEP in normal risk ERCP in a cohort of patients with a historically low PEP rate following the introduction of rectal NSAIDs and selective pancreatic stenting.

42 DEPRESSION-ASSOCIATED ALTERATIONS IN THE MATERNAL MICROBIOME DURING PREGNANCY: PRIMING FOR ADVERSE INFANT OUTCOMES?

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Background Women at high risk of prenatal depressive symptomology have higher rates of adverse obstetric outcomes (1) and altered infant development (2). The mechanisms
underpinning this may be linked to inappropriate remodelling of the microbiome during pregnancy and subsequent vertical transmission of a suboptimal microbiome at birth.

**Aim** This cross-sectional study aimed to assess the association between the maternal microbiome and depressive symptoms.

**Method** Women enrolled in the IMPROVED study at Cork University Maternity Hospital (3) completed the Edinburgh Postnatal Depression Scale (EPDS) and provided faecal samples during the second (n=46) and third trimester (n=33) of pregnancy. Vaginal swabs were collected prior to delivery (n=60). EPDS ≤8 and EPDS ≥9 were used to indicate low and high depressive symptoms respectively. Microbial community structure analysed by 16S rRNA gene sequencing.

**Results** Women reporting higher depressive symptoms in second trimester had reduced phylogenetic diversity (p=0.024) and species richness (chao1; p=0.040) of the gut microbiota. There were significant alterations observed at Phyla, Family and Genus level including an increase in the dominant Faecalibacterium (p=0.029) among the higher depressive group. The magnitude of the depression-associated gut alterations was greatly reduced in the third trimester. The vaginal microbiome remained largely unchanged by prenatal depressive symptoms.

**Conclusions** The experience of depressive symptoms in mid pregnancy is associated with marked alterations in the maternal gut microbiome that do not persist into late pregnancy. Further studies are planned to clarify the implications of these depression-associated maternal microbiome alterations during pregnancy for obstetric outcomes and infant development.

**44 CONSCIOUS SEDATION IN ERCP: THE UNCOMFORTABLE TRUTH**


10.1136/gutjnl-2017-314127.44

**Background** Compared with standard endoscopy, Endoscopic Retrograde Cholangio-Pancreatoscopy (ERCP) is an uncomfortable, complex procedure that typically requires higher doses of sedative and analgesic medication. Our unit, like many throughout Ireland and the UK, performs the vast majority of ERCPs under conscious sedation. Challenges with appropriate sedation levels and patient compliance during ERCP are common.

**Aim** To evaluate patient comfort (1-4) and sedation score (1-5) with conscious sedation using a scoring system based on the modified Gloucest score.

**Method** We prospectively evaluated consecutive ERCPs performed under conscious sedation over a three-month period in a single, tertiary referral centre.

**Results** 121 patients were evaluated. The median age was 73, and 60/121 (49.6%) were female. 46 patients (38%) were ≥75 years. 62 patients (51%) had a comfort score of ≤2, and 59 (49%) had a comfort score of ≥3. One patient required reversal of sedation due to respiratory compromise. Median doses of medication were: midazolam (4.27 mg), diazepam (7.5 mg), fentanyl (84 mcg), and pethidine (35.7 mg). 7 patients received more than one benzodiazepines, 7 with more than one opiates and 6 with all four medications.

**Conclusions** There are limited data to define what is acceptable sedation practice for ERCP. The CREP have recently recommended that >80% of colonoscopies should have a comfort score of 1 or 2. Though there are no validated comfort scores for ERCP, our data demonstrate that many patients undergoing ERCP with conscious sedation are subjected to an experience that would be considered unacceptable in general endoscopy.

**45 NEW-ONSET DIABETES AFTER TRANSPLANT (NODAT): INCIDENCE, RISK ANALYSIS AND IMPACT ON SURVIVAL**

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10.1136/gutjnl-2017-314127.45

**Background** Orthotopic liver transplant has become the standard of care for end-stage liver disease and hepatocellular cancer. Better immunosuppressant paved way for improved survival rates post-transplant. But with this longevity comes a higher prevalence of chronic diseases such as New Onset Diabetes After Transplant (NODAT), Hypertension, metabolic syndrome etc. which have a negative impact on graft function and patient survival.
Aim To study the incidence of NODAT, factors predictive of NODAT and impact of NODAT on mortality and post-transplant survival.

Method It was a retrospective cohort study of 283 living donor liver transplant recipients from 29/4/2011 till 26/4/2016. Data was collected from records. Simple means and standard deviation was calculated for continuous variables while frequency statistics were calculated for categorical ones. Risk factors were assessed using binary logistic regression analysis.

Results A total of 130 post liver transplant patients were analysed after exclusion. NODAT was present in 41/130 (31.5%) patients, while 19/130 (14.6%) patients had impaired fasting glycaemia. Acute cellular rejection and Post-transplant Hyperglycemia showed increased odds of acquiring NODAT post-transplant.

NODAT had significant association with mortality and decreased survival (p=0.05).

Conclusions This cohort showed that NODAT is an important post-transplant entity with significant impact on mortality and survival. Early identification of at-risk patients is suggested.

50 patients had only inpatient endoscopic procedures, 15 had both endoscopic and radiological investigations and 15 had only radiological investigations. Others included EUA and haemorrhoidectomy. n=46 (26.1%) had only outpatient investigations. Total bed days=n=83, n=44 (25%) had no investigations. Reasons included known pathology, recent endoscopy or CT imaging, recent intervention (surgical or endoscopic) or not fit for investigation. Most common diagnoses were diverticular bleed n=59, haemorrhoids n=12, malignancy n=10.

Conclusions Less than half had inpatient investigations suggesting that many admissions could have been avoided. The current results show a low mortality rate consistent with other published data. A pathway for the management of stable LGB bleeding could be developed to minimise unnecessary admissions and streamline access to intervention where needed.

46 INPATIENT ADMISSIONS FOR LOWER GASTROINTESTINAL BLEEDING IN THE BELFAST TRUST

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10.1136/gutjnl-2017-314127.46

Background Traditionally, lower GI bleeding (LGIB) is admitted surgically but the recent NCEPOD report has recommended an integrated pathway for all gastrointestinal bleeds.

Aim To retrospectively assess how LGIB is managed within the Trust.

Method Inpatient discharge data were gathered over a 12 month period (March 2015-March 2016). Cases included were those with LGIB as the primary reason for admission. Factors including length of stay, inpatient and/or outpatient endoscopic and radiological investigations. 30 day mortality rate was assessed.

Results 350 patients were identified, 174 were excluded (UGIB or not primary reason for admission). 176 patients were included, age range 17–100 (median 66). Median length of stay=3.19 days (range 0–27). Total bed days 562. 30 day mortality=3.9% (n=7, 2 secondary to PR bleeding and 5 due to co-morbidities). n=86 (48.9%) patients had inpatient investigations. See Figure 1.

47 A CASE OF PRIMARY GASTRIC MELANOMA: NO LIGHT AT THE END OF THE TUNNEL

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10.1136/gutjnl-2017-314127.47

Background Malignant melanoma of the gastrointestinal tract is usually a metastasis from a cutaneous source. Primary gastric melanoma is an extremely rare clinical entity, with only 14 reported cases worldwide. It is often advanced at time of diagnosis and is associated with a poor outcome.

Aim To describe a case of primary gastric melanoma.

Method A 76 year old gentleman, presented with a one month history of fatigue and exertional dyspnoea. Laboratory investigations indicated an anaemia, with a haemoglobin level of 11.0 g/dL. Subsequent gastroscopy visualised a large, atypical, crater-like ulcerated lesion distal to the cardia in the proximal stomach.

Results Provisional histology was suggestive of a poorly differentiated adenocarcinoma but subsequent cyto-morphology and immunophenotyping were consistent with melanoma, with positive S100 protein, HMB45 and Melan A. Further molecular genetic testing revealed a V600R mutation in the BRAF gene, which is the first primary gastric melanoma with this mutation to be reported in the literature. Given the rarity of the findings, an extensive secondary work-up was undertaken, which concluded the diagnosis primary gastric melanoma.

Conclusions Primary gastric melanoma is a rare disease that can present similarly to other upper gastrointestinal lesions, with weight loss, abdominal pain, malena, and anaemia. Given its rarity, the pathogenesis is poorly understood. Lesions are often endoscopically atypical. Important points to note would include the absence of a primary lesion, as supported by a full skin examination and PET-CT findings, which can help to delineate the limitation to the stomach, thus helping to inform subsequent management.

Abstract 46 Figure 1
Still Here After 27 Years
Continuing to Deliver Leading Edge Medical Devices and Outstanding Customer Service to Improve Patient Outcomes

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Drainage Solutions & Plastic Biliary Stents

Hand Woven GI Stents

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Background Spontaneous bacterial peritonitis (SBP) is a diagnosis associated with significant mortality. It has previously been shown that delayed paracentesis is associated with increased inpatient mortality in patients with SBP.

Aim The aim of this audit was to identify time elapsed between patient presentation and the performance of diagnostic paracentesis at a University teaching hospital.

Method We included all patients who presented to the emergency department with ascites in the setting of cirrhosis and who had a diagnostic paracentesis. In all, 122 patients over 12 months were included in our study. Data was collected retrospectively from electronic patient records. Samples were categorised according to 3 time ranges: <12 hours, 12-24 hours, >24 hours.

Results Time to paracentesis is outlined in Table 1. 29.5% of patients didn’t have a white cell count sent as part of their ascites taps. 13 of the 86 patients (15.1%) with WCC sent were diagnosed with SBP; 5 of these were diagnosed >24 hours after presentation. Mortality was higher in patients whose diagnostic paracentesis were delayed until >24 hours after presentation (3/3) compared to those with paracentesis performed at <24 hours (1/9). p=0.052.

Conclusions A significant number of patients experienced delayed paracentesis. Recommendation: Education of NCHDs in the importance of diagnostic paracentesis to guide management and reduce mortality. Further training in the skill of performing paracentesis. Re-audit following these proposals.
51 VITAMIN D DEFICIENCY SHOWS NO RELATIONSHIP TO DISEASE ACTIVITY IN AN IRISH INFLAMMATORY BOWEL DISEASE (IBD) POPULATION

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10.1136/gutjnl-2017-314127.51

Background Low levels of vitamin D have been widely reported in IBD with evidence suggesting a role in disease severity and treatment.

Aim Ireland has high rates of vitamin D deficiency both in IBD and general populations. Studies investigating correlation of vitamin D deficiency and disease parameters have been mixed.

Method We conducted a single centre retrospective study in our hospital from Jan 2015- June 2016. The aim was to assess the prevalence of vitamin D deficiency in IBD and non-IBD cohorts and to assess the impact of vitamin D deficiency on disease activity in IBD. Patients were separated into 4 groups: Crohns Disease (CD), Ulcerative Colitis (UC), general gastroenterology (GI) and general medical (non-GI). Basic demographic data disease specific information was recorded.

Vitamin D deficiency was defined as <30 nmol/L.

Results 395 patients were studied: 157 CD, 70 UC, 75 GI and 93 non-GI. IBD patients were found to have high rates of Vitamin D deficiency (33% levels<30 nmol/L). Serum Vitamin D did not differ significantly between groups with mean values of 44.9 nmol/L (CD), 50.7 nmol/L(UC), 45.4 nmol/L(GI) and 45.6 nmol/L(non-GI). Symptomatic IBD patients had significantly higher mean CRP levels (8.6 mg/L) versus those who were asymptomatic (3.5 mg/L), (p<0.001). 35% of IBD patients who were symptomatic had vitamin D deficiency compared with 27% of those who were asymptomatic.

Conclusions We found very high rates of vitamin D deficiency in both IBD and non-IBD patients. Absolute levels did not differ significantly between groups. This may be accounted for by high overall prevalence of Vitamin D deficiency in this population or by confounders in the control population.

52 THE EFFECT OF PARACETAMOL LEGISLATION ON ADMISSIONS FROM PARACETAMOL OVERDOSE IN IRELAND

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10.1136/gutjnl-2017-314127.52

Background Paracetamol overdose (POD) is a prevalent issue worldwide and ease of access has been described as a principal factor for the drug so commonly used. In 2001, Ireland introduced a pack size legislation limiting access to 24-tablets in a pharmacy and 12-tablets in a non-pharmacy setting within a single transaction. To date no study has been published to assess the impact of the legislation at a national level.

Aim The aim of this study is to assess whether the 2001-legislation has reduced hospital admissions from POD in Ireland.

Method Data for POD from 1997 to 2011 was obtained from Healthcare Pricing Office, HSE, which collects data for inpatient admissions to hospitals in Ireland. The data from the five years before and after the legislation was compared (1997-2001 vs 2002-2006). Data from 2002-2006 was then compared to a further five years (2007-2011) to assess whether the changes were maintained.

Results There were a total of 14,225 patients admitted from 1997-2006. 7,647 patients were admitted from 1997-2001 and 6,414 from 2002-2006. There was a statistically significant difference between the mean number of admission during these periods (1529±72.7 vs 1315.6±140.78; p-value 0.0166).

From the year 2007-2011, 5,779 patients were admitted. When comparing 2002-2006 with 2007-2011, a statistically significant difference was again noted (1315.6±140.78 vs 1143.80±85.73; p-value 0.0481).

Conclusions This study has demonstrated that the 2001-legislation has significantly reduced POD admissions in Ireland. Results of this study can potentially be used as a basis for legislation on other potential harmful substances for example minimum pricing for alcohol which the Irish government is currently reviewing.
BIG MEETING, Spring 2017

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LONG TERM FOLLOW UP OF MICROSCOPIC COLITIS

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10.1136/gutjnl-2017-314127.53

Background Microscopic colitis (MC) has been increasingly diagnosed in recent years. The two main variants are lymphocytic colitis (LC) and collagenous colitis (CC).

Aim To evaluate the long term natural history and follow-up of patients diagnosed with MC.

Method Patients diagnosed with MC were identified from the histopathology department database in our institution. Clinical details were obtained through a combination of chart review and follow-up telephone interview.

Results

Abstract 53 Table 1

<table>
<thead>
<tr>
<th>MC (% total)</th>
<th>LC</th>
<th>CC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>94</td>
<td>63 (67%)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>69 (73%)</td>
<td>44 (70%)</td>
</tr>
<tr>
<td>Male</td>
<td>25 (27%)</td>
<td>19 (30%)</td>
</tr>
<tr>
<td>Median age at diagnosis</td>
<td>56.5 yrs</td>
<td>55 yrs</td>
</tr>
<tr>
<td>Smoking</td>
<td>43 (46%)</td>
<td>25 (40%)</td>
</tr>
<tr>
<td>Presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>89 (94.7%)</td>
<td>58 (92%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (5.3%)</td>
<td>5 (8.3%)</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>44 (47%)</td>
<td>37 (58.7%)</td>
</tr>
<tr>
<td>Coeliac disease</td>
<td>11 (12%)</td>
<td>9 (14.3%)</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSAID</td>
<td>26 (28%)</td>
<td>19 (30.2%)</td>
</tr>
<tr>
<td>Statin</td>
<td>28 (30%)</td>
<td>18 (28.5%)</td>
</tr>
<tr>
<td>PPI</td>
<td>40 (43%)</td>
<td>29 (46%)</td>
</tr>
</tbody>
</table>

Abstract 53 Table 2

<table>
<thead>
<tr>
<th>LC</th>
<th>CC</th>
<th>LC+CC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients under follow up (f/U)</td>
<td>34 (54%)</td>
<td>25 (80.6%)</td>
</tr>
<tr>
<td>Patients have no follow up (f/U)</td>
<td>29 (46%)</td>
<td>6 (19.4%)</td>
</tr>
<tr>
<td>F/U colonoscopy 1</td>
<td>2.6 yrs</td>
<td>2.2 yrs</td>
</tr>
<tr>
<td>Median duration</td>
<td>Normal MC (LC/CC)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td></td>
<td>12 (60%)</td>
<td>8 (57.2%)</td>
</tr>
<tr>
<td>F/U colonoscopy 2</td>
<td>6.6 yrs</td>
<td>6.2 yrs</td>
</tr>
<tr>
<td>Median duration</td>
<td>Normal MC (LC/CC)</td>
<td>8 (80%)</td>
</tr>
<tr>
<td></td>
<td>2 (20%)</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>Median follow up duration</td>
<td>5.9 yrs</td>
<td>4.7 yrs</td>
</tr>
<tr>
<td>Treatment given</td>
<td>Budesonide Colestyramine Mesalazine</td>
<td>Budesonide Colestyramine Mesalazine</td>
</tr>
<tr>
<td></td>
<td>Salazopyrin</td>
<td>Salazopyrin</td>
</tr>
<tr>
<td></td>
<td>Prednisolone</td>
<td></td>
</tr>
</tbody>
</table>

Conclusions MC is commonly associated with other autoimmune conditions. A significant proportion of patients had no follow-up/did not seek follow-up which raises the possibility that their symptoms were not problematic. Further follow-up of patients with MC is necessary to gain better insight into the natural history of this condition.

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THE GEOGRAPHICAL DISTRIBUTION OF COLORECTAL POLyps IN THE WEST OF IRELAND POPULATION

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10.1136/gutjnl-2017-314127.54

Background BowelScreen, the faecal immunochemical test based national colorectal cancer screening programme, commenced in May 2013. There is a large variation in the global distribution of colorectal cancer, but there is limited data on local geographic variations.

Aim The primary aim was to investigate for local variations in geographic distribution of colorectal polyps in the UHG BowelScreen catchment area.

Method All screening colonoscopies completed were analysed for the presence of advanced pathology (i.e. polyp ≥10 mm and/or ≥5 polyps detected and/or tumour detected). Only towns with a population ≥1000 as per 2011 census figures were included.

Results Between 2013 and 2016; 1191 colonoscopies were included, with 790 patients having a polyp detected (67% of the total cohort) of whom 295 (25%) found to have advanced pathology. 153/1191 (13%) had polyps≥10 mm in size, 153/1191 (13%) had ≥5 polyps and 32/1191 (3%) had tumours diagnosed based on endoscopic appearance.

The prevalence of large polyps ranged from 3.2-32/10,000 per settlement. Similar trends were seen with respect to multiple polyps (from 0-23/10,000) and cancer (0-5/10,000). Hotspots of advanced findings were particularly notable in east Galway (Ballinasloe, Tuam, Loughrea) and mid Mayo (Swinford, Ballyhaunis, Belmullet).

Conclusions There appears to be a wide local variation in the local geographic distribution of advanced colorectal polyps. This variation may be due to a combination of demographic, lifestyle, environmental or genetic differences in each area. Further study is needed, and could identify areas where bowel screen advertising could be intensified to improve participation rates and yields of endoscopy.

55

PATIENT SURVEY TO ASSESS STOOL TESTING COMPLIANCE

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10.1136/gutjnl-2017-314127.55

Background Stool testing is increasingly used as a GI investigational tool. We are currently conducting a prospective study using non-invasive tests including stool testing in the initial assessment of patients referred to our gastroenterology unit. Faecal sample return rate in our study is 60% for patients<50 years, and 75% for ≥50 years.

Aim A patient survey was conducted to identify (1) reasons for reduced faecal testing compliance, and (2) ways to improve it.

Method The anonymous survey was randomly distributed to patients in gastroenterology clinics over 4 weeks.

47
Results Of 282 surveys distributed, 226 (80%) were returned. 3 were excluded. 223 surveys were stratified into group A: age <50 years (n=120), and group B: age >50 years (n=103). 87 (39%) patients were previously asked to provide a stool sample by a medical professional; 48 in group A and 39 in group B. 53% were male. 81 (93%) patients returned the faecal sample, with no statistically significant difference between the two groups. 82% and 84% felt adequately informed regarding the indication and method for stool collection. Reasons for not completing stool testing in 6 patients were, uncomfortable with test or technical difficulty. The good compliance with stool testing which does not correlate with our previous clinical experience, suggests those not completing stool testing were less likely to participate in the survey. 

Conclusions Compliance may be improved by patient education, user friendly stool collection kits, and a public based strategy addressing attitudes, fears, and awareness of stool testing.

56 PERFORMANCE OF A NOVEL MOLECULAR STOOL SCREENING TEST, THE FAECAL COLOGUARD® IN A COHORT OF IRISH SYMPTOMATIC AND SURVEILLANCE PATIENTS

A Alakkan*, BM Ryan. Department of Gastroenterology, and Clinical Medicine, Adelaide and Meath Hospital, and Trinity College, Dublin, Ireland

10.1136/gutjnl-2017-314127.56

Background Screening tests for precancerous polyps and early CRC reduce mortality. Cologuard is a stool-based, commercially available, molecular screening tool that detects occult blood in combination with multiple DNA abnormalities released from neoplastic colonic cells (from small polyps to cancers). Previous population-based studies reported a sensitivity and specificity of 69%/—92% and 87% respectively for detection of polyps.

Aim To evaluate the Cologuard in asymptomatic low risk surveillance and symptomatic patients.

Method Ethics approval was obtained and patients were recruited from endoscopy referrals and the colonoscopy surveillance waiting list. Inclusion and exclusion criteria in Table 1. Participants provided stool for Cologuard prior to colonoscopy. Cologuard and Colonoscopy results were correlated to calculate NPV, PPV, sensitivity and specificity.

57 COLONOSCOPY FOR WEIGHT LOSS – A WASTE OF RESOURCES OR AN IMPORTANT INDICATION?

D Storan*, G Harkin, J Rasool, K Naavati, M Altarab, E Slattery. University College Hospital, Galway, Ireland

10.1136/gutjnl-2017-314127.57

Background Unintentional weight-loss is a common clinical encounter. Frequently, these patients are referred for colonoscopy to rule out lower gastrointestinal pathology. Aim Determine the diagnostic yield in colonoscopies performed for unintentional weight-loss (WL-O) versus weight-loss and associated GI symptoms (WL-GIs).

Method Retrospective analysis of colonoscopies performed in our centre (May 2013-July 2016). Data was obtained from the Endoscopic Reporting System. Baseline characteristics were established. For sub-analysis, we stratified our cohort into four age groups (<30 years, 30-54 years, 55-74 years and >75 years). Results Of 5290 colonoscopies performed, 240 met our inclusion criteria (WL-O n=83, WL-GIs n=157). Baseline demographics were similar in both groups (WL-O Male 54%, mean age 56 years (SD ±16.6) compared with WL-GIs Male 52%, mean age 58 years (SD ±17.2)). Caeal intubation rates were similar in both groups (88% WL-O, 86% WL-GIs). Overall, colonoscopy was normal in 37.9% (64/169) and diverticulosis was detected in 24.9% (42/169), Colitis in 3% (5/169) and adenoma/polyp in 33.4% (85/240). For diagnostic yield between WL-O and WL-GIs, advanced adenoma detection rate was 7.2% (n=6) versus 8.3% (n=13) and CRC detection rate was 2.4% (n=2) versus 2.5% (n=4). CRC plus advanced adenomas was 9.6% (n=8) versus 10.8% (n=17)(p=0.774). Notably, in the WL-O group no high risk pathology was detected in colonoscopies in patients>75 years compared with n=3 in the WL-GIs group.

Conclusions For both groups diagnostic yield was low, comparable to the asymptomatic general population. Diagnostic yield is extremely low in colonoscopies for weight-loss only in patients>75 years. Weight-loss may not be a valid indication for colonoscopy, particularly in >75 years.
Background: Manometric studies are known to be inadequate in evaluating tone and opening patterns of digestive sphincters. The functional lumen imaging probe (FLIP) evolved as an important tool in evaluating sphincteric regions in the gastrointestinal tract.

**Method**

One subject volunteered for the procedure as the probe is already approved for diagnostic use in the gastrointestinal tract. The EndoFLIP system (Crospon, Galway, Ireland) was set up as previously described using probe model EF-353. An Olympus therapeutic endoscope was inserted as per normal upper gastrointestinal investigation. The probe was inserted into the endoscopic biopsy channel and positioned straddling the pylorus. Distension measurements were made with probe volumes of 20 ml, 30 ml and 40 ml before and after the administration of 10 mg of metoclopramide (Primperan).

**Results**

Activity dramatically changed in the pylorus after Primperan. The narrowest region the sphincter measured using the minimum cross sectional (CSAmin) area was relatively inactive and stable before the drug but after the CSAmin varied significantly during the 20 s measurement window, indicating changes in activity.

**Conclusions**

The FLIP system can successfully measure distensibility in the pylorus and these measurements may be useful in determining proper function in the region.

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**TAILORED THERAPY FOR RESCUE TREATMENT OF HELICOBACTER PYLORI INFECTION**

'D Brennan, M Hussey, D Tye, C O'Morain, S Smith, D McNamara. Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin, Ireland and School of Pharmacy and Pharmaceutical Sciences, Trinity College Dublin, Ireland. Joint last authors

Background: Due to increasing prevalence of antibiotic resistant Helicobacter pylori, the number of patients who require rescue treatment (after >1 failed eradication attempts) is increasing. First-line treatment for H. pylori is not standardised, therefore it’s difficult to recommend a specific rescue treatment. Prescribing a tailored regimen based on antibiotic sensitivities upon first eradication failure may be most effective.

**Aim**

To examine the efficacy of a tailored regimen based on antimicrobial susceptibility as a rescue treatment for H. pylori.

**Method**

Patients previously treated for H. pylori and undergoing endoscopy were prospectively recruited. Biopsies from H. pylori-positive patients (CLO test) were processed for sensitivity testing. Patients received treatment based on antibiotic sensitivities, for 7/14 days. A follow-up breath test was performed 8 weeks post-treatment.

**Results**

Of 881 gastroscopies done between April 2013-February 2017, 190 (22%) were H. pylori positive. Of these, 76 (40%) were previously treated: 41 (54%) received one prior treatment and 35 (46%) received >1. To date, 44 (58%) patients have completed the study; 20 (45%) received levofloxacin triple therapy; 10 (23%) a PPI and 2 antibiotics based on their sensitivities; 10 (23%) bismuth quadruple and 4 (9%) clarithromycin triple therapy. The efficacy of tailored treatment by intention-to-treat and per protocol analysis was poor, at 47.3% (26/55) and 59.1% (26/44) respectively. Patients who received one previous treatment were significantly more likely to achieve eradication than those who received >1 previous treatment (76.2% vs 43.5%, p=0.04).

**Conclusions**

Rescue eradication rates are disappointing and emphasise the importance of eradicating H. pylori infection the first time round.
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Date of preparation: August 2016. UK/EVC/0416/0004(1).
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...TARGAXAN® rifaximin–α reduces the risk of recurrence of overt hepatic encephalopathy.¹

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References:

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UK: X/0416/0201
Date of preparation: October 2016.

UNited Kingdom – Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at NorGINE Pharmaceuticals Ltd on 01952 826600.
PREVALENCE OF RAS/RAF MUTATIONS IN PANCREATIC CYSTIC LESIONS AND CORRELATION WITH MALIGNANT POTENTIAL

K Taylor*, A Begley, MA Catherwood, A Patterson, L Venkatraman, TF Loe, I Mainie, M Love, M Mitchell, RH Wilson, VM Coyle, P Kelly. Cancer Centre, Belfast City Hospital, Lisburn Road, Belfast, UK

10.1136/gutjnl-2017-314127.61

Background Incidence of pancreatic cystic lesions (PCL) is increasing due to ageing populations and increasing cross-sectional imaging. PCL are often benign but have potential for malignant transformation, particularly mucinous cysts. Surveillance strategies and surgical intervention have implications for health economics and patient morbidity/mortality. Despite multimodality investigation, establishing that a PCL is mucinous and its potential for malignant transformation is frequently inaccurate. Molecular characterisation of these lesions may improve classification.

Aim This exploratory study aims to: determine the prevalence of BRAF, KRAS and NRAS mutations in a cohort of PCL and to correlate these mutations with standard clinicopathological features and patient outcomes.

Method PCR and Sanger sequencing were used to determine KRAS, NRAS and BRAF mutational status of 20 patients with PCL. Patients were identified sequentially from MDM meetings as having PCL and undergoing diagnostic work-up including imaging, cytology and tumour marker measurement.

Results The majority of PCL were incidental findings; 10% (n=2) underwent malignant transformation during the follow-up period. Mutations in BRAF and NRAS were not identified. KRAS mutations were found in 10%. No clear association could be found between mutational status, biochemical markers and clinicopathological characteristics or patient outcome at this stage.

Conclusions There is potential to use mutational status to determine if PCLs are mucinous and likely of malignant transformation, however further investigation in a larger sample set with mature outcome data is required. It is likely that mutational status will be helpful as part of a multimodality classification process that also incorporates radiological, cytological and biochemical assessments.

FOLLOW-UP OF PATIENTS WITH ISOLATED ACTIVE ILEITIS: INCREASING DEVELOPMENT OF OVERT CROHN’S DISEASE OVER TIME


10.1136/gutjnl-2017-314127.62

Background Increased TI intubation at colonoscopy had led to increased identification of mild ileal inflammation. Patients with co-called Isolated Active ileitis (IAI) have mild TI inflammation, no chronicity on histology, and do not fulfill criteria for a diagnosis of Crohn’s Disease (CD). Causes include CD, NSAID use or infection. The natural history of IAI has remained unclear.

Aim Long term follow up of a cohort of patients diagnosed as IAI, to assess evolution to CD, persistent IAI and Self-Limiting Ileitis (SLI).

Method IAI patients were reviewed at a 10 year interval by means of clinical follow up, endoscopy, histology and small bowel imaging (SBI).

Results 50 patients; Median age 48 years; 16/50 (32%) male. At time of follow up, 29/50 (58%) had a follow up ileocolonoscopy with 16/29 (55%) showing persistent ileitis on histology. 38/50 had formal SBI with inflammatory changes on 11/38 (29%). Of the original cohort, SLI, persistent IAI and CD was reported in 7/50 (14%), 7/50 (14%) and 14/50 (28%), respectively. 22/50 patients were lost to follow up. 4 patients developed strictures and 3 required surgery. Predominant presenting symptoms included pain and diarrhoea in all groups, with no statistical difference in smoking, NSAID use and family history amongst the 3 subgroups.

Conclusions Over time a significant portion of patients with IAI evolve to overt small bowel CD. Neither presenting complaint nor clinical risk factors were predictive of disease progression, suggesting these all patients should be under surveillance for disease progression.

10 YEAR FOLLOW-UP STUDY OF THE LONG TERM EFFECTS OF ANTI-TNF THERAPY ON BONE METABOLISM IN A COHORT OF ANTI-TNF NAÏVE IBD PATIENTS

N O’Moran*, G Farrell, R Stack, M Hussey, Y Bailey, C Katz, S Veerappan, D McNamara, A O’Connor, N Breslin, C O’Moran, BM Ryan. Department of Gastroenterology, Tallaght Hospital, and Clinical Medicine, Trinity College Dublin, Ireland

10.1136/gutjnl-2017-314127.63

Background Anti-TNF therapy (ATT) has been shown to have beneficial effects on bone metabolism in the short term, but there is a dearth of long term prospective data.

Aim To evaluate the long term effects of ATT on bone metabolism.

Method Retrospective observational cohort study of ATT naïve IBD patients first evaluated in 2007 by DXA scan and by metabolic bone markers prior to, and one year post commencement of ATT. Patients were invited to undergo repeat DXA scan and serum bone marker measurement.

Results To date, 73% (n=38/52) patients from the original study have been recruited for 10 year follow up. There were 3 deaths, 4 refusals, 7 uncontactable. DXA scans and serum samples have been collected on 24/38 patients. 50% were female, mean age of 44.5 years (range 27-80). 67% (n=16) Crohn’s, 33% (n=8) UC. 6 patients continued with immunomodulator (IMM), 11 with ATT (Adalimumab (n=5), Infliximab (n=6)), 2 with combination therapy (ATT/IMM), 1 with 5-ASA, 4 no treatment.

Mean T score prior to ATT in 2007 was –1.46 (SD +/-1.24), and 0.81 (SD +/-1.04) at 10 years. The baseline and 10 year mean T-scores were –1.53 (SD +/-1.26) and –0.70 (SD +/-1.13) for patients remaining on ATT and –0.97 (SD +/-1.27) and –0.66 (SD +/-1.01) for those off ATT. Serum analyses are in process.

Conclusions In this ongoing 10 year follow up study, results suggest that long term (>10 years) treatment with anti-TNF therapy has a beneficial effect on bone metabolism.
**Background**

Strictures are a serious complication of ileal Crohn’s disease (CD). Current assessment tools poorly differentiate fibrotic from inflammatory lesions and do not predict response. The magnetic resonance index of activity (MaRIA) is a validated means to assess activity. Its ability to characterise fibrosis remains unclear. Recent evidence suggests relative contrast enhancement (REC) of >24% on delayed MRI sequences may accurately detect fibrosis.

**Aim**

Compare MaRIA, REC and biochemical activity in patients with ileal CD.

**Method**

Prospective study of patients undergoing MRE for known CD. MRE was performed as standard with additional coronal T1 sequences 7 min post gadolinium administration. Two independent blinded Radiologists calculated RCE and MaRIA at 70 s and 7 min. Demographics and CRP were recorded.

**Results**

26/29 MRE’s performed had ileal CD, median age = 41 years, male = 10 (38%), RCE > 24% and high T2 signal intensity (SI); 6/26 (23%) and 11/26 (42.3%). REC > 24% occurred in only 1/10 with a visible stenosis. Average MaRIA: 2/26 (7.7%)<7 mild; 3/26 (11.5%) 7-11 moderate; 21/26 (80.7%)>11 severe. MaRIA’s did not change significantly between 70 s and 7 min. As expected T2 SI increased with MaRIA’s>11, 26 x 13 (p<0.001, 95% CI 7.73 to 17.27). RCE did not correlate with MaRIA group, 2 0.09. Consistent with MRE findings, CRP was higher in patients with MaRAI > 11 (13.3 ± 5.2) and lower in patients with RCE > 24% (3.9 vs 14), p=0.04 95% CI 0.37 to 15.71 and p<0.01 95% CI 2.5 to 19.05 respectively.

**Conclusions**

RCE may be a useful adjunct to current MRE and help detect fibrosis in small bowel lesions and warrants further investigation.

**OESOPHAGEAL GRANULAR CELL TUMOURS-A LOCAL CASE SERIES**

1EA Gorman EA, 2D McManus, 3IBM Doyle, 4D McKernan, 5L Marine. 1Department of Gastroenterology, Belfast City Hospital, Belfast, UK; 2Department of Pathology, Belfast City Hospital, Belfast, UK.

**Background**

Granular cell tumours (GCT) are soft tissue tumours that present in the skin/oral cavity, with 5% presenting in the gastrointestinal tract.

We present a local case series, illustrating endoscopic, ultrasonographic and histological appearances of GCT in the oesophagus and subsequent management.

**Aim**

Describing clinicopathological characteristics of oesophageal GCT with follow up.

**Method**

Retrospective case notes review.

**Results**

Case 1-A 51 year old female presented with dysphagia. OGD showed two small oesophageal lesions (<1 cm) at 30/32 cm. Endoscopic Ultrasound (EUS) revealed a submucosal lesion. MDT discussion recommended a conservative approach, with yearly endoscopy and EUS.

Case 2-A 55 year old female presented with lethargy. OGD showed a small oesophageal lesion (0.6 cm) at 34 cm. EUS revealed a mucosal lesion with minimal submucosal involvement. MDT discussion for both patients recommended a conservative approach, follow up for >3 years has shown no ultrasonographic change.

Case 3-A 31 year old male presented with dyspepsia. OGD showed a small oesophageal lesion (<1 cm) at 34 cm. EUS revealed a submucosal lesion. MDT discussion adopted a conservative approach, with yearly endoscopy and EUS, and follow up at 2 years has shown no ultrasonographic change.

Case 4-A 67 year old female presented with dyspepsia. OGD revealed a small oesophageal lesion (<1 cm) in the distal oesophagus. EUS is awaited.

**Conclusions**

GCT’s are rare, with low malignant potential. They are usually asymptomatic, and have a classical endoscopic appearance of a firm, yellow, submucosal lesion. EUS is critical in staging, with MDT discussion. A conservative approach appears justified, with yearly endoscopy and EUS for surveillance.
CONSCIOUS SEDATION PRACTICE IN ERCP: A SINGLE CENTRE REVIEW

A Monged*, D Cheiryen. Beaumont Hospital, Dublin, Ireland

10.1136/gutjnl-2017-314127.67

Background ERCP is a complex endoscopic procedure which requires adequate sedation to increase patient tolerance and improve procedural success. Achieving the desired level of conscious sedation which allows for satisfactory completion of a therapeutic ERCP can be challenging. Few guidelines exist to support appropriate conscious sedation practice in ERCP.

Aim The aim of the study is to evaluate conscious sedation practices for ERCP in a single, tertiary referral centre in Dublin, Ireland.

Method A retrospective analysis was conducted for ERCPs performed from October 2014 to October 2016. ENDORAAD software was utilised to collect data.

Abstract 67 Table 1 Overall drug dosage

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean</th>
<th>Range</th>
<th>Stand Dev</th>
<th>Total (% of 905)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam (mg)</td>
<td>5.7</td>
<td>15–1 mg</td>
<td>2.7</td>
<td>232 (25%)</td>
</tr>
<tr>
<td>Diazepam (mg)</td>
<td>9.8</td>
<td>30–2 mg</td>
<td>4.6</td>
<td>803 (89%)</td>
</tr>
<tr>
<td>Fentanyl (mcg)</td>
<td>83.2</td>
<td>125–25 mg</td>
<td>23</td>
<td>870 (96%)</td>
</tr>
<tr>
<td>Pethidine (mg)</td>
<td>47</td>
<td>100–25 mg</td>
<td>11</td>
<td>204 (23%)</td>
</tr>
</tbody>
</table>

Abstract 67 Table 2 Patients ≥70 years

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean</th>
<th>Range</th>
<th>Stand Dev</th>
<th>Total (% of 419)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam (mg)</td>
<td>5</td>
<td>10–1</td>
<td>2</td>
<td>55 (13%)</td>
</tr>
<tr>
<td>Diazepam (mg)</td>
<td>8</td>
<td>20–2</td>
<td>3.5</td>
<td>329 (79%)</td>
</tr>
<tr>
<td>Midazolam</td>
<td>3.8</td>
<td>10–2</td>
<td>2</td>
<td>35 (8.4%)</td>
</tr>
<tr>
<td>and Diazepam</td>
<td>7.8</td>
<td>17–2</td>
<td>3.6</td>
<td>384 (92%)</td>
</tr>
<tr>
<td>Fentanyl (mcg)</td>
<td>75</td>
<td>100–25</td>
<td>24</td>
<td>1 (0.2%)</td>
</tr>
<tr>
<td>Pethidine (mg)</td>
<td>50</td>
<td>50</td>
<td></td>
<td>100 (25%)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>87</td>
<td>25–100</td>
<td>24</td>
<td>27 (6.5%)</td>
</tr>
<tr>
<td>and Pethidine</td>
<td>42.6</td>
<td>25–50</td>
<td>11.6</td>
<td>55 (13%)</td>
</tr>
</tbody>
</table>

Abstract 67 Table 3 Patients <70 years

<table>
<thead>
<tr>
<th>Drug</th>
<th>Mean</th>
<th>Range</th>
<th>Stand Dev</th>
<th>Total (% of 485)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam (mg)</td>
<td>8</td>
<td>3–15</td>
<td>2.8</td>
<td>46 (9.3%)</td>
</tr>
<tr>
<td>Diazepam (mg)</td>
<td>11.6</td>
<td>3–30</td>
<td>4.8</td>
<td>343 (70.5%)</td>
</tr>
<tr>
<td>Midazolam</td>
<td>5.6</td>
<td>2–10</td>
<td>2.5</td>
<td>96 (20%)</td>
</tr>
<tr>
<td>and Diazepam</td>
<td>10.0</td>
<td>2–30</td>
<td>4.4</td>
<td>309 (63.7%)</td>
</tr>
<tr>
<td>Fentanyl (mcg)</td>
<td>87.8</td>
<td>25–125</td>
<td>20</td>
<td>100 (20.4%)</td>
</tr>
<tr>
<td>Pethidine (mg)</td>
<td>50.9</td>
<td>100–25</td>
<td>11.1</td>
<td>26 (5.4%)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>93.5</td>
<td>25–100</td>
<td>17</td>
<td>148 (30.7%)</td>
</tr>
<tr>
<td>and Pethidine</td>
<td>47</td>
<td>25–100</td>
<td>10</td>
<td>55 (13%)</td>
</tr>
</tbody>
</table>

Results 904 patients had ERCPs in Beaumont hospital under conscious sedation between 2014-2016. The median age was 65.6 (range 19-89). 419 were ≥70 years. The most frequently used benzodiazepine and opiate used for ERCPs in our review was diazepam (89% of all patients), and Fentanyl (96% of all patients). 51% of patients<70 years received more than one benzodiazepine or opiate, compared to 14.8% of patients≥70 years. In total 14 patients required reversal of sedation due to respiratory compromise, of which 11 were ≥70 years.

Conclusion The use of more than one benzodiazepine or opiate was more common in patients<70 years of age. Our data should be compared to that of other tertiary referral centres in Ireland, with the ultimate aim of developing guidelines for conscious sedation practice for ERCP.

THE BIFIDOBACTERIUM LONGUM 35624\* CULTURE TRANSITS IN HIGH NUMBERS THROUGH THE HUMAN GUT

1'S Healy, 1'M Casey, 3'K Kiel, 3'J Quigley, 4'S Shanahan, 4'L Murphy. 1'Alimentary Health Ltd. Building 4000, Cork Airport Business Park, Cork; 3'APC Microbiome Institute, University College Cork, Cork, Ireland; 3'Division of Gastroenterology and Hepatology, Lynda K and David M Underwood Centre for Digestive Disorders, Houston Methodist Hospital, Well Cornell Medical College, Houston, USA

10.1136/gutjnl-2017-314127.68

Background Most probiotic products rely on in vitro laboratory tests to assess transit and lack data on survival through the human gastrointestinal tract (GIT). However, in vitro tests are not representative of the multiple physiological states of the gut.

Aim To confirm transit of the Bifidobacterium longum 35 624 strain, found in Alflöres\*, in different formats in humans.

Method 35 624 strain was administered in a capsule, straw, sachet or milk format to volunteers for 7 days at doses ranging from 1×10^7–1 × 10^10 CFU/day (n=1–6) followed by a wash-out period. The transit of viable 35 624 strain through the human GIT was assessed from stool collected at various timepoints by bifidobacteria selective agar plates and/or typing representative colonies using strain-specific PCR.

Results Independent of form, the 35 624 strain transited in humans to high numbers, ranging from 1 × 10^6 – 1 × 10^8 CFU/g of stool in a dose-dependent manner at Day 7. Furthermore, despite antibiotic use in a 10-year-old cystic fibrosis sufferer (250 mg Zithromax 3 times/week), the 35 624 strain transited well (≥1 × 10^6 CFU/g). Co-administration of the antibiotic and probiotic resulted in a 1 log decrease in levels recovered from stool compared to administration of the probiotic 12 hour post antibiotic.

Conclusion Independent of delivery format, the 35 624\* strain was detected in stool at day 7 in a viable form at levels greater than 1 × 10^5 CFU/g of stool. Transit of viable 35 624\* strain in a patient with long term antibiotic use was confirmed demonstrating that the Zithromax did not affect the 35 624\* viability under the conditions of the experiment.
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Friday 6th October 2017
Park Avenue Hotel, Belfast.

USG Autumn Meeting 2016

Peter Watson President USG, Bryan McLaughlin & Neil Upton MSD
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Colm Moynihan and Declan Barry, Pentax Stand

Dr Mary Shuhaibar

Prof Helen Fenlon

Prof Ian Tomlinson

Dr Cara Dunne and Emer O’Connell, Takeda
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Dr. Maire Buckley and Dr Deirdre O’Donovan

Prof John Crowe and Dr Sinead Byrne

Dr Geraldine McCormick, Dr Richard Farrell and Dr Jane McCarthy, leading the applause
ISG Winter Meeting 2016

Dr Sengupta, Dr James East and Dr Gareth Horgan

Prof Colm O’Morain

Prof Garry Courtney an Dr Orla Crosbie

Mr Jurgen Mulsow and Prof Des Winter

Audience View
Michelle Condell Takeda and Prof Padraic MacMathuna presenting 1st Clinical Oral Prize to Dr Lillian Barry

Michelle Condell Takeda and Prof Padraic MacMathuna presenting 2nd Clinical Oral Prize to Dr Mary Hussey
ISG Winter Meeting 2016

Laragh DeBhulbh, AbbVie and Prof Padraic MacMathuna presenting 1st Poster Prize to Dr Catherine Rowan

Laragh DeBhulbh, AbbVie and Prof Padraic MacMathuna presenting 2nd Poster Prize to Dr Neil O’Morain
ISG Winter Meeting 2016

Prof Deirdre McNamara
Catherine Rowan and Jun Liong Chin
Dr Nadeem Iqbal and Dr Aman Shah Afridi
Steve Betts, Brenda Colton, Karl O’Brien  Mylan
Danielle at the Initiative Stand
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On Target for Remission

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PRECAUTIONS AND WARNINGS: Prior to therapy evaluate renal function and conduct hematological investigations, including complete blood count. Consider liver function testing prior to therapy. During therapy, regularly monitor hepatic and renal function, and hematological status; not for use in patients with renal impairment. Patients with pulmonary disease, particularly asthma, should be carefully monitored. Caution in patients with raised blood urea, proteinuria, liver impairment, previous dyspeptic or peptic ulcer background, and in the elderly. Not for use in patients with a history of mesalazine-induced cardiac hypersensitivity. Monitor closely in patients sensitive to salicylates. Immediately discontinue treatment and seek medical attention for acute symptoms of intolerance such as abdominal cramps or acute pain, fever, severe headache or rash or symptoms of lymphoproliferative disease such as unexplained bleeding, hemorrhages, purpura, anemia, persistent fever or sore throat. Data in children aged 6 to 18 years are limited. Tablets contain lactose (70mg/150mg); not for lactase-intolerant patients. Instruct patients to notify their medical practitioner if they develop any unusual or persistent gastrointestinal symptoms. mesalazine can increase the myelosuppressive effects of azathioprine, 6-mercaptopurine, or thiopurine. Concomitant use of nonsteroidal anti-inflammatory drugs (NSAIDs) may increase the risk of renal impairment. mesalazine may increase the risk of complications of renal function, nephrotic syndrome, renal failure (possibly reversible), oligospermia (irreversibly), chest pain. Frequency not known: exacerbation of colitis, lupus-like syndrome with pericarditis, pleuritis/pneumonia, rash and anaphylaxis.

LEGAL CATEGORY: POM

MARKETING AUTHORIZATION NUMBER: Asacol® 400mg GR Tablets PA 2016/1, Asacol® 800mg GR Tablets PA 2016/2

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DATE OF PREPARATION: February 2016; CCE: 2016/5

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