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Irish Society of Gastroenterology

Summer Meeting

12 - 13 June 2014
Killashee House Hotel
Naas, Co. Kildare

Asacolon 400mg & 800mg GR Tablets

Once Daily treatment for the maintenance of remission in ulcerative colitis

ASACOLON®

mesalazine

On Target for Remission

9 OUT OF 10 patients treated with once daily delayed-release oral mesalazine maintain **clinical remission** at month 6[1]

ASACOLON® 400mg and 800mg GR Tablets: Reddish brown, oblong, coated tablets each containing 400mg or 800mg mesalazine. **INDICATIONS:** Treatment of mild acute ulcerative colitis. Maintenance of remission of ulcerative colitis. Maintenance of surgically-induced remission of Crohn's disease. **DOSAGE AND ADMINISTRATION:** Oral use. To be swallowed whole (not chewed) one hour before food. **Adults: Ulcerative colitis:** Induction of remission: 2.4g daily in divided doses. If required the dose may be increased to 4.8g daily. Maintenance of remission: 400mg tablets: 1.2 to 2.4g per day, once daily or in divided doses, 800mg tablets: 1.6 to 2.4g per day, once daily or in divided doses. **Crohn's Disease:** Maintenance of post-surgical remission: 2.4g per day, once daily or in divided doses. **Elderly:** As for adults, unless renal function is impaired. **Children:** Limited data are available. Children aged 6 and over: Active disease: titrate to individual, latter dose 30 to 50mg/kg/day in divided doses, maximum 75mg/kg/day, do not exceed 4.8g/day. Maintenance: titrate to achieved, initial dose 15 to 30 mg/kg/day in divided doses, do not exceed 2.0g/day. **CONTRAINDICATIONS:** History of allergy to salicylates. Hypersensitivity to mesalazine or any excipient. Severe hepatic or renal impairment. Gastric and duodenal ulcers. Children aged under two years. **PRECAUTIONS AND WARNINGS:** Prior to therapy evaluate renal function and conduct hematological investigations, including complete blood count. During therapy, regularly monitor hepatic and renal function and hematological values. Not for use in patients with renal impairment. Patients with pulmonary disease, particularly asthma, must be carefully monitored. Caution in patients with raised blood urea, peroxiuria, liver impairment, previous myo- or pericarditis or allergic 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 blood dyscrasia such as unexplained bleeding, hematoma, purpura, anaemia, persistent fever or sore throat. Data in children (aged 6 to 18) are limited. Tablets contain lactose (75mg/162mg), not for lactose-intolerant patients. Intact tablets in stool may be simple tablet coating. **INTERACTIONS:** Sulfasalazine decreases absorption of digoxin, but no data on interaction of digoxin with mesalazine. Mesalazine can increase the myelosuppressive effects of azathioprine, 6-mercaptopurine, or thioguanine, concomitant use may precipitate leukopenia. Life-threatening infection can occur. Patients should be closely observed for signs of infection and myelosuppression. Leukocyte and lymphocyte cell counts should be monitored weekly, especially at initiation of combination therapy. Concurrent use of nephrotoxic agents, such as NSAIDs, azathioprine, or mercaptopurine, may in theory increase the risk of renal reactions. Mesalazine may decrease the anticoagulant effect of warfarin. **USE DURING PREGNANCY AND LACTATION:** Limited data on use in pregnancy. One case of neonatal renal failure was reported. Mesalazine crosses the placental barrier. Asacolon should only be used during pregnancy if the benefit outweighs the risk. Caution required during high doses. N-acetyl-5-aminosalicylic acid and mesalazine are excreted in breast milk. The clinical significance has not been determined. Limited data on lactation are available. Hypersensitivity reactions such as diarrhoea in the infant cannot be excluded. Use only if the benefit outweighs the risk. If the infant develops diarrhoea, discontinue breast-feeding. **UNDESIRABLE EFFECTS:** Common: rash, drug fever. Uncommon: anaemia, tinnitus, paraesthesia, pruritus, urticaria, drug intolerance. Rare: headache, dizziness, myocarditis, pericarditis, abdominal pain, alopecia, flatulence, nausea, vomiting, dyspepsia. Very rare: blood dyscrasias, bone marrow depression, agranulocytosis, blood disorder, hypersensitivity reactions such as allergic exanthema, drug fever, Lupus erythematosus syndromes, pancolitis, peripheral neuropathy, allergic and fibrotic lung reactions, pneumonitis, interstitial pneumonia, eosinophilic pneumonia, lung disorder, acute pancreatitis, changes in liver function, hepatitis, blood bilirubin increased, alopecia, myalgia, arthralgia, impairment of renal function, nephrotic syndrome, renal failure (possibly reversible), oligospermia (reversible), chest pain. Frequency not known: exacerbation of colitis, lupus-like syndromes with pericarditis, pleuropericarditis, rash and arthralgia. **LEGAL CATEGORY: POM. PRODUCT AUTHORISATION NUMBER:** Asacolon® 400mg GR Tablets PA 1206/1/2, Asacolon® 800mg GR Tablets PA 1206/1/3. **PA HOLDER: TILLOTTS PHARMA LIMITED.** ©Tillott Drug House, Magna Drive, Magna Business Park, Citywest Road, Dublin 24, Ireland. **DATE OF PREPARATION:** December 2013. **CODE:** 2013/10. **FULL PRESCRIBING INFORMATION AVAILABLE ON REQUEST FROM THE MARKETING AUTHORISATION HOLDER.** Asacolon® is a trademark.

1. Sandborn, WJ et al. Once-daily dosing of delayed-release oral mesalazine (4800 mg tablet) is as effective as twice-daily dosing for maintenance of remission of ulcerative colitis. Gastroenterology. 2010 Apr;138(4):1294-302.

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Welcome Message from the President Professor Humphrey O'Connor

Dear Colleagues and Friends,

It is a great pleasure as President of the Irish Society of Gastroenterology to welcome you to our Summer Meeting at Kilashee House Hotel in Naas. It promises to be a great occasion with a varied and interesting academic programme aiming to keep up with new developments in Gastroenterology as well as revisiting old dogmas. One of the main strengths of our Society is the ability to bring together Physicians, Surgeons, and other Specialties associated with Gastroenterology from all parts of this island and further afield and I certainly hope that this proud tradition will be further enhanced this week.

We kick off on Thursday morning with high-class free. papers followed by two renowned Hepatology speakers , Graham Foster on Hepatitis C and Mark Hudson on managing the complications of Cirrhosis. At present we need constant updating on advances in IBD and the session on IBD should give us that with our own Alan Moss from Boston ably supported by some top oral free papers.

Later on Thursday afternoon we are hosting an important Symposium on Management of Severe Acute Pancreatitis focusing on the important interface between surgical and nonsurgical management and critical lifesaving decisions. Speakers include Ross Carter and Euan Dickson from Glasgow and Gerry McEntee who needs no introduction. It should be a great session.

I hope you then find time to attend the AGM of the Society immediately after the end of presentations on Thursday evening, it should not take any longer than 30 minutes.

Nutrition is key to health and Friday starts with our colleagues from IrSPEN, led by Prof John Reynolds and his team. Our guest speaker Prof. Maria O'Sullivan from TCD brings a wealth of knowledge to her talk on Vitamin D.

The session on Autoimmune Liver Disease brings together three heavyweights in the field led by Prof. David Adams, Prof James Neuberger both from my old alma mater in Birmingham and Galway graduate Prof Michael Heneghan. This should be a very valuable clinical update. The final session of the meeting focuses on the contentious topic of Barrett's Oesophagus led off by Trinity graduate Prof Stephen Attwood on Current Guidelines, Prof Dermot O'Toole on Irish experience, and Prof Nick Shaheen from the US and a genuine world authority in the field. This session promises to be a real highlight.

I would again like to thank our friends from Industry for coming and supporting our meeting in great numbers. On behalf of the Board, I would like to express our deep appreciation for their continued ongoing support

A wholehearted welcome to our nursing colleagues who are critical to the safe and effective delivery of care to our patients. During the year ISG management met with senior officers of ISEN with a view to cementing relations between ISG and ISEN and I am pleased to say that agreement has been reached which will safeguard the relationship well into the future.

Finally, I would like to thank the Board of ISG for their guidance and support, our CEO Michael Dineen, and our office staff. In essence despite all the science and learning, ISG meetings are a lot about meeting up with friends and colleagues and here's to a really enjoyable occasion.

Humphrey O'Connor
President ISG
Consultant Gastroenterologist

In adult patients with moderate to severe active Ulcerative Colitis who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies.[1]

EFFICACY THAT LASTS[1-2,a]

The first and only subcutaneous anti-TNF with 4-week efficacy during maintenance treatment[1,2,b]

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Based on results of PURSUIT Maintenance study.

[a]Patients with body weight less than 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks, thereafter. Patients with body weight greater than or equal to 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks, thereafter.[1]

Simponi

golimumab

Simponi 50mg Solution for Injection in pre-filled pen Simponi 50mg Solution for Injection in pre-filled syringe Simponi 100mg Solution for Injection in pre-filled syringe golimumab. *Prescribing Information Briefer to GP (PIB) (see below prescribing Simponi). Simponi is contraindicated in: Hypersensitivity to golimumab or to any of the excipients. Active tuberculosis (TB) or other severe infection such as sepsis and opportunistic infections. Moderate to severe heart failure (NYHA class III/IV). **Therapeutic Indications:** Rheumatoid Arthritis (RA): Simponi, in combination with methotrexate (MTX), is indicated for the treatment of moderately to severely active rheumatoid arthritis in adults when the response to disease modifying anti-rheumatic drugs (DMARD) therapy including MTX has been inadequate, the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with MTX. Simponi, in combination with MTX, has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function. Psoriatic Arthritis (PsA): Simponi, alone or in combination with MTX, is indicated for the treatment of active and progressive PsA in adults when the response to DMARD therapy has been inadequate. Simponi has been shown to reduce the rate of progression of peripheral joint damage as measured by X-rays in patients with polyarticular symmetrical subtypes of the disease and to improve physical function. Ankylosing Spondylitis (AS): Simponi is indicated for treatment of severe, active AS in adults who have responded inadequately to conventional therapy. Ulcerative colitis (UC): Simponi is indicated for treatment of moderately to severely active UC in adult patients who have had an inadequate response to conventional therapies including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies. **Dosage and administration:** Simponi should be injected subcutaneously. Treatment should be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of RA, PsA, AS or UC. After proper training in subcutaneous injection technique, patients may self-inject, if their physician deems it appropriate. *RA:* Simponi 50mg given once a month, on the same date each month, concomitantly with MTX. *PsA:* Simponi 50mg given once a month, on the same date each month, alone or in combination with MTX. *AS:* Simponi 50mg given once a month, on the same date each month. Clinical response is usually observed within 12-14 weeks of treatment. If, at 4 dosed, Continued therapy should be reconsidered in patients who show no evidence of therapeutic benefit within this time period. In patients weighing more than 100kg who do not achieve adequate clinical response after 3 or 4 doses, increasing the dose of golimumab to 100 mg once a month may be considered, taking into account the increased risk of certain serious adverse reactions with the 100 mg dose compared with the 50 mg dose. *UC:* Patients weighing < 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks. Patients weighing ≥ 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks. During maintenance treatment, corticosteroids may be tapered, following clinical remission guidelines. Clinical response is usually achieved within 12-14 weeks of treatment. After 4 dosed, If lacked dose: If a patient forgets to inject Simponi on the planned date, the forgotten dose should be injected as soon as the patient remembers. The patient should be instructed not to inject a double dose. *Older patients (≥ 65 years):* no dose adjustment required. *Renal/hepatic patients:* In these and patients with renal and hepatic impairment, Simponi is not recommended in these populations. **Contraindications:** Patients with a known sensitivity to golimumab or any of the excipients. Patients with active tuberculosis (TB) or other severe infection such as sepsis and opportunistic infections, patients with moderate or severe heart failure (NYHA class III/IV). **Precautions and Warnings:** Infections: Patients must be monitored closely for infection before, during and for 6 months after cessation of treatment. Exercise caution when considering Simponi in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Simponi should not be given to patients with clinically important active infections. Patients should be advised of the potential risk factors. Bacterial infections including sepsis and pneumonia, Mycobacterial (including TB), invasive fungal and opportunistic infections, including fatalities, have been reported. There was a greater incidence of serious infections, including opportunistic infections and TB, in patients receiving golimumab 100 mg compared with patients receiving golimumab 50 mg. Serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease, could predispose them to infections. There have been reports of active TB in patients receiving Simponi, including patients previously treated for latent TB. Patients should be evaluated for active or latent TB before Simponi treatment. All such tests should be recorded in the Patient Alert Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be monitored closely for signs and symptoms of active TB and advised to seek medical advice if signs and/or symptoms of TB appear. Alcoholic & HBV reactivation Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi. *Malignancies and lymphoproliferative disorders:* Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy; additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded. Rare cases, usually fatal, of hepatosplenic T-cell lymphoma (HSTCL) have been reported, the majority of cases occurred in adolescent and young adult males all on concomitant treatment with azathioprine (AZA) or 6-mercaptopurine (6-MP). The potential risk with the combination of AZA or 6-MP and Simponi should be carefully considered. A risk for the development of HSTCL in patients treated with TNF blockers cannot be excluded. Colon dysplasia/carcinoma: Screen for dysplasia in all patients with UC who are at increased risk or had a prior history of dysplasia or colon carcinoma. In newly diagnosed dysplasia patients the risks and benefits of continued Simponi use should be carefully assessed. Malignancies: All TNF blocking agents including Simponi and Myeloid cell carcinoma (other TNF blocking agents) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancers. Heart Failure: Simponi should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in the event of worsening symptoms of heart failure. Neurological events: Use of anti-TNF therapy, including Simponi, has been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and peripheral demyelinating disorders. Discontinuation of Simponi should be considered if these disorders develop. Carefully consider the benefits and risks before initiation of therapy in patients with a history of demyelinating disorders. Surgery: Patients requiring surgery whilst on Simponi therapy should be closely monitored for infections. Autoimmune processes: If a patient develops symptoms suggestive of a lupus like syndrome following treatment with Simponi and is positive for antibodies against double stranded DNA, treatment should be discontinued. Hematological reactions: There have been post marketing reports of pancytopenia, leucopenia, neutropenia, aplastic anaemia, and thrombocytopenia in patients receiving TNF blockers. Concomitant including concomitant use have been reported infrequently in clinical trials. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant hematologic abnormalities. Vaccinations: Live vaccine administration of Simponi should not be given concurrently. Allergic reactions: If an anaphylactic reaction or other serious allergic reaction occurs, administration of Simponi should be discontinued immediately, and suitable treatment initiated. The needle cover of the pre-filled pen contains latex and may cause allergic reactions in those sensitive to latex. *Special populations:* Adverse events, serious adverse events and increase in infections in patients aged ≥65 were comparable to those observed in younger patients. However, caution should be exercised when treating the elderly, particular attention should be paid to infections. Simponi contains sorbitol (E420). Patients with rare hereditary problems of fructose intolerance should not take Simponi. **Interactions:** Combination of Simponi and other biological therapeutics used to treat the same conditions as Simponi, including anakinra and abatacept is not recommended. **Pregnancy and Lactation:** Administration of Simponi is not recommended during pregnancy and breast feeding. Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Simponi treatment. **Side effects: Refer to SmPC for complete information on side effects.** *Very Common (≥ 1/10):* upper respiratory tract infection, Common (≥ 1/100 to <1/10): bacterial infections, viral infections, bronchitis, sinusitis, superficial fungal infections, anaemia, allergic reactions, abnormally positive, dizziness, headache, hypertension, dyspepsia, gastrointestinal and abdominal pain, nausea, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, rash, pyrexia, asthenia and injection site reaction, virus nasopharyngitis, Serious, including fatal adverse events have been reported including sepsis shock, lymphoma, leukaemia, melanoma, Myeloid cell carcinoma*, hepatosplenic T-cell lymphoma*, leucopenia, thrombocytopenia, pancytopenia, aplastic anaemia, serious systemic hypersensitivity reactions (including anaphylactic reaction), skin exfoliation, neoplasm unspecified, demyelinating disorders, congestive heart failure, arrhythmia, ischaemic coronary artery disease, thrombosis, interstitial lung disease and lupus like syndrome. * Observed with other TNF blocking agents, but not observed in clinical studies with golimumab. **Package quantities:** 1 50 mg pre-filled pen containing 50 mg of golimumab in 0.5 ml solution for injection or 1 50 mg pre-filled syringe containing 50 mg of golimumab in 0.5 ml solution for injection or 1 100 mg pre-filled pen containing 100 mg of golimumab in 1 ml solution for injection. **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** 50 mg Pre-Filled Pen EU/1/09/549/001, 50 mg Pre-Filled Syringe EU/1/09/549/002, 100 mg Pre-Filled Pen EU/1/09/549/003. **Marketing Authorisation Holder:** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands © Merck Sharp & Dohme Ireland (Human Health) Limited, 2013. All rights reserved. **Date of Revision of Text:** October 2013. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. **Date of preparation:** March 2014.

References: 1. EU Summary of Product Characteristics for SIMPONI 21/2014. 2. Sandborn WJ, Feagan BG, Marano C, et al. Subcutaneous Golimumab Maintains Clinical Response in Patients with Moderate-To-Severe Ulcerative Colitis. Gastroenterology 2014;146:85-186.

MSD Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland.

GOLST 111065 0008

ISG Summer Meeting 12th & 13th June 2014
at Killashee House Hotel, Naas

Programme

Thursday 12th June

9.30 **Premium Open free Papers (1-6)**

10.30 **Coffee, Posters viewing and meet the Industry**

11.00 **Session 1 – Liver Free Papers (7-10)**
Sponsored by Norgine

Liver free papers

Prof Graham Foster, Prof of Hepatology.
Barts & London School of Medicine & Dentisry. UK
Title: ***"Hepatitis C - all over bar the shouting?"***

Prof Mark Hudson
Consultant Hepatologist, Newcastle Hospitals
Title: ***"Cirrhosis - an overview of its management and managing the complications"***

12.30 **Lunch, Posters viewing and meet the Industry**

1.30 **Session 2 – IBD**
Sponsored by AbbVie

IBD free papers. (11 – 14)

Prof Alan Moss, Assoc Professor of Medicine,
Beth Israel Deaconess Medical Center. Boston.
Title: ***"Evolution of Biologic Therapy for Inflammatory Bowel Disease"***

3.00 **Coffee, Posters viewing and meet the Industry**

3.30 **Session 3 – Severe Acute Pancreatitis - Critical Decisions and Management**
Sponsored by MDS

Mr Ross Carter, Consultant Surgeon at NHS Greater Glasgow & Clyde
Mr Euan Dickson, Consultant Hepatobiliary & Pancreatic Surgeon at Glasgow Royal Infirmary.

Title: ***"Triggers for Intervention for Acute Pancreatitis"***

Mr Gerry McEntee, Consultant Surgeon, Mater Hospital. Dublin
Title: ***"The Diminishing Role of Surgery in Severe Pancreatitis"***

5.15 **AGM**

7.30 **Reception and Dinner**

Friday 13th June

9.00 **Session 4 – Nutrition**
Sponsored by Norgine

Nutrition free papers (15-17)

Prof. Maria O'Sullivan,
Assoc Prof of Human Nutrition,
TCD/St James Hospital. Dublin.
Title: ***'Vitamin D as an anti-inflammatory therapy in IBD – new hope or false dawn?'***

10.00 **Session 5 – Autoimmune Liver Disease.**
Sponsored by MSD

Prof James Neuberger, Consultant Hepatologist & Hon Professor in Medicine,
Queen Elizabeth Hospital. Birmingham.
Title: ***Update on PBC***

Dr. Michael Heneghan,
Consultant Hepatologist & Transplant Physician
London Liver Centre. UK
Title: ***"Autoimmune Hepatitis: Challenges and Pitfalls"***

Prof David Adams,
Professor of Hepatology & Dean of Medicine
Centre for Liver Research.
University of Birmingham. UK.
Title: ***"PSC – Autoimmune Disease, driven by the Gut"***

11.30 **Coffee, Posters viewing and meet the Industry**

11.50 **Session 6 – Barrett's Oesophagus- What to do ! Barrett's Free Papers (18-20)**
Sponsored by AbbVie

Prof Stephen Attwood, Consultant Surgeon,
Northumbria Healthcare,
North Tyneside Hospital. UK.
Title ***"Guidelines for the Management of Barrett's Oesophagus: the BSG and a Risk Stratified approach"***

Prof Dermot O'Toole, Upper GI Consultant
Title : St James Hospital, Dublin
"Barrett's in Ireland : where are we now?"

Prof Nicholas Shaheen,
Professor of Medicine & Epidemiology.
University of North Carolina. USA.
Title: ***"Why What We Are Doing Now for Barrett's Doesn't Much Matter"***

1.50 **Prize Giving**

2.00 **Close of Meeting and Lunch**

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13th June 2014 KILLASHEE HOUSE HOTEL NAAS

Time	Chair	Speaker	Topic
0830-0900		Registration	
0900-0910	Deirdre Clune		Introduction of new committee members
0910-0920	Margaret O'Donnell	Marina Byrne Corbett, CNM 2 Naas General Hospital	Welcome To Naas!
0920-0950	Mary Hackett Brennan	Ms Nicola Dooley Aut Even Hospital, Kilkenny	Lean Programme and Endoscopy
0950-1020	Margaret O Donnell	Mr Sean Nugent Consultant Gastroenterology Aut Even Hospital, Kilkenny	How irritable is an irritable bowel?
10.20-11.10	**COFFEE**		
1110-1140	Mary Hackett Brennan	All Committee Members	ISEN Going Forward and into the future
1140-1215	Leah Palado	Mr Ian Callanan MBFRCSI MBA Clinical Audit Facilitator	Audits driving you around the bend!
12.15-13.00	Elaine Egan	Prof. David Smith Assoc. Prof. of Health Care Ethics RSCI, Dublin	"More tubes, more probes -- what are you doing to me".
13.00-14.00	**LUNCH**		
1400-1430	Elaine Egan	Dr. Zaid Heetun, SpR Gastroenterology St Lukes Hospital Kilkenny	Have you an Itchy Feeling Pruritius Ani & Proctitis
1430-1500	Mary Hackett Brennan	Dr Momand Khan Registrar Gastroenterology St Luke's Hospital Kilkenny	"Do you quiver on your journey to the liver"? ERCP's
1500-1530	Leah Palado	Johanna Rea CNS & ANP Candidate SVUH, Dublin	Role of CNS & ANP in Endoscopy
1530- 1540	Deirdre Clune	Education Officer	Education updates

Honorary Officers and Board Members:

Professor Humphrey O'Connor
President ISG
Consultant Gastroenterologist

Dr Gavin Harewood, Hon. Secretary ISG
Consultant Gastroenterologist

Dr Barbara Ryan, Hon. Treasurer, ISG
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Dr Karen Hartery,
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Mr Fiachra Cooke,
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Dr Tony Tham,
Consultant Gastroenterologist

Dr Subhasish Sengupta,
Consultant Gastroenterologist

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Professor Larry Egan
Dr Suzanne McKiernan
Professor Paud O'Regan
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Professor Garry Courtney
Dr Richard Farrell
Professor Colm O'Morain

Past Presidents

2011-2013	Professor Aiden McCormick
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2005-2007	Professor John Crowe
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1999-2002	Dr John Collins
1997-1998	Dr Paud O'Regan
1995-1996	Dr Diarmuid O'Donoghue
1993-1994	Mr Gerry O'Sullivan (R.I.P.)
1991-1992	Dr Tom O'Gorman
1989-1990	Professor Tom PJ Hennessy
1987-1988	Dr Michael J Whelton
1985-1986	Professor TG Parks
1983-1984	Mr Joseph McMullin (R.I.P.)
1981-1982	Dr John Fielding (R.I.P.)
1979-1980	Mr Sean Heffernan (R.I.P.)
1977-1978	Dr Robert Towers (R.I.P.)
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1969-1970	Professor Peter Gatenby
1967-1968	Dr Byran G Alton (R.I.P.)
1964-1966	Professor Patrick Fitzgerald (R.I.P.)
1962-1964	Professor Oliver Fitzgerald (R.I.P.)

Speakers Biographical Sketches

Prof. Graham Foster
Barts and the London School of Medicine and Dentistry, UK

Graham Foster is currently Professor of Hepatology in the Centre for Digestive Disease at Barts and The London School of Medicine and Dentistry, London. He completed his medical training in Oxford and The Royal London Hospital, before undertaking a PhD on the effect of HBV on the cellular response to interferon under the supervision of George Stark and Ian Kerr at the Imperial Cancer Research Fund in London. Professor Foster then established clinical and laboratory research at St Mary's Hospital, London, on the effect of HCV on cellular response to interferon prior to taking up his current appointment in 2003. Professor Foster's research interests are the immunomodulatory effects of IFN-α subtypes, and the effect that HCV has on this, and management of chronic hepatitis C infection. He has published widely on the subject of viral hepatitis, and is a regular invited speaker at major international conferences, as well as performing editorial duties for the Journal of Viral Hepatitis, Journal of Interferon and Cytokine Research, and Viral Hepatitis Update.

Dr Mark Hudson

Qualified from Aberdeen University in 1992 and trained in Newcastle Hospitals, King's College Hospital Liver Failure Unit, The Royal Free Hospital and Aberdeen Hospitals. I was appointed Consultant Hepatologist & Gastroenterologist in 1995, and subsequently the Clinical Lead for Heptatology.

Chair and Clinical Lead for the North East & North Cumbria Hepatology work.

Currently a member of the British Association for Studies of the Liver (BASL) Committee and lead for hepatology training and education.

In 2010 I wrote the hepatology curriculum for gastroenterology and sub-speciality training in advanced hepatology.

I am a member of the NHSBT Liver Advisory Group and also a member of the DoH Clinical Advisory Group to the National Clinical Diector of Liver Services.

Dr Karen Hartery
Gastroenterology SpR
Beaumont Hospital Dublin

Karen is a graduate of University College Cork. She is currently working as a Gastroenterology SpR in Beaumont Hospital Dublin and also currently represents the SpR grouping on the board of ISG.

Prof. Alan C. Moss, MD
MD, FACG, FEBG, AGAF
Associate Professor of Medicine,
Harvard Medical School
Gastroenterologist, Beth Israel Deaconess Medical Center (BIDMC)

Education
- Medical School – Royal College of Surgeons in Ireland, MB, BCh, BAO, LRCP&SI 1997
- Residency – Mater Misericoradiae University Hospital, Dublin, 1999-2000
- Fellowship – Mater Misericoradiae University Hospital, Dublin, 2000-2005
- Medical Doctorate (by research) – University College Dublin, 2002-2004
- Advanced Fellowship – Beth Israel Deaconess Medical Center, 2005-2007

Appointments
- Attending Gastroenterologist, Beth Israel Deaconess Medical Center, 2007-

Administrative Roles
- Director of Translational Research, Center for Inflammatory Bowel Disease, BIDMC
- Program Director, IBD Fellowship, BIDMC

Key Honors & Awards
- Fellow of the American College of Gastroenterology
- Fellow of the American Gastroenterology Association
- Fellow of the European Board of Gastroenterology
- Goldwitz-Allen Memorial Lectureship, State University of New York
- IBD Research Award, American College of Gastroenterology

Key Committees
- Immunology & Inflammatory Bowel Diseases Section, AGA Institute Council
- Abstract Review Committee, American College of Gastroenterology
- Pilot Study Steering Committee, CCFA Clinical Research Alliance

Key Editorial Boards
- Associate Editor (US Edition), Oxford Handbook of Gastroenterology & Hepatology
- Associate Editor (IBD), Frontiers in Gastroenterology (BMJ)

Publications Summary
- 97 peer-reviewed papers, 8 book chapters, 2 books as Editor
- Published research in; Gut, Clinical Gastroenterology & Hepatology, American Journal of Gastroenterology, Inflammatory Bowel Diseases, European Journal of Immunology,
- Research cited by 670 independent papers (h-index : 17)

Grant Funding History
- NIDDK, Helmsley Charitable Trust, AGA Foundation and industry

Mr C Ross Carter
MB ChB, FRCS (Glas), FRCS (ICE), MD
Glasgow Hospital

Mr Carter's surgical training was based primarily in the West of Scotland but also involved a period of training in Japan to acquire specific clinical and technical training in the management of upper GI cancers. He has been a tertiary level specialist in Upper GI disease for over 15 years and is now the most experienced of three pancreatic surgeons providing the specialist pancreatic service for the West of Scotland

population. He is the past Honorary Secretary of the Pancreatic Society of Great Britain and Ireland and the Secretary of the Pancreatic Section of the British Society of Gastroenterology. He has an International reputation in his field with over 50 invited International lectures and clinical demonstrations in the last 10 years.

His clinical interests involve the surgical and endoscopic (ERCP) management of gallstone disease, dyspepsia including the surgical management of reflux oesophagitis. He has over 15 years experience in the field of bariatric surgery.

Research: Laboratory and clinic research into the treatment of pancreatic cancer, acute and chronic pancreatitis

Professor David Adams MD, FRCP, FMedSci
Professor of Hepatology, Dean of Medicine
Director NIHR BRU in Liver Disease and Centre for Liver Research

David Adams is Professor of Hepatology and Dean of Medicine for the College of Medical and Dental Sciences. He is also director of the Centre for Liver Research and the National Institute for Health Research (NIHR) Birmingham Liver Biomedical Research Unit and lead for translational research in the MRC Centre for Immune Regulation.

David's clinical interests are transplant hepatology and autoimmune liver disease. Laboratory research interests are focused on mechanisms of immune-mediated liver disease. After initial training in hepatology in Birmingham he continued his immunology training with Dr Stephen Shaw at the Experimental Immunology Branch of the National Cancer Institute, Bethesda, USA before being appointed to the Chair of hepatology in Birmingham in 1997. He is currently an associate editor of Liver Transplantation and the American Journal of Physiology and special section editor for the Journal of hepatology. He served on the scientific committee and governing board of the European Association for Study of the Liver between 2004-2007 and currently sits on its Ethics committee. he was a councillor for the European Society for Organ Transplantation between 2004-2008. He was made a Fellow of the Academy of Medical Sciences in 2000. He has a long-standing interest in understanding how leukocyte-endothelial interactions regulate the recruitment of effector cells in chronic liver disease and his group have defined molecular mechanisms used by hepatic endothelium to control the entry of leukocytes from the blood. They have recently begun to use this information to develop cell therapy for liver disease by targeting pathways involved in the recruitment of damaging effector cells or by promoting the recruitment of therapeutic cells including dendritic cells, stem cells and regulatory T cells that may be used to manipulate immune responses in patients in vivo.

Prof. James Neuberger
Professor James Neuberger is the associate medical director at NHS Blood and Transplant and Professor of Hepatology, Queen Elizabeth Hospital, Birmingham.

He qualified in Medicine at Oxford in 1972 and worked as a Senior House Officer in London and then as a registrar in Leeds.

Appointed to Kings College Hospital Liver Unit as a research fellow in 1976 he went on to be a senior registrar and then Senior lecturer. He became involved in the liver transplant programme run between Addenbrookes Hospital and Kings College Hospital.

Appointed to the Liver Unit in Birmingham in 1987 he is now Consultant and Hon professor in medicine. He has worked in many aspects of liver disease and liver transplantation and has been involved with UK Transplant (UKT) for over 10 years. He is also an editor of Transplantation and on the board of several liver and transplant journals.

Prof Stephen Attwood
FRCS, FRCSI, MCh, MB, BCh, BAO, BA Mod

Areas of interest: Upper Gastrointestinal Surgery, Minimally invasive surgery (Laparoscopy and Flexible Endoscopy) particularly Gastro-oesohageal Reflux disease and hiatus hernia, Barrett's Oesophagus, Gall stones, Abdominal wall hernia and diseases of the spleen and pancreas.

Background Information: Interests in teaching and training of medical students, nurses, other clinical professions and supervisor of post graduate degrees including MD for medical graduates and masters degrees for nursing post graduates.
Research Interests: Research Programmes underway in the area of Gastro-oesophageal reflux disease and its association with oesophageal carcinoma, committee member of the following trials : ASPECT Trial – a National Cancer prevention Trial in patients with Barrett's oesophagus

Cognate Trial – a National Cancer diagnosis and staging trialusing Endoscopic Ultrasuond Lotus Trial – an International Multicentre study on the long term benefits of Laparoscopic anti reflux surgery.

Research Programme underway in the use of Virtual or Augmented Reality in the assessment and trainng of surgeons in Laparosocpic Surgery.

Described and researching the treatment of Adult Eosinophilic oesophagitis, a condition sometimes referred to as Oesophageal Asthma.

Research into minimal invasive treatment of early oesophageal adenocarcinoma using Argon beam plasma coagulator.

Professor of Medicine and Epidemiology Director of the Center for Esophageal Diseases & Swallowing Division of Gastroenterology & Hepatology

Prof. Nicholas Shaheen

Nicholas Shaheen is Associate Professor of Medicine and Epidemiology at the UNC School of Medicine and UNC School of Public Health, and Director of the UNC Center for Esophageal Diseases and Swallowing. He attended college at Harvard University and earned his medical degree at the University of Chicago, Pritzker School of Medicine, where he fulfilled his internship and residency requirements. He completed his clinical fellowship training at UNC, where he also earned his Masters degree at the School of Public Health. He then completed a National Institutes of Health fellowship in Epidemiology.

For the past ten years, Dr. Shaheen has been a faculty member at UNC. His research interest is in the epidemiology and management of esophageal diseases. He is the author of numerous journal articles and book chapters related to reflux disease, motility disorders, Barrett's esophagus, and esophageal cancer. He is currently on the editorial board of Clinical Gastroenterology and Hepatology and Evidence-Based Gastroenterology, and is a reviewer for numerous journals.

Research interests:
Barrett's esophagus, reflux disease, esophageal cancer.
Honors and Awards:

- 2003, 2005, 2007, 2009, 2011, 2012: "Best Doctors in America."
- 2011: Clinical Teacher of the Year, UNC Academy of Educators
- 2010: AGA Institute Master's Award in Gastroenterology Research
- 2006, 2010: Eugene Bozymski Award for Excellence in Endoscopy Teaching, UNC GI Fellowship

Dr Michael Heneghan
Consultant Hepatologist and
Transplant Physician

Dr Michael Heneghan is a Consultant Hepatologist and Transplant Physician at the Institute of Liver Studies, King's College Hospital, London. He is clinical lead for Hepatology and Liver Outpatient services at King's College Hospital.

Dr Heneghan has specific expertise in the assessment and management of Liver Transplant patients in both the pre- and post-transplant phase.

His areas of interest include Autoimmune Liver disease, Hepatocellular Cancer and long-term outcomes of patients with chronic liver disease. He has been involved in live-donor liver transplantation since 1999.

Dr Heneghan graduated from University College Dublin and he undertook Gastroenterology training in Ireland prior to pursuing a career in Liver Disease at King's College Hospital, London, and Duke University Medical Center, Durham, North Carolina, USA.
He subsequently was Medical Director of Liver Transplantation and Asst. Prof. of Medicine at Duke University prior to returning to King's College Hospital in 2003.

He is a member of a number of learned societies including the American Association for the Study of Liver Disease, British Society for the Study of the Liver, American Gastroenterological Association, European Association for the Study of the Liver and the International Liver Transplantation Society where he is a member of the Vanguard Committee.

He is an advisor to the Transplantation subgroup of the Human Tissue Authority and the PBC Foundation. He has published extensively (more than 100 original articles and book chapters) and lectures Nationally and Internationally on the fields of Liver Transplatation, Hepatocellular Cancer, Autoimmune Hepatitis, Vascular liver disease, pregnancy related liver disease and Portal Hypertension.

Prof. Dermot O'Toole
St. James's Hospital & Trinity College Dublin

The upper gastrointestinal cancer team at St. James's Hospital treated or diagnosed 200 patients with oesophageal or gastric cancer in 2007. (Ref. Cancer Audit Programme, St. James's Hospital)
Upper Gastrointestinal Cancer Programme-Key Points

- Rapid access oesophageal clinic. All patients referred are seen within one week.
- Well developed MDT model Specialist Medical gastroenterologist in endoscopic ultrasound, radiofreqency ablation and endoscopic mucosal resection.
- High volume centre for all complex surgeries, including two and three stage resections, transhiatal oesophagectomy and minimally invasive approaches
- Defined link with St. Lukes's hospital
- Integrated perioperative care pathway defined and implemented.
- Audit data published internationally and consistent with consistent with benchmarks from leading centres in Europe and North America
- Consultant medical oncologist
- Consultant radiation oncologist

Prof. Maria O'Sullivan
Clinical Medicine, Associate Professor in Human Nutrition

Associate Professor in Human Nutrition, Trinity College Dublin. A Principal Investigator with a strong research interest in anti-inflammatory roles of vitamin D, obesity and nutrition in digestive diseases. I have several committee roles in Societies such as IrSPEN (www.irspen.ie) and the Nutrition Society.

Editor in Chief of the Proceedings of the Nutrition Society

Member of the Scientific Committee; Member of the Publications Committee, the Nutrition Society UK (2012-) 2012

Chair of the Research Committee, and Management Committee member for the Irish Society for Clinical Nutrition & Metabolism (IrSPEN) 2013

Research Committee Member, Health & Social Care Professions, Ireland 2010

Irish Representative on the Management Committee for the European COST action 'BM1007: Mast Cells and Basophils - Targets for Innovative Therapies 2011-14' 2011-14

Dr Subhasish Sengupta
MD(India), MD (UCD), MRCP(UK), FRCPI

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 worked 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.

Prof. Humphrey O'Connor
President ISG
Consultant Gastroenterologist

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 Tullamore 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 pancreaticobiliary 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 Glen Doherty
Consultant Gastroenterologist

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 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 Crohns 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 Tony C.K. Tham
MB BCh BAO, MD, FRCP, FRCPI

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 60 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies". He is currently co-writing the third edition.

He has contributed to several other book chapters. He is the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency. He sits on the Specialist Advisory Committee for general internal medicine at the Joint Royal College of Physicians Training Board. He is also on the British Society of Gastroenterology committee on clinical standards. He is an assessor for doctors applying for entry into the specialist register. 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.

Dr Johnny Cash
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 Gavin Harewood
Secretary ISG
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 serves as the Secretary for the Irish Society of Gastroenterology. 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.

Dr Barbara Ryan
MD,MSc,FRCPI 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 Techincal 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.

Oral Presentations – Summer Meeting 2014 on 12th. & 13th. June 2014 at Killashee House Hotel Naas

Ref.	Day &Time	Abstract No.	Author	Title
1	Thurs 9.30	14S124	Sinead Smith	Evaluation of a molecular genetics-based approach for the detection of Helicobacter pylori and antibiotic resistance.
2	Thurs 9.40	14S116	Thomas Fitzgerald	Somatostatin immunohistochemistry in gastrointestinal-pancreatic neuroendocrine tumours
3	Thurs 9.50	14S129	Cara Dunne	Colorectal cancer screening in an Irish population using FIT testing
4	Thurs 10.00	14S160	Sarah Whelan	Soluble CD1D: a novel regulator of invariant Natural Killer T cells in human hepatic metastases?
5	Thurs 10.10	14S114	Zaid Heetun	Adalimumab is effective in patients with Inflammatory Bowel Disease in clinical remission on infliximab
6	Thurs 10.20	14S132	Grainne Holleran	Gene expression levels of angiogenic factors in small bowel angiodysplasia
Liver Session				
7	Thurs 11.00	14S171	Zita Galvin	C al significance of minimal hepatic encephalopathy
8	Thurs 11.10	14S107	Brooke Layard	Use of Histoacryl glue injection for acutely bleeding oesophageal varices
9	Thurs 11.20	14S115	Shane O'Driscoll	Liver Transplantation in the Treatment of Hereditary Haemorrhagic Telangiectasia: A Review of Irish Cases
10	Thurs 11.30	14S102	Margaret Connaughton	In Vitro Comparison of Octaplas-Lg, Standard Octaplas and Fresh Frozen Plasma in the Treatment of Coagulopathy Due To Liver Disease
IBD Session				
11	Thurs 13.30	14S118	Edel McDermott	Patient Education in Inflammatory Bowel Disease; a patient-centred, mixed methodology study.
12	Thurs 13.40	14S121	Barry Hall	Crohn's disease in an Irish population - a genotype-phenotype analysis
13	Thurs 13.50	14S163	Marie Boyle	Pregnancy and IBD: Critical analysis of obstetrical, neonatal and maternal IBD outcomes
14	Thurs 14.00	14S167	Aongas Lavelle	Spatial variation in the colonic microbiota in health and ulcerative colitis
Nutrition Session				
15	Friday 9.00	14S133	Lina Zgaga	Plasma Vitamin D Concentration Is Associated with Survival Outcome Following a Diagnosis of Colorectal Cancer
16	Friday 9.10	14S143	Clifford Kiat	Targeting Optimal Metabolic Parameters in Type 1 Diabetes Mellitus and Coeliac Disease: An Extra Challenge
17	Friday 9.20	14S150	Mary Shubaibar	Is there a weakness in bone health strength assessment in IBD patients?
Barretts Session				
18	Friday 11.50	14S111	Finbar McCarthy	IL-1B and SERPINA-3 are novel markers of aggressive Barrett's oesophagus phenotype identified using RNA deep sequencing analysis.
19	Friday 12.00	14S136	Paul Carroll	Minimally invasive Ivor-Lewis oesophagectomy following neoadjuvant chemoradiotherapy for the treatment of oesophageal cancer: First 30 consecutive unselected cases.
20	Friday 12.10	14S127	Ashraf Monged	Endoscopic Oesophageal Stricturotomy as promising modality in the treatment of benign resistant oesophageal strictures

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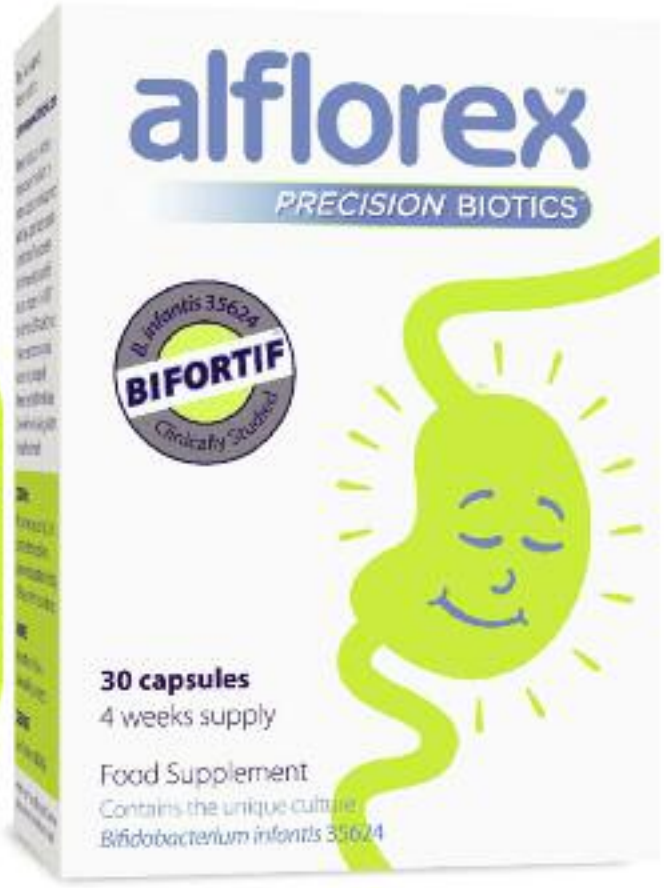

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ABSTRACT 1 (14S124) ORAL PRESENTATION

Title of Paper: Evaluation of a molecular genetics-based approach for the detection of Helicobacter pylori and antibiotic resistance.

Author(s): Sinead Smith[1], Rana Bakhtyar Haider[1], Grainne Holleran[1], Barry Hall[1], Humphrey O'Connor[1], Andy Lawson[2], Colm O'Morain[1,3], Deirdre McNamara[1].

Department(s)/Institution(s): [1]Department of Gastroenterology & Clinical Medicine, Tallaght Hospital & Trinity College Dublin; [2]Gastrointestinal Infections Reference Unit, Public Health England; 3Department of Gastroenterology, Ch

Introduction: Eradication rates for Helicobacter pylori infection have fallen significantly in line with a rapid increase in antimicrobial resistance. The European Helicobacter Study Group has advised local surveillance of antibiotic resistance to guide clinicians in their choice of therapy. Recently developed molecular assays provide an alternative to standard culture and antimicrobial susceptibility testing. Single point mutations (A2146C, A2146G and A2147G) in the H. pylori rrl gene, which encodes a 23S ribosomal RNA component involved in protein translation, confer resistance to clarithromycin. Mutations conferring levofloxacin resistance lie at positions 87 and 91 of the H. pylori gyrA gene, which encodes the A subunit of the DNA gyrase enzyme involved in DNA replication.

Aims/Background: To evaluate the performance of the GenoType HelicoDR assay for the detection of H. pylori and antibiotic resistance compared to standard culture and antimicrobial susceptibility testing.

Methods: Patients (>18 years) undergoing routine gastroscopy, without any known contraindication to standard gastric biopsy, were prospectively recruited for the study and informed consent was obtained. H. pylori infection was detected at gastroscopy by the rapid urease Campylobacter-like organism (CLO) test. Biopsies from H. pylori-positive patients were cultured onto Columbia blood agar for standard antimicrobial susceptibility testing using Etest strips (Biomerieux). DNA was subsequently harvested from the biopsy samples and analysed for resistance-mediating mutations using the GenoType HelicoDR assay (Hain Lifesciences).

Results: To date, 45 samples from CLO-positive patients have been analysed. H. pylori DNA was detected in all of the samples using the GenoType HelicoDR assay. H. pylori was successfully cultured from 56% (25/45) of the infected patients. Molecular testing indicated that genotypic resistance to clarithromycin was 42% (19/45). 18 of the clarithromycin-resistant strains had the A2147G mutation, while 1 had the A2146G mutation. Genotypic resistance to levofloxacin was 11% (5/45). All levofloxacin resistant strains were mutated at position 91 of the gyrA gene. Of the 25 samples from which both culture and molecular test results were available, the concordance in antimicrobial susceptibility data was 84% (21/25). Molecular analysis detected resistance in 4 samples deemed sensitive by the Etest. The time taken to obtain resistance data was 1.5 days and 10 days for the molecular test and culture-based test respectively.

Conclusion: Resistance rates for clarithromycin and levofloxacin in our patient cohort were 42% and 11% respectively. Molecular detection of H. pylori and antibiotic resistance offers a rapid alternative to standard culture and antimicrobial susceptibility testing. In order to assess the potential use for molecular assays in the clinic, further studies to investigate the impact of genotypic resistance on treatment outcome are required.

ABSTRACT 2 (14S116) ORAL PRESENTATION

Title of Paper: Somatostatin immunohistochemistry in gastrointestinal-pancreatic neuroendocrine tumours

Author(s): Fitzgerald T, Murphy J, Sharif O, Nadeem N, Lavelle L, Skehan S, Geoghegan J, O'Shea D, Tamagno G, Swan N.

Department(s)/Institution(s): Departments of Histopathology, Radiology, Endocrinology, Surgery, Oncology / St. Vincent's University Hospital, Elm Park, Dublin 4

Introduction: Overexpression of somatostatin receptors (SSTR's) in gastrointestinal-pancreatic neuroendocrine tumours (GPNET's) is used for tumour localisation, staging and is a target for somatostatin receptor tumour therapy. SSTR scintigraphy with whole body imaging (Octreotide scan) is the standard modality used to confirm overexpression but identification of SSTR in formalin fixed paraffin-embedded tissue samples is an alternative method due to recent commercially available immunohistochemical antibodies.

Aims/Background: The aim of this study was to assess the sensitivity of SSTR immunohistochemistry (IHC) using the two most commonly expressed subtypes (2A and 5), to correlate expression with tumour grade and to compare staining characteristics between primary and metastatic tumour.

Method: A total of 97 GPNET's (36 pancreatic, 61 gastrointestinal) were analysed using a semi-quantitative score.

Results: SSTR IHC was positive in 88% of cases with the majority positive for SSTR 2a (82/97) compared to SSTR 5 (6/97) but with 3 cases positive for SSTR 5 alone. Pancreatic tumours were positive in 92% and gastrointestinal tumours in 85%. There was a negative correlation between advancing tumour grade and SSTR IHC positivity (92% grade 1, 81% grade 2, 36% grade 3). Of the 20 cases with preoperative Octreotide scans available SSTR IHC was positive in all 10 positive scans and was also positive in 9/10 negative scans. There was no difference in the pattern of SSTR IHC staining in the 12 cases where primary and metastatic tumour was available.

Conclusion: SSTR IHC is a sensitive test in GPNET's and should form part of the standard pathological examination for these tumours.

ABSTRACT 3 (14S129) ORAL PRESENTATION

Title of Paper: Colorectal cancer screening in an Irish population using FIT testing

Author(s): Sinnott M, Patchett SE, Mulcahy HE, Carr B

Department(s)/Institution(s): VHI Healthcare, Abbey Street Dublin 1, Bon Secours Hospital, Glasnevin, Dublin 9

Introduction: Colorectal cancer is the commonest internal cancer in the Irish population. The National Colorectal Cancer Screening Program commenced in early 2012 using the faecal immunochemical test (FIT) as a prescreening tool. A single sample is collected and value of 100 ng/ml is used as a cut off point to determine if a sample is positive or negative. Nevertheless, this is an arbitrary value and there are few data on optimum cut-off values.

Aims/Background: We used data from a recent VHI screening program, that measured samples on two occasions, to further investigate cut-off values.

Method: Screening invitations were sent to asymptomatic individuals aged between 50 and 75 years insured with a single healthcare group. Those who responded were sent a screening pack including two FIT kits. Those testing positive (one of two samples with a value of 100 ng/ml or more) were invited for colonoscopic screening.

Results: Two hundred and ninety FIT positive patients (median age 64 years, range 51-75 years; 176 male) completed the study. The cancer detection rate was 6% (18 of 290). In addition, a further 49% (143 of 290) had precancerous polyps, while 8 others had significant non-cancerous pathology including Crohn's disease, ulcerative colitis, radiation proctitis and angiodysplasia. Using a cut-off point of 100 ng/ml, if only sample 1 had been tested, 2 of 18 cancers would have been missed. If only sample 2 had been tested, 2 cancers would have been missed. In contrast, if a cut-off point of 70 ng/ml had been used, a single cancer would have been missed using only sample 1, while no cancer would have been missed using only sample 2

Conclusion: Using a cut off point of 100 ng/ml will likely result in some cancers being missed in a FIT based cancer screening program. This may have implications for the Irish National Cancer Screening Service and for patients attending the service.

ABSTRACT 4 (14S160) ORAL PRESENTATION

Title of Paper: Soluble CD1D: a novel regulator of invariant Natural Killer T cells in human hepatic metastases?

Author(s): Sarah Whelan[1], Ronan Fahey[1], Andrew Lloyd[1], Ravichand Siddachari[2], Margaret O'Brien[1], Justin Geoghegan[2], Cliona O' Farrelly[1]

Department(s)/Institution(s): [1]Comparative Immunology Group, School of Biochemistry & Immunology, TBSI, Trinity College Dublin. [2] Liver Unit, St. Vincent's Hospital, Dublin 4.

Introduction: Human invariant natural killer T (iNKT) lymphocytes are important anti-tumour cells characterised by the expression of an invariant T-cell receptor and found in relatively large proportions in healthy human liver. We have previously shown that iNKT cell numbers and their activity are decreased in livers from patients with hepatic malignancy. iNKT cell function is restricted by the non-classical MHC molecule CD1D but little is known about CD1D in human liver.

Aims/Background: To examine CD1D in liver tissue from brain-dead organ donors and patients undergoing resection for liver metastases.

Method: Reverse Transcriptase - Polymerase Chain Reaction (RT-PCR) was used to detect CD1D in human liver; we found evidence of several splice variants in metastatic liver leading us to hypothesise that a soluble form could inhibit iNKT cells. Bioinformatics analysis using publicly available sequence databases identified and mapped putative splicing events in the CD1D genomic region. A soluble splice variant of CD1D was predicted and primer sets were designed to detect it, which we designated soluble CD1D (sCD1D) as well as the annotated full CD1D transcript. Liver tissue was obtained from donor (n=29) and colorectal cancer patients with liver metastasis (n=28).

Results: Quantitative Real-time Polymerase Chain Reaction (qRT-PCR) revealed high levels of the novel soluble splice variant of CD1D in human tumour bearing liver in comparison to relatively low levels in donor liver tissue (Geometric mean relative expression in donor = 0.0003 and tumour bearing liver = 0.002313, $p<0.0001$).We also detected high levels of sCD1D in serum from patients with colorectal cancer (n=5) in comparison to low levels found in donor serum, (n=10). We then developed a qRT-PCR method for detecting iNKT cells. Having found that this method correlated with flow cytometry, we used it to compare iNKT cell numbers in liver biopsies from healthy donors (n=10) and patients with liver metastasis (n=10). iNKT cells were signficantly depleted in tumour-bearing livers in comparison to normal donor liver, (Geometric mean relative expression in donor = 0.0003 and tumour bearing liver = 0.001725, $p<0.0001$).

Conclusion: Here we show high levels of soluble CD1D and relatively low NKT cell numbers in metastatic liver; we propose that soluble CD1d directly causes iNKT cell depletion, thus inhibiting their important anti-tumour activity. High levels of soluble CD1d in serum from these patients may reflect compromised anti-tumour activity in the liver and therefore provide a novel prognostic tool.

ABSTRACT 5 (14S114) ORAL PRESENTATION

Title of Paper: Adalimumab is effective in patients with Inflammatory Bowel Disease in clinical remission on infliximab

Author(s): Mohmand Khan, Zaid Heetun, Jenny Moloney, Garry Courtney, Abdur Rahman Aftab

Department(s)/Institution(s): St Luke's Hospital, Kilkenny

Introduction: Adalimumab is effective in patients with inflammatory bowel disease (IBD) previously exposed to infliximab.1,2 A prospective randomised trial suggested a detrimental effect of change over from infliximab (INF) to adalimumab (ADA) in patients in clinical remission on infliximab.3

Aims/Background: To evaluate our rates of remission following change of INF to ADA

Method: All patients receiving INF for IBD over the past 7 years were identified from the hospital pharmacy. Names of all patients receiving ADA were obtained from the TCP Homecare Team Database. Patients' names and details were matched with the IBD database. Charts for each patient were reviewed.

Results: Out of 701 patients registered on the dababase, 28 patients were identified as having had both INF and ADA. 5 patients had received ADA first then INF and were excluded from this study. 23 patients (average age 39.9 years, 56.5% females, 26.1% Ulcerative Colitis (UC) and 73.9% Crohn's disease (CD), average follow-up 37.7 months) were changed from INF to ADA. 2 patients (8.7%) received INF as rescue therapy and the remainder received INF for refractory disease. Following INF induction (all patients), 4 patients did not receive INF maintenance. ADA was started after an average of 25.5 months. 11 patients (47.8%) were changed due to convenience (C group), 6 (26.1%) due to loss of response to INF (L group), one (4.3%) due to no response to INF (N group) and 5 (21.7%) because they had previously received INF (T group). In 8 patients (34.8%) ADA had to be increased to weekly – 2 (18.2%) in the C group, 2 (33.3%) in the L group, one (100%) in the N group and 3 (60%) in the T group. 4 patients were changed back to INF – 1 (9.1%) in the C group, 2 (33.3%) in the L group and one (20%) in the T group. Of these 4 patients, 2 patients went into clinical remission, one had surgery and one was changed to thalidomide. Of the 19 patients on ADA, 17 were in prolonged clinical remission (89.5%), one had surgery and one was clinically improved. Overall, 17 out of 23 patients (73.9%) changed from INF to ADA were clinical remission. 10 out of 11 patients (90.9%) in the C group were in clinical remission at follow-up. Neither patient age, sex, disease

duration, diagnosis, presence of fistulae were found to predict dose increase or failure of ADA on multiple logistic regression analysis.

Conclusion: Our data would suggest that change-over from INF to ADA in patients in clinical remission on INF is safe and effective. ADA can also be used to induce clinical remission in patients with loss of response to INF.

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ABSTRACT 6 (14S132) ORAL PRESENTATION

Title of Paper: Gene expression levels of angiogenic factors in small bowel angiodysplasia

Author(s): Grainne Holleran, Barry Hall, Sinead Smith, Deirdre McNamara.

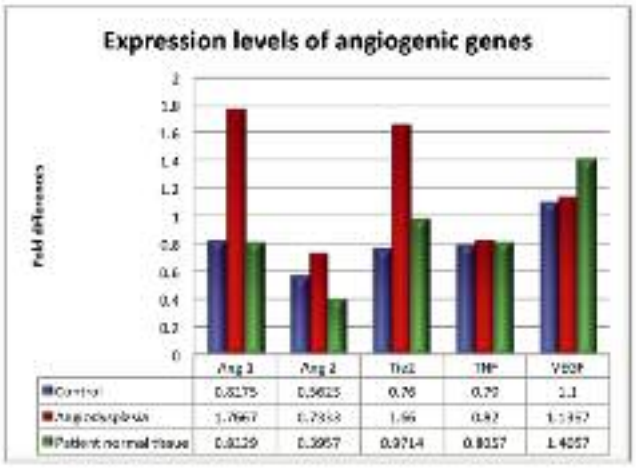
Department(s)/Institution(s): AMNCH and TCD

Introduction: Angiodysplasias are known to account for 50% of small bowel bleeding sources, but diagnosis and effective treatment of these lesions is limited by a poor understanding of the pathophysiology of the condition. By measuring serum angiogenic factors in patients with small bowel angiodysplasias (SBA), we have already identified abnormalities in the angiopoietin pathway; with elevated levels of Ang2 and decreased levels of Ang1, associated with the condition. To determine the significance of these findings we need to determine whether these factors and their receptors are specifically located in SBA tissue.

Aims/Background: To measure gene expression levels of various angiogenic factors and receptors in SBA tissue compared to adjacent normal tissue and to normal SB tissue in controls.

Method: Following informed consent, patients aged 18-80 years of age undergoing double balloon enteroscopy for a variety of small bowel disorders at Tallaght hospital were invited to participate. From patients with SBA, one standard biopsy was taken from a single angiodysplasia lesion, and a further biopsy was taken from macroscopically adjacent normal mucosa. In controls, a single small bowel mucosal biopsy was taken at random. Biopsy samples were immediately placed in RNAlater solution and stored in a fridge overnight before being stored at -80oC for batch analysis. Using a standard technique, RNA was isolated and a reverse transcription reaction was performed on each sample using the Fermantas first strand cDNA synthesis kit (Thermo Scientific). The resulting cDNA was used in quantitative PCR reactions to determine the relative expression of Ang1, Ang2, Tie2, VEGF and TNF. Relative gene expression was calculated using the comparative cycle threshold (CT) method and was normalised to the control gene GAPDH. Statistical analysis was performed using SPSS version 20. Fold differences of each gene were expressed as a mean and compared between groups, with a p value of <0.05 considered significant.

Results: In total, 20 biopsy samples were collected; including 9 from angiodysplasia mucosa, 7 from adjacent normal mucosa, and 4 from normal mucosa in controls. Detectable levels of genes encoding Ang1, Ang2, Tie2, TNF and VEGF were found in all biopsy samples. There were significantly higher levels of Ang1 and its receptor Tie2 in angiodysplasia tissue compared to adjacent normal mucosa and to controls, with mean fold differences of 1.77 vs 0.82 and 0.81 for Ang1 (p=0.049), and 1.66 vs 0.76 and 0.52 for Tie2 (p=0.02) respectively. Levels of Ang2 appeared higher in angiodysplasias than both adjacent mucosa and controls, however; this was only statistically significant between the angiodysplasias and their adjacent mucosa (p=0.04). There were no differences in levels of TNF or VEGF expression between any of the samples.



Conclusion: Expression of levels of genes encoding Ang1 and Ang2 and their receptor Tie2 are higher in the mucosa overlying small bowel angiodysplasias than unaffected mucosa. This further strengthens the identification of the angiopoietin pathway as a key factor in the pathophysiology of SBA formation.

ABSTRACT 7 (14S171) ORAL PRESENTATION

Title of Paper: Clinical significance of minimal hepatic encephalopathy

Author(s): Galvin Z, Dillon A, Lowry D, Russell J, Stewart S.

Department(s)/Institution(s): Mater Misericordiae University Hospital

Introduction: Minimal hepatic encephalopathy (mHE) is the primary cause of cognitive deficits in patients with cirrhosis.

Aims/Background: To investigate if mHE is associated with poorer outcomes and also to determine which psychometric test correlates best with patient outcome.

Method: Consecutive compensated cirrhotic patients attending the outpatient department over a two year period were recruited for the study. Psychometric testing, including the psychometric hepatic encephalopathy score (PHES), the repeatable battery for assessment of neuropsychological status (RBANS) and the critical flicker fusion (CFF) test, were performed at each visit. mHE was diagnosed in clinically unimpaired patients who scored </= two standard deviations(sd) below the mean for each of the psychometric tests. The study endpoints were the development of ascites, hepatic encephalopathy, bleeding varices or death.

*For adult patients with moderately to severely active ulcerative colitis (UC)**

* HUMIRA is indicated for treatment of moderately to severely active Crohn's disease, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or who are intolerant to or have medical contraindications for such therapies. HUMIRA is indicated for the treatment of severe active Crohn's disease in paediatric patients (from 6 years of age) who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies. HUMIRA is indicated for treatment of moderately to severely active ulcerative colitis in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine or azathioprine, or who are intolerant to or have medical contraindications for such therapies.

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Date of Preparation: May 2014 | IBEH/J/5140138

*For adult patients with moderately to severely active Crohn's Disease (CD)**

HUMIRA

Results: Of 124 patients, 11 patients decompensated/had a liver-related death during the study (median follow up 15.4months). On univariate analysis mHE, as diagnosed by the PHES and not as diagnosed by RBANS or CFF, was significantly associated with death/decompensation ($p<0.05$) (Kaplan Meier analysis Log rank 4.23; $p=0.04$). The PHES total score was then dichotomised according to a cut-off point identified by a ROC curve. A cut-off threshold of -2.72 sd below the mean was chosen as the score that gave the highest sum of sensitivity and specificity to predict decompensation or death. A Kaplan Meier analysis, using this threshold to divide the cohort into two groups, was significantly associated with death or decompensation (Log rank 16.18; $p=0.00006$).

Conclusion: Compensated cirrhotic patients with mHE, diagnosed by PHES, are more likely to decompensate and less likely to survive than compensated cirrhotic patients without mHE. Using a cut-off threshold that is lower than that used to diagnose mHE appears to offer an advantage in terms of predicting likelihood of decompensation or death.

ABSTRACT 8 (14S107) ORAL PRESENTATION

Title of Paper: Use of Histoacryl glue injection for acutely bleeding oesophageal varices

Author(s): B.V. Layard, N.I. McDougall, W.J. Cash

Department(s)/Institution(s): The Liver Unit, Royal Victoria Hospital, Belfast

Introduction: Variceal haemorrhage is associated with significant morbidity and mortality in patients with liver cirrhosis. Band ligation remains first line therapy, however, when this fails there are limited therapeutic options available and insertion of transjugular intrahepatic portosystemic shunts is not feasible in some patients. The use of Histoacryl glue injection for primary control of bleeding gastric varices is well published. There is little literature describing histoacryl glue injections in bleeding oesophageal varices.

Aims/Background: To assess the safety and efficacy of Histoacryl glue injection in patients with bleeding oesophageal varices.

Method: We performed a retrospective analysis of cases from a single-centre over a 3 year period (1st August 2010 – 31st July 2013) using a Theatre Management System trawl to identify patients' in whom Histoacryl glue injection was attempted. 8 patients were identified, in whom intravariceal injection of Histoacryl glue was used to control bleeding oesophageal varices. Outcome measures were: initial haemostasis, recurrent bleeding, complications, mortality, results of follow-up OGD and 1-year survival.

Results: 164 patients underwent OGD for acute variceal bleeding or follow–up surveillance. 8 patients received Histoacryl glue injection, all of whom had acute variceal bleeding. Of the 8 patients receiving glue injection, 2 (25%) had failed primary haemostasis immediately post banding; 3 (37.5%) had unsuccessful banding without sengstaken tube insertion , 2 (25%) had unsuccessful banding and sengstaken tube insertion, and 1 (12.5%) had a combined mallory-weiss tear and bleeding oesophageal varices which required treatment with adrenaline injection, followed by banding and subsequent glue injection.

Transjugular intrahepatic portosystmeic shunts were considered for all patients but were either not technically feasible due to anatomical variation or there were contraindications e.g. very high MELD scores or hepatic encephalopathy.

In 6 of the 8 patients (75%), haemostasis was achieved with glue injection, 5 (83.3%) of which experienced no complications from the procedure. 1 patient developed Klebsiella sepsis from a small injection site fistula relating to the oesophageal varix injection but subsequently recovered.
2 of the 8 patients (25%) died from recurrent bleeding, one a late rebleed at day 7 .
Of the 6 patients in whom haemostasis was achieved, initial follow up OGD revealed barely noticeable or eradicated varices in 4 patients (66.7%) and varices requiring rebanding without complication in 2 patients (33.3%).
1-year survival in these 6 patients was 100%.

Conclusion: We conclude that the use of Histoacryl glue injection in the management of bleeding oesophageal varices is safe and efficacious. It is particularly useful for patients who are unsuitable for a TIPS procedure where conventional endoscopic methods have been unsuccessful. Further studies are required to demonstrate the reproducibility of our success rates.

ABSTRACT 9 (14S115) ORAL PRESENTATION

Title of Paper: Liver Transplantation in the Treatment of Hereditary Haemorrhagic Telangiectasia: A Review of Irish Cases

Author(s): Shane O'Driscoll (1), Elaine Ni Mhurchu (2), Daniel Schmidt (2), Aiden McCormick (2)

Department(s)/Institution(s): (1) University College Dublin, School of Medicine and Medical Science (2) St Vincent's University Hospital, Dublin

Introduction: Hereditary haemorrhagic telangiectasia (HHT), or Osler-Weber-Rendu Syndrome, is a genetic vascular condition characterised by the development of arteriovenous malformations which can affect most organs of the body. Studies show that up to 74% of patients with HHT have hepatic involvement but only a minority of patients are symptomatic. HHT-associated liver disease manifests as intrahepatic shunting between arterial and venous systems.

Aims/Background: HHT-associated liver disease is a rare but well described indication for transplantation. This review aims to describe the Irish experience of liver transplantation in this setting.

Method: Between 1994 and 2012 the National Liver Transplant Unit in St. Vincent's University Hospital carried out orthotopic liver transplantation on five patients with hereditary haemorrhagic telangiectasia. Before transplant, four of the patients were diagnosed as having HHT-associated liver disease while one patient was diagnosed with concurrent Primary Biliary Cirrhosis and was excluded from the review. All five patients met the Curacao criteria for clinical diagnosis of HHT. These diagnoses were later confirmed on histopathological examination of the explanted liver after transplant.

Results: The four patients with confirmed liver involvement were all female. Two of the four were related, a mother and daughter. In the four with HHT liver involvement the dominant clinical presentations, classified according to Garcia-Tsao, were: high-output cardiac failure in two, high-output cardiac failure with portal hypertension in one, and biliary disease in one. All four had a raised cardiac output (mean=12.1L/min, range=9.0-16.4L/min). The mean age at time of transplant was 48 years (range=33-70 years). All four are still alive with a mean duration of follow-up of 79 months (range=5-230 months).
After OLT no severe complications were noted aside from an episode of acute cellular rejection in each of the four patients, which

responded successfully to high-dose steroids. Patients also reported an improvement in symptoms at follow-up.

Conclusion: In conclusion, OLT is an important therapeutic option in patients with symptomatic HHT-associated liver disease. It is shown to improve symptoms while having a low level of mortality and morbidity.

ABSTRACT 10 (14S102) ORAL PRESENTATION

Title of Paper: In Vitro Comparison Of Octaplas-Lg, Standard Octaplas And Fresh Frozen Plasma In The Treatment Of Coagulopathy Due To Liver Disease

Author(s): Margaret Ann Connaughton, Jun Liong Chin, P. Aiden McCormick, Paul O'Brien, Joan M Fitzgerald

Department(s)/Institution(s): St. Vincent's University Hospital, University College Dublin, Ireland.

Introduction: Solvent detergent treated plasma (standard Octaplas-SD) from non-renumerated North American donors was introduced in Ireland circa 2002 to minimise transmission of variant Creutzfeldt Jacob Disease. Due to our institutional concerns over its safety and efficacy during liver transplantation, Fresh Frozen Plasma (FFP) is still used intraoperatively.1 Recently, Octaplas-LG (ligand gel), a new prion filtered solvent detergent treated plasma with increased levels of protein S and plasmin inhibitor, has become available.

Aims/Background: We compared the efficacy of Octaplas-SD, Octaplas-LG and FFP in correcting coagulopathy due to chronic liver disease.

Method: 40 samples from 25 patients with chronic liver disease and cirrhosis (INR>1.5) were studied. Quantitative analysis was first carried out on Octaplas-SD, Octaplas-LG and FFP, which included full coagulation screen and factor concentrate measurements. Thromboelastography was used to perform qualitative analysis of in vitro correction of coagulant deficient samples with each plasma product.

Results: Octaplas-LG has slightly higher levels of fibrinogen, Factor V, Factor VIII, Protein C, Protein S and factor, compared to Octaplas-SD and FFP (p>0.05). Qualitative analysis with thromboelastography showed no significant difference in correcting coagulopathy for all three plasma products in vitro (p >0.05). The percentage improvement in R time (16.7%, 17.9% and 19.9%), K time (18.5%, 12.4%, 16.1%), angle (19.4%, 19%, 22.8%) and MA (5.7%, 2.8%, 3.7%), were not statistically significant for Octaplas-SD, Octaplas-LG and FFP respectively.

TEG Measurements (% improvement)	Octaplas SD	Octaplas LG	FFP	P value
R time	16.7	17.9	19.9	0.271
K time	18.5	12.4	16.1	0.153
Angle	19.4	19.0	22.8	0.511
MA	5.7	2.8	3.7	0.172

Table showing percentage change for the various thromboelastography parameter for each plasma product *in vitro*

Conclusion: We conclude that Octaplas-LG and Octaplas-SD is as effective as FFP in correcting coagulopathy for cirrhotic patients in vitro.

ABSTRACT 11 (14S118) ORAL PRESENTATION

Title of Paper: Patient Education in Inflammatory Bowel Disease; a patient-centred, mixed methodology study.

Author(s): E. McDermott, G.Healy, D. Keegan, G. Mullen, K. Byrne, A. Guerandel, K. Malone, G. Doherty, G. Cullen, H. Mulcahy

Department(s)/Institution(s): Dept of Gastroenterology SVUH, Dept of Psychiatry SVUH.

Introduction: Recent consensus guidelines from the European Crohns and Colitis Organisation (ECCO) concluded that optimising quality of care in inflammatory bowel disease (IBD) involves information and education. International literature suggests there is a role for education in improving health related quality of life. However there is no standardised patient education programme in IBD and patient education varies widely from centre to centre.

Aims/Background: To assess patients' education needs in IBD to facilitate design of an IBD patient education programme.

Method: We performed focus groups of 12 patients with IBD and used qualitative analysis to generate hypotheses on patients' perspectives towards education. We then developed a quantitative questionnaire, which was tested on a pilot group of 23 patients. This resulted in a final questionnaire consisting of a series of statements concerning content, medium and outcomes of an educational programme on a Likert scale, from 0-100, with 100 being strongly agree.
The questionnaire was disseminated to 104 consecutive IBD patients attending a tertiary referral centre. 3 patients declined to participate and 3 patients returned incomplete questionnaires. Thus 98 patients (54 male, 59 Crohns disease, median age 38years and disease duration 9 years) were included in the final analysis.

Results: Patients were most keen to receive education on 'what to expect in future', medications and diet, all 3 scoring a median 93/100. They wanted to receive this information from specialist doctors or nurses (93/100) and they believed it could improve their quality of life (80/100). While the internet was the preferred source of general information (i.e. when planning a holiday), it was the least preferred source of IBD education, along with group sessions and educational apps, at 74, 72 and 70 respectively.

Conclusion: This is the first patient-centred study on patient education in IBD. Patients' preferences for education include non-traditional components such as what to expect and diet and patients seem to distrust the internet as an IBD information source. This questionnaire should be validated in other national and international centres and results used for developing a tailored IBD education programme.

ABSTRACT 12 (14S121) ORAL PRESENTATION

Title of Paper: Crohn's disease in an Irish population - a genotype-phenotype analysis

Author(s): B Hall[1], G Holleran[1], S O'Sullivan[2], S Smith[1], B Ryan1, C Medina[2], D McNamara[1]

Department(s)/Institution(s): [1] Department of Gastroenterology, AMNCH, Tallaght, Dublin 24, Ireland [2] School of Pharmacy, Trinity College Dublin, Dublin, Ireland

Introduction: The innate immune system is equipped with pattern-recognition receptors that recognize pathogen-associated molecules, such as the cytosolic NOD2 receptor. Loss of function mutations in NOD2 (G908R, R702W, 1007fs) have been associated with Crohn's disease (CD) and, in particular, with severe phenotypes. However, NOD mutations are thought to occur less frequently in Celtic populations and their association with phenotype is unclear.

Aims/Background: To assess rates of NOD2 mutation and correlate this with disease phenotype in an Irish cohort.

Method: Following informed consent, one 15ml whole blood sample was collected prospectively from patients with established CD and controls. Montreal phenotype was recorded for CD subjects. Individuals with a normal surveillance ileo-colonoscopy, negative histology and lack of symptoms were recruited as controls. DNA extraction was performed using a commercially available kit (QiaAmp DNA). The samples were analysed using PCR (Taqman, Life Technologies) for selected mutations. The frequency of selected NOD2 mutations in blood was compared using genotyping analysis between subjects with established CD and controls. The frequency of mutations was compared between groups and among phenotypes using McNemar's test.

Results: To date, 80 subjects have been enrolled: 56 (70%) with IBD and 24 (30%) controls. Within the IBD cohort 47 (58%) had CD and 9 (12%) ulcerative colitis (UC). In total, 46 (57%) were females with a mean age of 40 years. Ileo-colonic, ileal, colonic, stricturing and penetrating phenotypes occurred in 27 (57%), 13 (28%), 7 (15%), 28 (59%) and 6 (13%) respectively, while 28 (59%) had undergone surgery. In total 23% of subjects had a NOD2 mutation, 16 (34%) CD and 2 (8%) controls, ($p<0.02$, 95% CI 0.04-0.46). Table 1. No patient had more than one mutation and no patient with UC had a NOD2 mutation. Previous surgery ($p<0.08$, 95% CI 0.09-0.62) was strongly correlated with a NOD2 mutation.

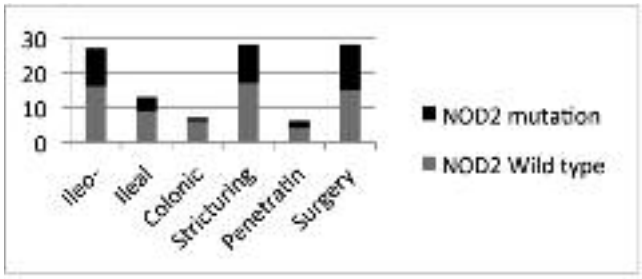

Table 1. Genotype-phenotype analysis

Conclusion: In our cohort, NOD 2 mutations appear more prevalent than previously described in the Celtic population (34% vs 11%). In our study NOD2 SNP's appear to be associated with surgery only and may not be a useful biomarker of severity. A larger analysis is warranted to further correlate NOD2 genotype with clinical phenotype.

ABSTRACT 13 (14S163) ORAL PRESENTATION

Title of Paper: Pregnancy and IBD: Critical analysis of obstetrical, neonatal and maternal IBD outcomes

Author(s): M. Boyle; S. Naimimohasses; P. MacMathuna; J. Leyden

Department(s)/Institution(s): Mater Misercordiae University Hospital, Dublin, Ireland.

Introduction: Inflammatory bowel disease (IBD) affects women during their reproductive years. Particular issues of concern for the female IBD patient include the impact of IBD on fertility and course of pregnancy, drug safety, mode of delivery, neonatal outcomes including congenital anomalies and safety of breast feeding. Close liaison between GI and obstetrical services should be standard of care.

Aims/Background: To analyse the outcomes for mother and baby in a cohort of pregnant women.

Method: Forty seven patients with IBD were identified through the Electronic Patient Record System over the time period June 2010-June 2014. Further information on outcomes was gathered from consultation by telephone.

Result: Of 47 pregnancies in our cohort, 6 patients are currently pregnant and complete data was available in 33.
Pre-Pregnancy disease status: Mean patient age was 34 years; median disease duration was 10 years (Range 1-25 years): 19(57.8%) had Crohns disease, 13(39.3%), ulcerative colitis, 1(3%) indeterminate colitis. 22(66.7%) have colitis, 5 (15.2%) have ileocolonic disease, 4(12.1%) have proctitis, 2(6%) have ilelitis. 2(6%) have perianal disease. Mean number of hospitalisations was 2 per patient (range 0-12). Medications: pulse steroids in the last year in 8(24.2%) and. 9(27.3%) had a history of previous surgery.
Pregnancy History: 32 (97%) conceived naturally with 1 (3%) by assisted reproduction. Women had a mean of 2 pregnancies (Range 1-4). 20 (60.6%) sought pre-pregnancy counselling. 26(78.8%) of pregnancies were planned. 29(87.9%) had quiescent disease at conception of pregnancy. Medications: 7(21.2%) were on no treatment at time of conception. 5(15.1%) were on Azathioprine and biologics, 4(12%) on biologics alone, 2(6%) on Azathioprine alone, 7(21.2%) on Azathioprine and 5-ASA, 8(24.2%) on 5-ASA alone. 4(12%) of patients stopped their medications in pregnancy. Disease recurrence occurred in 13(39.3%) [75% of those who discontinued medications], (23% in 1st trimester, 53.8% in 2nd trimester, 23% in 3rd trimester). Of these, 5/13 (38%) required pulse steroids. 5(38%) 7% required emergency surgery with Progression to delivery. Vaginal deliveries were observed in 74.1% with 36.9% caesarean sections.
Pregnancy Outcome: 7(21.2%) had miscarriages. 26(78.8%) live births. 6(23%) were premature (<40 weeks). 5 (15%) were of low birth weight (LBW, <2.5kg). Neonatal issues recorded: Congenital abnormalities (2/26, 7.6%) [1 cardiac anomaly, 1 microtia].Of the miscarriages, 4/7 (57.1%) were on biologics, 5/7 (71%) had inactive disease at conception and 3/7 (42%) were associated with a flare in pregnancy. Post-partum, 9/26 (34.6%) of women breast fed. 100% continued their medications. 8/27 (29.6%) of patients experienced a disease flare in less than 6 months.

Conclusion: Only 60% of women sought pre-pregnancy advice. 46% of this group experienced disease recurrence. Despite safety data, 12% stopped their medications. 39.3% experienced flares. Approximately one third of women experienced disease recurrence/flare during their pregnancy.Close liaison between GI and obstetrical services should be standard of care and patient education regarding conception and pregnancy in IBD should be incorporated into outpatient IBD care for all women of childbearing age.

ABSTRACT 14 (14S167) ORAL PRESENTATION

Title of Paper: Spatial variation in the colonic microbiota in health and ulcerative colitis

Author(s): Lavelle A[1,2], Lennon G[1,2], O'Sullivan O[3], Docherty N4, Balfe A[1], Mulcahy HM[2], Doherty G[2], O'Donoghue D2, Hyland J2, Ross RP3,6, Coffey JC5, Sheahan K2, Cotter PD[3,6], Shanahan F[6], Winter DC[1,2], O'Connell PR[1,2]

Department(s)/Institution(s): [1]University College Dublin, School of Medicine and Medical Science; [2]Centre for Colorectal Disease, Saint Vincent's University Hospital, Dublin; [3]Teagasc, Food Research Centre, Moorepark, Fermoy, County Cork; [4]Department of Physiology, Trinity College Dublin; [5]4i Centre for Interventions in Infection, Inflammation and Immunity, Graduate Entry Medical School, University of Limerick; [6]Alimentary Pharmabiotic Centre, University College Cork

Introduction: The relevance of alterations of the spatial composition of the colonic microbiota associated with ulcerative colitis, a disease with an intrinsic spatial component, is yet to be fully evaluated. We coupled multimodal sampling with deep sequencing of the gut microbiota to develop an integrated assessment of the microbial community in health and ulcerative colitis.

Method: Four healthy volunteers undergoing routine colonoscopy and five patients undergoing surgical colectomy for medically-refractory ulcerative colitis were sampled at four colorectal locations, incorporating the luminal microbiota, the mucus gel layer and whole mucosal biopsies, yielding a total of 97 samples sequenced to an average depth of 31,642 reads by amplicon-based pyrosequencing. Paired histological samples were scored for mucosal inflammation.

Result: Inter-personal variability was the dominant variable in the combined dataset, accounting for approximately half of the total variance. Within individuals, Asymmetric Eigenvector Map analysis demonstrated differentiation between the luminal and mucus gel microbiota, in both health and ulcerative colitis, with no differentiation between colorectal regions. At a taxonomic level, differentiation was evident between the two cohorts, as well as between the luminal and mucosal compartments, with a small group of taxons uniquely discriminating the luminal and mucosal microbiota in colitis. There was no correlation between regional inflammation and a breakdown in this spatial differentiation or bacterial diversity.

Conclusion: Our study demonstrates overriding conformational stability of the microbiota within individuals, with conserved differentiation between the luminal and mucosal communities. Taxonomic differences between health and UC, as well as between the lumen and mucosa in both cohorts were also evident. The bacterial alterations in our cohort behaved as a field effect and were not correlated with local mucosal inflammation.

ABSTRACT 15 (14S133) ORAL PRESENTATION

Title of Paper: Plasma Vitamin D Concentration Is Associated with Survival Outcome Following a Diagnosis of Colorectal Cancer

Author(s): Lina Zgaga 1, Evropi Theodoratou 2, Susan M Farrington 2, Dominik Glodzik 2, Harry Campbell 2, Malcolm G Dunlop 2

Department(s)/Institution(s): 1 Department of Public Health and Primary Care, Trinity College Dublin, Dublin, Ireland 2 Institute of Genetics and Molecular Medicine, University of Edinburgh, United Kingdom

Introduction: Vitamin D intake may influence cancer survival.

Aims/Background: We set out to determine whether Vitamin D has an effect on survival from colorectal cancer (CRC) in Scotland, where Vitamin D deficiency is prevalent. To mitigate against potential confounding due to reverse causation (advanced CRC could induce Vitamin D deficiency), we tested for association between Vitamin D plasma level and within-stage survival, and we tested for interaction effects between Vitamin D level and genotype at the Vitamin D Receptor (VDR) gene locus.

Method: We prospectively studied 1,598 patients with stage 1-3 CRC. Tumour stage was assigned from detailed clinical, imaging and pathology records. Blood was sampled post-operatively (median 105 days; interquartile range 53-200) and plasma assayed for 25-OHD by liquid chromatography-tandem mass spectrometry. To mitigate against potential confounding effects of reverse causation, we sought association between plasma 25-OHD and stage-specific survival, and tested for interaction between 25-OHD level and genetic variation at the vitamin D receptor (VDR) locus. VDR polymorphisms (rs1544410, rs10735810, rs7975232, rs11568820) were genotyped by Taqman. We recovered haplotypes within the VDR gene using BEAGLE software. We tested for association between CRC-specific/all-cause survival and i) plasma 25-OHD; ii) VDR genotype/haplotype; iii) after applying a VDR genotype/25-OHD interaction term. We conducted Kaplan-Meier survival analysis, then incorporated age, gender, tumour stage/location, operation type, season and time to sampling in Cox proportional hazards models to estimate hazard ratios (HR) adjusted for factors known to affect survival.

Results: In main effect analyses, we found a strong association between lower post-operative 25-OHD concentration and poorer CRC-specific (p=0.002) and all-cause mortality (p=0.0001). Adjusted HR for CRC-specific and all-cause mortality were 0.67 (95% CI: 0.52-0.87) and 0.66 (95% CI: 0.53-0.81) respectively when comparing the highest with lowest tertile of 25-OHD concentration. This effect was particularly apparent for stage 2 disease (CRC-specific mortality HR=0.46, 95% CI: 0.28-0.75, P=0.0019). There was a significant interaction effect between Vitamin D level and (i) VDR genotype (rs11568820) for CRC-specific mortality (P=0.016; P=0.028 for all-cause mortality), (ii) with total number of protective alleles (P=0.005; P=0.022 for all-cause mortality), and (iii) a significant interaction with VDR GAGC haplotype (Cdx2-FokI-BsmI-ApaI) for all-cause mortality (P=0.008; and a suggestive interaction with CRC-specific mortality, P=0.11). VDR genotype itself did not influence survival.

Conclusion: Higher post-operative circulating 25-OHD concentration is associated with substantially better survival in patients with stage 1-3 CRC, following potentially curative management of CRC. The data strongly support a causal relationship, because 25-OHD interacts with VDR genotype to influence survival outcome. These data suggest Vitamin D supplementation may favourably influence CRC outcome.

ABSTRACT 16 (14S143) ORAL PRESENTATION

Title of Paper: Targeting Optimal Metabolic Parameters in Type 1 Diabetes Mellitus and Coeliac Disease: An Extra Challenge

Author(s): Clifford Kiat, Thomas Cotter, Sean Dinneen, Esther O'sullivan

Department(s)/Institution(s): Diabetes Day Centre, Galway University Hospital

Introduction: Patients, especially children, with Type 1 Diabetes (T1D) have an increased risk of developing other autoimmune

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disorders including Coeliac Disease (CD) While the prevalence of CD in the general population is approximately 1%, in patients with T1DM, the prevalence of CD is higher with studies reporting rates between 0.6% to 16.4%.Gluten free diet (GFD) imposes practical limitations in dietary options. Many of the gluten-free foods have a high glycemic index. This might influence glycemic values, HbA1c, insulin requirement, lipid profile, and possibly the development of long-term diabetic complications. Moreover, GFD could modify height, weight, body mass index (BMI)

Aims/Background: To determine whether differences exist in the metabolic parameters of patients with TID and CD compared to those of the with T1D only.

Method: In this study we selected the subgroup of pts with T1D attending our service between June 2011 and June 2013 who have concomitant CD (n=30). To determine whether differences exist in their metabolic parameters compared to those of the total cohort of patients with T1D attending our service in the same time-period (n=905), we did a cross-sectional analysis of clinic measurements of weight, BMI, BP, HbA1c, lipid profiles, albumin creatinine ratios and Tissue Transglutamine IgG antibody titres (TTG) (as a marker of adherence to a gluten free diet).

Results: The CD+T1D group consisted of 18(60%) females and 25(83%) adults (>18 yrs) and had a mean age of 37 (SD 19). The T1D group consisted of 431(48%) females and 798(88%) adults (>18 yrs) and had a mean age of 37(17). HbA1c in the CD+T1D group was 76.4mmol/mol (SD 17.4) vs 70.3 (17.7) in the T1D group. There was no difference between males and females, but in both groups children had higher HbA1c values (83.6 and 75.7 respectively). In the CD+T1D group ADA target Chol, Triglyceride, LDL and HDL values were achieved by 87%, 97%, 87%, 93% respectively compared to 73%, 82%, 62% and 85% in the T1D group. 35% of the former were on cholesterol lowering drugs compared with 31% of the latter. The CD+T1D gp had BMI in target in 68% of cases, the T1D gp in 46%.

Conclusion: CD+T1D presents a challenge to achieving target HbA1c.

ABSTRACT 17 (14S150) ORAL PRESENTATION

Title of Paper: Is there a weakness in bone health strength assessment in IBD patients?

Author(s): Shuhaibar M*, Walsh C, O'Morain C on behalf of the Irish EC-IBD group (part of The European Collaborative study on IBD).

Department(s)/Institution(s): Department of Gastroenterology, Adelaide and Meath Hospital/ Trinity College Dublin, D2

Introduction: Bone health reflected in osteoporosis and osteopenia have been under diagnosed generally and particularly in inflammatory bowel disease (IBD) patients.

Aims/Background: This study aimed to evaluate the rate of DEXA scanning in a prospective homogenous population of IBD patients from the early 1990's in the Greater Dublin area hospitals. We also assessed factors that may affect the ordering of DEXA scans.

Method: In this 19 year follow up study co-ordinated by the IBD research centre at the Adelaide and Meath Hospital, 128 patients were available to complete the study questionnaire following an informed consent. We applied a statistical multiple regression analysis to identify factors that may result in patients having or not having a DEXA scan based on their primary diagnosis of CD or UC.

Results: Overall 46.03% of patients received DEXA scans during the 19 year follow up study until its completion in 2010. Of those scanned 67.44% had CD and 33.73% had UC. Osteoporosis was diagnosed in 26.67% of scanned CD patients and in 21.43% of UC group, whereas osteopenia was diagnosed in 43.33% and 42.86% of CD and UC respectively. There were normal scans reported in 30% of CD and 35.71% of scanned UC patients. Patients were more likely to have had DEXA if they had positive family history of IBD with a $p < 0.0001$and had interest in IBD with $p= 0.007$.

Conclusion: This study outlined the prevalence of osteopenia and osteoporosis in a homogenous prospective IBD cohort and the importance of screening using DEXA scans. Osteoporosis has been recognised as one of the extra intestinal manifestations of IBD in recent international guidelines. Given DEXA rates in our cohort we recommend increasing doctor and patient awareness of bone health in IBD. This will help in improving patients' quality of care and may prevent unnecessary future fractures.

ABSTRACT 18 (14S111) ORAL PRESENTATION

Title of Paper: IL-1B and SERPINA-3 are novel markers of aggressive Barrett's oesophagus phenotype identified using RNA deep sequencing analysis.

Author(s): MacCarthy, Finbar P.1; Duggan, Shane P.1, 3; Feighery, Ronan2; O'Sullivan, Jacintha 2; Phelan, James2; Ravi, Narayanasamy2; Kelleher, Dermot1, 3; Reynolds, John V.2; O'Toole, Dermot1

Department(s)/Institution(s): 1. Dept. of Clinical Medicine, Trinity Centre for Health Sciences, Trinity College Dublin, Dublin, Ireland. 2. Dept. of Surgery, Trinity Centre for Health Sciences, Trinity College Dublin, Dublin,

Introduction: The identification of aggressive markers in Barrett's oesophagus (BO) would help stratify groups at risk of progressing to oesophageal adenocarcinoma (OAC) allowing tailored surveillance strategies. Stratifying progressive BO risk using genomic techniques has been disappointing to date. We have applied a novel high throughput RNA sequencing analysis characterizing the BO transcriptome across the metaplasia-dysplasia sequence to identify potential markers of progression in an unbiased fashion in patients with BO.

Method: Matched biopsy samples for histology and RNA extraction were taken from BO patients of known histological grade (samples were independently examined by two expert GI pathologists to diagnose intestinal metaplasia (SIM), LGD and HGD). RNA was extracted from matched samples and sequenced to 60bp length (paired-end).21 samples were sequenced (HGD,7; LGD, 7 and SIM, 7). Reads obtained were mapped to NCBI build37.2 using TopHat. Read count generation, normalisation and differential expression (DE) analysis was performed using the HTSeq-DESeq pipeline. Significantly DE genes (>2 fold change in expression with B-H adjusted p-value <0.1) were further assessed for network and biological relevance using Ingenuity Pathway analysis. Candidate genes were selected and validated in a larger cohort (n=64) using RT-PCR and the protein expression levels of candidates further validated in a larger independent cohort of patients by serum ELISA and Immunohistochemistry.

Results: A mean of 52.4x106 (range 48-66x106) reads was obtained per sample.14, 003 genes had ≥10 reads mapping in all samples. DE analysis was performed in 3 groups with 2 conditions at

a time using the lower grade cohort as control and the higher grade as comparator: SIM vs. LGD (demonstrated 218 DE genes, 131 up-regulated in LGD, 87 down-regulated compared to SIM), SIM vs. HGD (49 DE, 27 up, 22 down) and LGD vs. HGD (317 DE, 81 up, 216 down). Network and functional analysis of DE genes confirmed overrepresentation of processes involved in oncogenesis (e.g. cell survival, proliferation, and cellular assembly). Six network-central candidate genes (FOSB, IL-1B, SERPINA3, KLK7, GSTM5 &SCUBE2) were selected for RT-PCR validation and 2 genes (IL-1B and SERPINA-3), demonstrated progressive significant increases in expression across the dysplasia sequence to OAC. This was confirmed on protein validation, with highly significant differences in secretions of IL-1B & SERPINA-3 (in serum) between SIM, dysplasia and OAC using ELISA. Further protein validation by Immunohistochemistry in a SIM, LGD and HGD tissue microarray also demonstrated significant increase in expression of IL-1B and SERPINA-3 between SIM and HGD in the epithelial compartment.

Conclusion: The use of RNA-sequencing as a detailed and unbiased analysis method identifies IL-1B and SERPINA-3 as interesting candidates over-expressed along the metaplasia-dysplasia-cancer sequence in BO. Prospective validation of these genes as potential markers of progressive Barrett's phenotype is in progress.

ABSTRACT 19 (14S136) ORAL PRESENTATION

Title of Paper: Minimally invasive Ivor-Lewis oesophagectomy following neoadjuvant chemoradiotherapy for the treatment of oesophageal cancer: First 30 consecutive unselected cases.

Author(s): Paul Carroll, Derek Power, Seamus O'Reilly, Fred Vernimmen, Jennifer Gilmore, Peter MacEneaney, Anitha Griffith, Michael W. Bennett, Tara-Jane Browne, Martin Buckley, Caroline Daly, Thomas Murphy

Department(s)/Institution(s): Department of Surgery, Mercy University Hospital, Cork

Introduction: Trimodality therapy comprising of neoadjuvant chemoradiotherapy and oesophagectomy is an established treatment for resectable locally advanced oesophageal cancer. In an effort to reduce the morbidity associated with open oesophagectomy minimally invasive techniques have been developed, however concerns remain regarding feasibility, safety and oncological validity.

Aims/Background: We report the results of our first 30 consecutive unselected minimally invasive Ivor-Lewis oesophagectomies (MIO) following carboplatin and paclitaxel chemotherapy with concurrent radiotherapy (41.4Gy in 23 fractions).

Method: A prospective database of all MIO following neoadjuvant chemoradiotherapy between 2011 and 2014 was reviewed. The operative approach consisted of a laparoscopic mobilization of the stomach with formation of a gastric conduit, pyloroplasty, jejeunostomy, thoracoscopic mobilization of the oesophagus with an en bloc 2-field lymphadenectomy and a thoracoscopic stapled high intrathoracic anastomosis.

Results: The median age was 65 years (range: 41-76) and 80% were male. 80% were adenocarcinoma and 20% squamous cell carcinoma. There was one conversion to open thoracotomy. 70% of patients had an uncomplicated post-operative course. 20% were treated for atrial fibrillation and 13.3% for pneumonia. There was one anastomotic leak. Median length of stay was 8 days (6-25 days). 30-day/in-hospital mortality was 3.3%. 30-day post discharge readmission rate was 13.3%. 93% had a curative (RO) resection with an overall median lymph node yield of 30 (15-58 LNs).

Conclusion: Minimally invasive Ivor-Lewis oesophagectomy is feasible and can be safely incorporated into the trimodality treatment of oesophageal cancer in an Irish healthcare setting with low morbidity and mortality with reduced hospital stay and excellent short-term oncological outcomes.

ABSTRACT 20 (14S127) ORAL PRESENTATION

Title of Paper: Endoscopic Oesophageal Stricturotomy as promising modality in the treatment of benign resistant oesophageal strictures

Author(s): Monged A, Mohamed G, O'Suilleublian C*, Buckley M

Department(s)/Institution(s): Gastroenterology Department, Department of surgery*, Mercy University Hospital, Cork, Ireland.

Introduction: The majority of benign oesophageal strictures result from long-standing gastroesophageal reflux disease . Treatment usually involves dilation combined with acid-suppressive therapy. Other causes of resistant strictures include post radiation, oesophageal sclerotherapy, caustic ingestions and surgical anastomosis. In the majority of patients, this can be accomplished with oesophageal dilation, though in cases of refractory strictures, additional therapy is required. There is little published data on the treatment of resistant esophageal strictures (ROS).

Aims/Background: To describe our experience with Endoscopic Oesophageal Stricturotomy (EOS) for resistant oesophageal strictures

Method: From January 2012 to July 2013 all patients with oesophageal strictures resistant to treatment with balloon dilatation +/- bougienage were selected for EOS. Data on Age, sex, co-morbidity, clinical presentation, procedural details, and outcome were retrospectively collected, anonymized, and analized. Endoscopic Oesophageal Stricturotomy procedures were exclusively done by an experienced endoscopist (M.B.) . Patient with resistant strictures assessed for suitability for Stricturotomy. Using Needle knife stricturotome (RX Needle Knife Boston scientific/ 5.5 F/1.8mm). Four quadrant incisions were made and tissue excised. Stricturotomy was followed by hydrostatic balloon dilatation if residual stenosis was present.

Results: A total of five male dysphagic patients; median age 58, (range 29-81), with resistant oesophageal strictures was treated with EOS, during the study period. Two patients had strictures due to peptic fibrosis, two due to exposure to radiotherapy, and one had post surgery for oesophageal atresia. 80% (4/5) had multiple previous trials of unsuccessful balloon. One session of Stricturotomy was enough for 80% of patients, however, for one patient (20%) EOS was needed to be repeated 5 times. Only 40% (2 patients) needed balloon dilatation following the EOS. In all patients, successful response following initial EOS was obtained.

Conclusion: EOS is highly effective in treating selected patients with resistant benign oesophageal strictures. Initial response has been achieved to all five patients, refractory oesophageal stricture was noted in one patient, that has finally showed good response after the 5th Stricturotomy session. Short focal strictures may be more suitable for EOS.The risk of perforation following EOS is not yet known, and need to be elucidated in longer studies.

Conclusion: Stricturotomy is a valuable method in the treatment of patients with resistant oesophageal strictures.

ABSTRACT 21 (14S144) POSTER PRESENTATION

Title of Paper: Fully Covered Self-Expanding Metal Stents (FCSEMS) in Management of Difficult Common Bile Duct (CBD) Stones.

Author(s): K Hartery[1], C Lee[2], HE Mulcahy[2] F Murray[1], SE Patchett[1]

Department(s)/Institution(s): Beaumont Hospital[1] and St. Vincent's University Hospital2, Dublin, Ireland.

Introduction: Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy is the treatment of choice for CBD stones. However, 20% of patients will require at least 1 repeat ERCP when duct clearance is unsuccessful. These "difficult cases" include patients with stones >1cm, >3 stones, impacted stones, difficult anatomy, or high-risk patient due to other co-morbidities. Guidelines from ESGE, ASGE, and BSG advocate the temporary placement of stents to relieve biliary obstruction with the belief that the constant friction forces generated may assist in stone fragmentation facilitating stone extraction at future ERCP. Following insertion of a plastic stent, a 70% complete duct clearance rate has been observed with the remainder requiring repeat stenting. It has been further postulated that FCSEMS due to their greater outward radial force may be more efficient in this role in comparison to plastic stents.

Aims/Background: We evaluated the efficacy and safety of FCSEMS at two Dublin-based medical centres in the management of complex biliary stone disease. This retrospective case review included 20 patients who underwent ERCP with insertion of FCSEMS for complex biliary stone disease over a 20-month period.

Method: All patients in whom a covered metal stent was inserted for indication of failed duct clearance of CBD stones were identified retrospectively from an electronic reporting system (Endorad). Patients in whom FCSEMS were inserted for indications other than stone disease were excluded from review. Patients' ERCP reports were reviewed for demographics, and interventions performed. Information on CBD stone size and number was compiled from radiology reports. Duct clearance was considered successful when balloon occlusion cholangiogram revealed a clear duct.

Results: Biliary FCSEMS were inserted in 20 patients over a 20 month period. The mean age of the patients was 61.7 years (IQR, 50.5-70); 8 were male. The mean stone size and number was 1.2cm and 2.3 respectively. The mean number of ERCPs performed prior to FCSEMS insertion was 1.2. In some patients FCSEMS were inserted at initial failed ERCP (n=5). In these 5 patients, the average stone size and number was 1.5cm and 2.2 respectively. Mechanical lithotripsy was used in 1 patient. To date 13 stents have been removed with average stent in situ for 76.8 days. The average follow-up period post stent removal was 165.6 with range of 4 to 549 days. There was a 100% (13/13) success rate.. Two patients suffered mild-moderate post-ERCP pancreatitis requiring conservative management as inpatient. There were two cases of distal stent migration, neither of which was clinically significant.

Conclusion: The use of FCSEMS is a promising option enabling adequate biliary drainage and successful clearance in most patients with complex biliary stone disease. Due to the higher cost of these stents their use should be individualized to appropriate patients.

ABSTRACT 22 (14S168) POSTER PRESENTATION

Title of Paper: Inflammation associated transcription changes and up-stream regulators in inflamed tissue from Ulcerative Colitis.

Author(s): Balfe Aine[1,6]; Lennon Grainne[1,6]; Killick Kate[2]; Spillane Cathy[3]; Lavelle Aonghus[1,6]; Blackshields Gordon[3]; Docherty G. Neil[4]; Coffey J. Calvin[5]; Winter Desmond[6]; O'Connell P. Ronan[1,6]

Department(s)/Institution(s): (1) School of Medicine and Medical Science University College Dublin Ireland (2) Systems Biology Ireland, University College Dublin Ireland (3) Molecular Pathology Research Group, Department of Pathology, Trinity College Dublin (4) Conway Institute of Biomolecular and Biomedical Sciences, School of Medicine and Medical Science University College Dublin Ireland (5) Graduate Entry Medical School, University Hospital Limerick University of Limerick Ireland (6) Centre for Colorectal Disease, St. Vincent's University Hospital Dublin Ireland.

Introduction: Systems biology analysis of transcriptomic data has the potential to elucidate complex biological mechanisms. Most current methods interrogate gene sets and their pathways; however genes and pathways are connected via up-stream regulators and networks.

Aims/Background: This study investigated the altered molecular functions, canonical pathway and up-stream regulators associated with inflammation in Ulcerative Colitis (UC).

Method: Snap frozen biopsies were collected from 3 healthy controls and 4 patients with active UC at 4 colonic regions (caecum, transverse, left, rectum), yielding a total of 28 samples. Global gene expression analysis was performed using Affymetrix GeneChip Human Gene 2.0ST array. Paired biopsies were stained for characterisation of inflamatory cell infiltrates. Differentially expressed genes were identified (FDR≤0.05). Ingenuity Pathway Analysis (IPA) was used to identify over-represented functional categories, canonical pathways and up-stream regulators.

Result: Increased inflamatory associated gene expression and pathways were observed in biopsies from inflamed UC tissue. This was consistent with observed elevated inflamatory cell infiltrates in the corresponding paired biopsies. IPA identified Lipopolysaccharide (LPS) as the dominant up-stream activator of differential gene expression between health and UC (Zscore>3.316). 263 genes were associated with LPS regulation. Additional network analysis indicated LPS stimulated the expression of IFN□, IL-1□, IL-4, TNF, and NF□B.

Conclusion: LPS is a potent toxin secreted by gram negative bacteria that inhabit the human colon. It's known to elicit inflamatory responses in *in-vivo* cell culture models and *in-vitro* models of UC. These data further support the hypothesis that bacterial derived stimuli have a role to play in UC. This study demonstrates the potential to elucidate the complex network of inflammatory pathways and regulators involved in disease.

ABSTRACT 23 (14S103) POSTER PRESENTATION

Title of Paper: Early Experience of High Resolution Manometry in a Specialist GI Physiology Centre

Author(s): Lawlor P+, Moran T+, Brennan M+, Macarthy F++, Ravi N*, Reynolds JVR*.

Department(s)/Institution(s): +GI Function Unit, St James's Hospital, Dublin. ++Department of Gastroenterology, St James's Hospital, Dublin. *Department of Surgery, Trinity Centre for Health Sciences, St James's Hospital, Dublin.

Introduction: Oesophageal water perfused manometry has been in common use for approximately 30 years for both the diagnosis and

investigation of motility disorders. High resolution manometry (HRM) is a new technology which has many advantages over conventional manometry, including simplicity, shorter procedure time, and a more detailed analysis of the lower oesophageal sphincter (LOS) using integrated relaxation pressure (IRP) and intrabolus pressure (IBP). One of the most interesting developments with HRM has been the classification of achalasia into distinct subtypes, something which is difficult to do with standard manometry. HRM uniquely details dynamic function of the Upper Sphincter and allows for the assessment of oesophageal peristalsis in relation to contractile pressure, oesophageal clearance and outflow resistance.

Aims/Background: A review of 92 patients referred to a specialist centre in 2012, were evaluated with high-resolution manometry (50 male and 42 female with an age range of 19-84yrs).

Method: The patients were selected on the basis that they had dysphagia and in other cases where inconclusive standard manometry was performed (Table1). The results were interpreted using the Chicago Classification guidelines for patients in a supine position.

Results: Only 10 patients had normal peristalsis with a normal IRP< 15mmHg. Six patients had a hypertensive oesophagus, of which five were reclassified as Jackhammer Oesophagus. Thirteen (14%) patients in the group were found to have oesophago-gastric junction abnormalities indicated by an IRP>15mmHg and increased intrabolus pressure. Achalasia type patterns were identified in fourteen patients; ten of which were found to have Type II achalasia and two patients had Type III with spastic contractions. Twelve patients that may have previously been described as non specific could now be reclassified. Eight patients were classified as having weak peristalsis with breaks in the proximal oesophagus, while the other four patients had frequent failed peristalsis. A sub group of twenty one patients were referred for dysphagia post treatment. Nine of these patients had previous Lap Nissen fundoplication and were found to have profiles consistent with slipped wraps or raised intrabolus pressure. Four patients who had a Heller's Myotomy, demonstrated a profile consistent with a successful myotomy, and four patients had successful dilatations. Two post oesophagectomy patients showed preserved peristalsis in the oesophageal remnant. Nine patients were referred with Globus Hystericus or UOS dysphagia; four of this group were diagnosed with hypertensive UOS and a further three with weak peristalsis. The UOSP was depleted in two patients with a history of stroke and polio. (Table 2)

Table 1. Provisional Patient Diagnosis for Referral
Provisional referral Diagnosis N o (%) Final Diagnosis based on Chicago Classification 2012
Dysphagia/ Food sticking 24 26 2 Jackhammer Oesophagus; 2 Achalasia T type II
6 Weak peristalsis with break;3 Frequent Failed Peristalsis; 2 Non specific
6 OGJ Obstruction; 2 Normal (1 HH) ; 1 Hypertensive UOS
Achalasia 14 15.2 12 Achalasia Type I = 2 ;Type II = 8; Type III = 2
1 Adenocarcinoma; 1 OGJ Obstruction
Globus sensation /UOS dysfunction 10 10.8 3 Hypertensive UOS; 2 OGJ Obstruction with poor peristalsis
2 Weak Peristalsis with breaks; 1 Hypotensive UOS; 2 UOSP depleted due to polio/ stroke
Hypertensive LOS 5 5.4 3 Impaired relaxation with raised Intrabolus pressure; 1 frequent failed with impaired relaxation; I Hyper LOS
Chest pain/ Nutcracker Oesophagus 7 7.6 3 Jackhammer Oesophagus ; 1 Hypertensive Oesophagus; 1 multiphasic waves mid oesophagus;
2 normal studies (I with HH)
Post Fundoplication Dysphagia 9 9.7 2 Slipped Wrap; 4 Raised intrabolus pressure due to wrap
1 OGJ obstruction ; 2 frequent failed peristalsis
Post Hellers Myotomy 5 5.4 4 Successful myotomy ; 1 weak peristalsis with poor clearance
Reflux/ Regurgitation 5 5.4 2 Normal Motility; 2 OGJ Obstruction; 1 HH
Post Dilo 5 5.4 4 Type II recurrence post dilo; I successful

Others 8 8.7
4 Normal Motility; 1 Scleroderma ;1 external Compression on Oesophageal body;
2 Post Oesophagectomy with preserved distal motility;

Table 2. Post Chicago Classifications
Category Number of patients (total =92) % of all referrals for HRM
Achalsia patterns 14 15.2
OGJ Obstruction/ impaired relaxation 13 14.2
Jackhammer Oesophagus 5 5.4
Hypertensive (Nutcracker) Oes 1 1.1
Weak peristalsis with breaks 8 8.7
Frequent Failed Peristalsis 4 4.3
Hypertensive UOS 4 4.3
UOSP depleted 3 3.2
Nissen Wrap dysfunction 9 9.8
Hellers Myotomy 5 5.4
Normal 10 10.8
Post Dilatation 5 5.4
Post Oesophagectomy 2 2.1
Others 2 2.1

Conclusion: HRM provides a better and clearer understanding of motility patterns in the dysphagic patient and is proving to be a worthy technique. It is fast becoming the gold standard in oesophageal motility testing and is the preferred method of investigation amongst physiologists that have used both the conventional and HRM systems.

ABSTRACT 24 (14S105) POSTER PRESENTATION

Title of Paper: Diagnostic Yield of Colonoscopy as per indication

Author(s): Mohmand Khan, Zaid Heetun, Waheed Shah, Fatima Azad, Garry Courtney,

Department(s)/Institution(s): St Luke's Hospital, Kilkenny

Introduction: Colonoscopy is an invasive and over-stretched resource so we evaluated the diagnostic yield of colonoscopy as per indication.

Method: The first 350 patients registered as having a colonoscopy starting from January 2013 on the endoscopy database were recruited for the study. Details of the patients, quality of the preparation, indication for endoscopy and result of the procedure were obtained from the database and chart review. A positive finding at endoscopy was defined as the presence of colorectal carcinoma or inflammatory bowel disease or any other findings that would explain the patient's symptoms. The presence of polyps and diverticulosis were not considered significant as these were considered incidental findings and did not account for symptoms.

Results: The mean age of the population was 55.5 years (range 15 to 91 years) and females accounted for 54.9%. 230 (65.7%) patients underwent their procedure as out-patients. The quality of

preparation was higher in the out-patient cohort (86.5% compared to 77.5% for the in-patients) but did not reach statistical significance (p=0.51). The overall caecal intubation rate was 92.6% and adjusted caecal intubation rate was 97.3% (after taking into account poor preparation). The polyp detection rate was 21.7%. There was significant variation in the diagnostic yield according to indication. Patients having a colonoscopy for assessment of inflammatory bowel disease had the highest diagnostic yield (75%) whereas no pathology was found in patients having an endoscopy for weight loss and chronic constipation (diagnostic yield of 0%). The indications of altered bowel habit, chronic diarrhoea, PR bleeding and abdominal pain had a diagnostic yield of 15.4%, 26.7%, 9.1% and 10% respectively. Pathology was encountered in 4.2% of cases having a colonoscopy for microcytic anaemia and interestingly, 12.5% of patients with normochromic anaemia had significant pathology on endoscopy. Patients having a colonoscopy for 2 or more indications had a diagnostic yield of 21.3%.

Conclusion: Our study demonstrates significant variation in diagnostic yield according to indications. Patients with chronic constipation and weight loss should not be routinely considered for colonoscopy due to low diagnostic yield. Patients with normochromic anaemia should be evaluated with endoscopy due to the high pick-up rate of pathology.

ABSTRACT 25 (14S128) POSTER PRESENTATION

Title of Paper: EUS guided FNA - Are slides necessary?

Author(s): Kale V, Jadhav S, Iqbal N, Breslin NP, Jeffers M, Ryan BM

Department(s)/Institution(s): AMNCH, Tallaght, Dublin.

Introduction: Endoscopic ultrasound (EUS) guided FNA has become an indispensible tool in the diagnosis of lesions of the gastrointestinal tract and surrounding organs like pancreas and lymph nodes. It provides minimally invasive yet highly accurate tissue sampling. The quality of tissue sampling depends on several factors.
Most centres in Ireland do not have access to an immediate onsite cytopathology to assess the adequacy and quality of specimens. FNA samples are frequently divided in the endoscopy room into both 'needle rinse' specimens and slides. This can be time consuming.

Aims/Background: Firstly to assess if yield from 'needle rinse alone' specimens would be similar to specimens divided into 'rinse solution and slides'.
Secondly, to compare if the yields differed according to sample location; specifically- to compare pancreatic and non-pancreatic lesions.

Method: A previous audit in our institution had suggested that needle rinse preparation alone would provide sufficient information for diagnosis in pancreatic FNAs (2008-2010). As a result, the practice of preparation of slides from pancreatic specimens was discontinued. We re-audited the results of Pancreatic FNAs done from 2011 to 2013 and compared yields to the original audit results from 2008-2010.

We also audited the FNAs from non-pancreatic lesions to see if slides contributed to establishment of a final diagnosis.

Results: 55 EUS-FNA were done from 2011-2013 on pancreatic lesions, which had 'rinse alone'. There were 37 malignancy, 3 atypical and 11 benign lesions. 6 had insufficient samples. The results were comparable to the previous audit from 2008-2010 (n= 35).

There were 55 EUS-FNA for non-pancreatic lesions. 24 diagnostic on both slides & rinse. In 13 cases, rinse alone +ve. 9 were +ve only on slides. 9 negative by both methods.

Conclusion: Re-audit on yield on pancreatic lesions, validates that 'rinse alone' method is adequate and effective. On the other hand, results from non-pancreatic lesions suggest that the current practise of preparing slides along with rinse specimen should be continued to maximise diagnostic yield.

ABSTRACT 26 (14S131) POSTER PRESENTATION

Title of Paper: Eosinophilic Oesphagitis in a Paediatric Gastroenterology Department: An Irish Experience

Author(s): N Lagan, S Quinn

Department(s)/Institution(s): National Children's Hospital, AMNCH, Tallaght

Introduction: Eosinophilic Oesphagitis (EoE) is a new disease entity initially described in the 1990's, which is increasing in prevalence. It is a chronic immune/antigen mediated disease, which causes "oesphageal dysfunction".
Diagnosis of EoE includes the symptoms of oesphageal dysfunction and the presence of >15 eosinophils per high power field (eos/hpf) on oesphageal biopsy.

Aims/Background: The aim of our study is to evaluate the occurrence of EoE in our patient population in 2013 and to review the characteristics of these patients.

Method: Retrospective chart review of patients diagnosed with EoE in 2013 at the National Children's Hospital, Tallaght. Demographics, symptoms, endoscopy findings and histopathology were recorded.

Results: 304 patients had upper endoscopic procedures in 2013. 8.5% (n=26) had a diagnosis of EoE of which 73% (n= 19) were new diagnoses. 69% (n=18) of patients were male. Median age was 12years.
Dysphagia was the most common presenting complaint. 65% (n=17) had an associated history of atopy. There was endoscopic evidence of EoE in 88% (n=23) and median peak mucosal eosinophilia on biopsy was 40eos/hpf. Only patient had the presence of helicobacter pylori and none had coeliac disease.

Conclusion: EoE is a new disease. 6.3% of total endoscopic procedures had a new diagnosis of EoE and therefore suggesting an increasing incidence. This requires further exploration.

ABSTRACT 27 (14S135) POSTER PRESENTATION

Title of Paper: Can Dysphagia Referrals to Acute Gastroenterology Service be diverted to a Dysphagia Evaluation Clinic?

Author(s): Julie Regan[1, 2], Maeve Murphy[1, 2], Deirdre McNamara[2, 3, 4]

Department(s)/Institution(s): [1]SLT Dept., Tallaght Hospital, [2]Trinity Academic Gastroenterology Group (TAGG),[3]Gastroenterology Dept., Tallaght Hospital, [4] Associate Professor/Interim Dept Head, Clinical Medicine, TCD

Introduction: General practitioners often refer adults with dysphagia to Gastroenterology. However, outpatient waiting lists for Gastroenterology services and for Endoscopy are lengthy. Trained speech and language therapists (SLTs) are already conducting trans-nasal endoscopy to the level of the pharynx (Fiberoptic Endoscopic

Evaluation of Swallowing or FEES) as part of dysphagia evaluation. The development of a hospital based Dysphagia Evaluation Clinic where adequately trained speech and language therapists (SLT's), with support from Gastroenterology, perform trans-nasal oesophagoscopy and manometry on adults with dysphagia may ease the burden on outpatient Gastroenterology waiting lists and speed up the evaluation of patients with dysphagia.

Aims/Background: This study examines (i) how many adults with dysphagia are being referred from general practitioners (GP's) to an acute Gastroenterology service; (ii) the nature of dysphagia in adults referred to Gastroenterology and the type of evaluations conducted within this group and (iii) potential candidacy of this group for a joint speech and language therapy (SLT) and Gastroenterology Dysphagia Evaluation Clinic.

Method: A prospective audit of GP referrals to an acute Gastroenterology service was conducted in a teaching hospital over a three week period (October-November 2012). Outpatient GP referrals to Gastroenterology which included either "dysphagia" or "swallowing" were identified and referral details were recorded. Eighteen months later, medical and SLT charts of patients with dysphagia were retrospectively reviewed.

Results: Two-hundred and nineteen referrals (mean age 46 years; age range 18-90 years, 89 males) were included in data analysis. Six percent (12/219) of referrals to Gastroenterology were patients with symptoms of dysphagia (mean age 50 years; range 36-67 years; 4 males). Two-thirds (9/12) of these referrals were classified by the Gastroenterology service as urgent. The average time between GP referral and first Gastroenterology appointment for patients with dysphagia was 116 days (urgent/urgent endo=60 days; routine/routine endo= 285 days). Patients referred from GPs all had dysphagia for solids and with food or tablets sticking in throat or oesophagus. All of these patients attended for an OGD. Just one-third (4/12) were referred to SLT for swallow evaluation, three of whom had a fiberoptic endoscopic evaluation of swallowing (FEES).

Conclusion: Six percent of referrals to Gastroenterology are dysphagia related. All of these patients were referred to Endoscopy. Just one third of these patients with dysphagia were referred to SLT. The development of an SLT led Dysphagia Evaluation Clinic, to include transnasal oesophagoscopy (TNO) and oesophageal manometry (OM) with support from Gastroenterology, may expedite the evaluation of patients with dysphagia and reduce demand on endoscopy.

ABSTRACT 28 (14S141) POSTER PRESENTATION

Title of Paper: Does tailored therapy based on antimicrobial susceptibility testing overcome the increasing failure of standard empirical therapy for Helicobacter pylori infection?

Author(s): Rana Bakhtyar Haider[1], Sinead Smith[1], Grainne Holleran[1], Barry Hall[1], Colm O'Morain[3], Niall Breslin[1], Humphrey John O'Connor[2], Deirdre McNamara[1].

Department(s)/Institution(s): 1Departments of Gastroenterology & Clinical Medicine Tallaght Hospital & Trinity College Dublin, 2Department of Gastroenterology & Clinical Medicine, Naas Hospital, 3Charlemont Clinic, Dublin.

Introduction: First-line triple therapy for H. pylori involves the use of a PPI with amoxicillin & clarithromycin or Metronidazole, or clarithromycin & Metronidazole in case of penicillin-allergy for one week. However, due to increased resistance to these commonly employed antibiotics, eradication has fallen considerably short of the 80% intention-to-treat (ITT) rates that are considered the minimal acceptable levels as recommended in the Maastricht guidelines. Despite these worrying trends, there are no centres routinely monitoring Irish resistance rates. Data which could help adapt new first line therapies and improve outcome.

Aims/Background: To compare the efficacy of standard empirical triple therapy with tailored therapy based on antimicrobial susceptibility testing

Method: A prospective, multicentre, randomised controlled study was conducted after ethical approval in all participating hospitals. Treatment naïve H. pylori-infected patients (>18 years old), as assessed by a positive antral CLO-test at endoscopy, were invited to participate and informed consent was obtained. Information on age, gender, previous antibiotic use& smoking history was recorded. A single antral biopsy was processed for antimicrobial susceptibility testing employing both standard culture and E-testing & genotyping for antibiotic resistance associated SNPs. Patients were randomised to receive either standard empirical therapy with Amoxicillin, Clarithromycin &PPI or tailored treatment based on their antibiotic resistance profile which included standard triple therapy or if resistance was detected triple therapy with Amoxicillin, Levofloxacin & PPI or Denoltab, Tetracycline, Metronidazole & PPI based quadruple therapy. A follow up UBT was performed after 6-8 week to assess treatment success.

Results: To date 247 consecutive patients had CLO tests assessed at endoscopy. Of these 52 (21%) were H.pylori positive. Infected patients tended to be younger men with a mean age of 47 versus 53 years, $p<0.05$ and 56% versus 46% were male. In all 47(90%) patients have been randomised to a treatment arm and 40(85%) have completed the study. Of those 40, 15 (37.5%) and 25 (62.5%) received tailored and empirical therapy respectively. In the tailored arm 6 (40%) received quadruple and 4 (27%) Levofloxacin and 5 (33%) standard triple therapy. Eradication rates were higher for tailored versus empirical therapy, 87% (13/15) and 68% (17/25).This trend did not reach statistical significance. Only 1(3%) patient had a severe side effect with mild anaphylaxis to amoxicillin. Overall 42% of strains were clarithromycin resistant and 7 of 8 (88%) patients who failed empirical therapy had resistant strains, $p<0.001$. Of the 2(13%) who failed tailored therapy neither treatment type nor resistance profiles were predictive.

Conclusion: Resistance levels to clarithromycin are high at 42%. Targeted therapy can enhance eradication rates. Larger numbers will be required before a new first line treatment can be recommended.

ABSTRACT 29 (14S145) POSTER PRESENTATION

Title of Paper: Transient Elastography: Real World Experience In A General Hepatology Outpatient Service

Author(s): Audrey Dillon, Zita Galvin, Stephen Stewart

Department(s)/Institution(s): Liver Centre, Mater Misericordiae University Hospital, Dublin

Introduction: Transient Elastography (Fibroscan™) is used increasingly in the non invasive assessment of hepatic fibrosis. While it has been studied in the trial setting, there is little data on its reliability in the "real world". Fibroscan was integrated into our general hepatology outpatients in 2011.

Aims/Background: The aim of this study was to review the

reliability of the Fibroscan measurements performed.

Method: Data on all Fibroscans performed in our institution was retrieved from the Fibroscan machine database. Reliability of the result was determined using the manufacturer's guidelines. Statistical analysis was performed using SPSS v 22.

Results: Over a 25 month period, 1910 exams were performed on 1323 patients. 587 patients had more than 1 exam, and 517 examinations were on the same day. The most common reasons for performed the examination were Hepatitis C 530 (28%); Hepatitis B 300 (16%); Non alcoholic fatty liver disease 261 (14%) and Alcohol Liver Disease 250 (13%). 15 operators used the machine over this period, and 4 performed more than 100 procedures (range 1 – 614). 1325 (69%) examinations were reliable by manufacturer criteria. In univariate analysis, unreliable measurements were associated with NAFLD [OR 0.725 (95% CI 0.55 – 0.95, p = 0.02)]. Operator experience, other reasons for examination and probe size were not statistically significant.

Conclusion: In our practice, 31% of examinations gave unreliable results. In particular, performing the examination for evaluation of NAFLD was associated with an unreliable result. While Fibroscan is a useful non invasive method of fibrosis evaluation, it has limitations in the assessment of NAFLD.

ABSTRACT 30 (14S148) POSTER PRESENTATION

Title of Paper: Are human anti-human (HAHA) antibodies important in determining response to biologic therapies in inflammatory bowel disease?

Author(s): B Hall[1], G Holleran[1], S Warnock[1], Y Bailey[1], S Byrne[1], S Smith[1], J Wang2, C Medina[2], B Ryan[1], J Gilmer[2], D McNamara[1]

Department(s)/Institution(s): [1]Department of Gastroenterology, AMNCH, Tallaght, Dublin 24, Ireland

Introduction: The advent of anti-TNF therapies have revolutionised the treatment of inflammatory bowel disease. However, despite the success of these agents up-to 60% of patients lose efficacy over time. Switching from one anti-TNF to another often elicits a response which suggests that the basis for failure is unrelated to the therapeutic target itself. The concept of immunogenicity relates to the ability of bio-technology derived proteins to form antibodies (HAHA) against themselves. HAHA antibodies have been associated with low serum drug levels and poor clinical efficacy. However, their true relevance to clinical response has yet to be fully elucidated.

Aims/Background: To determine the correlation between drug trough levels, HAHA antibody positivity and clinical parameters including inflammatory status as defined by biochemical and clinical characteristics.

Method: Following informed consent, patients between 18-80 years of age currently taking infliximab were invited to participate in the study. A Harvey-Bradshaw Index (HBI) was recorded for patients with Crohn's disease, along with clinical and biochemical parameters including height, weight, additional medications and C-reactive protein level. Two serum samples were collected no more than 48 hours prior to the patients next scheduled anti-TNF dose. Drug trough levels were measured using sandwich ELISA. Primary (capture) antibodies (Serotec) to the therapeutic antibody were treated with appropriately diluted serum samples. Captured drug was detected with horse radish peroxidase (HRP) conjugated detection antibody (Serotec). Rabbit anti-mouse polycolonal F(ab') products were used to quantitate captured drug. A drug trough level less than 100ng/ml was considered low and anti-drug antibody level above 1000ng/ml was considered positive.

Results: In total, 43 patients were included in the study, 20 (46%) were female and mean age was 38 (range 18-69). Overall, 23 (53%) patients were on concomitant immunosuppressant and the median duration of infliximab therapy was 3 years. Median weight and height were 70kg and 172cm, respectively. In all, 11 (25%) patients had clinically active disease as defined by a HBI>5. The median HBI was 3 (range 2-17) and median CRP was 1mg/dl (1-28). In total, 7 (16%) patients had a low serum drug trough level and 36 (83%) were positive for anti-drug antibodies. Of note, the median drug trough level of patients with documented antibodies was 290ng/ml compared to a median of 590ng/ml for patients without antibody formation (p<0.0029 CI 95% 102.69-463.70). Antibody status and drug trough level did not correlate with CRP however there was a trend towards increased clinical disease activity with low drug trough level (12.5% inactive disease vs 36% with active disease) but this did not reach statistical significance (p<0.08).

Conclusion: Low drug trough levels in our cohort are less than previously documented (16% vs 43%) while the majority of patients had detectable antibody status. Antibodies are associated with lower trough levels however further studies will be required to fully ascertain their clinical relevance.

ABSTRACT 31 (14S106) POSTER PRESENTATION

Title of Paper: Influence of long-term steroids on graft survival following Liver Transplant: A Retrospective Cohort Study

Author(s): Z Heetun[1], A Cooney[1], J E Hegarty[1], P A Mc Cormick[1]

Department(s)/Institution(s): Department of Hepatology, National Liver Transplant Unit, St Vincent's University Hospital, Dublin, Ireland

Introduction: To assess the effect of long-term maintenance steroids on graft survival and Hepatitis C recurrence after liver transplantation, a large retrospective study was conducted at the National Liver Transplant Unit, Ireland.

Method: All patients undergoing a first orthotopic liver transplant for Hepatitis C were identified from the Liver Transplant Database. Patients who died or were re-transplanted within one year were excluded from the study. Clinical information was obtained upon chart review. Patients were divided into two groups: patients who were exposed to steroids for less than one year and patients on long-term steroids for more than one year. Patients were followed-up until they either died, were re-transplanted, had biopsy proven Hepatitis C Recurrence or to end of study (1st January 2013).

Results: 72 patients had their first transplant for Hepatitis C during the study period. 4 patients were excluded because they either died or were re-transplanted within one year. 36 patients were not on long-term steroids (NS Group) and 32 patients were on an average dose of 5 mg of prednisolone daily for more than one year (S Group). Mean follow-up was 5.3 years. The two groups were well matched for age, immunosuppressive regimen and presence of hepatocellular cancer. There was a trend towards higher incidence (but not statistically significant) of diabetes and obesity in the S Group compared to the NS Group. The overall graft and patient survival at 5 years was 68% and 71.4% respectively. Graft survival in the NS Group compared to the S Group at 5 years was 70.4% and 65.2% respectively. Patient survival in the NS Group was 76.9% at 5 years compared to 65.2% in the S Group (p>0.05 for graft and

MOVIPREP® and MOVIPREP® Orange Abbreviated Prescribing Information.

REFER TO THE SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING.

Presentation: A box containing two transparent bags, each containing two separate sachets, A and B. Sachet A contains macrogol 3350 100g, sodium sulphate anhydrous 7.5g, sodium chloride 2.691g and potassium chloride 1.015g as white to yellow powder. Sachet B contains ascorbic acid 4.7g and sodium ascorbate 5.9g as white to light brown powder. MOVIPREP also contains aspartame (E951), acesulfame potassium (E950) and a lemon or orange flavour. **Uses:** Bowel cleansing prior to any clinical procedure requiring a clean bowel. **Dosage and administration:** *Adults and elderly:* A course of treatment consists of two litres of MOVIPREP. A further litre of clear fluid is recommended during the course of treatment. A litre of MOVIPREP consists of one Sachet A and one Sachet B dissolved in water. This reconstituted solution should be drunk over a period of one to two hours. This should be repeated with a second litre of MOVIPREP. The two litres of MOVIPREP may be consumed either as a divided dose, 1L the evening before the procedure and 1L in the early morning of the procedure, or as a single dose the evening before the procedure. There should be at least one hour between the end of intake and the start of the procedure. No solid food should be taken from the start of the treatment and until after the procedure. *Children:* Not recommended in children below 18 years of age. **Contraindications, warnings etc:** Contra-indications: Known or suspected gastrointestinal obstruction or perforation; disorders of gastric emptying; ileus; phenylketonuria; glucose-6-phosphodehydrogenase deficiency; toxic megacolon complicating severe inflammatory conditions of the GI tract or hypersensitivity to any of the ingredients. Do not use in unconscious patients. *Warnings:* Diarrhoea is an expected effect. Administer with caution in fragile patients in poor health or serious clinical impairment such as severe renal insufficiency, cardiac impairment (NYHA grade III or IV), severe acute inflammatory disease or dehydration and those with an impaired gag reflex or impaired consciousness. Dehydration, if present, should be corrected before using MOVIPREP. Patients prone to aspiration should be closely monitored during administration, particularly if this is via a naso-gastric tube. If symptoms indicating shifts of fluid or electrolytes occur, plasma electrolytes should be measured and any abnormality treated appropriately. In debilitated fragile patients, patients with poor health, those with clinically significant renal impairment and those at risk of electrolyte imbalance, the physician should consider performing baseline and post-treatment electrolyte and renal function test. If patients experience symptoms which make it difficult to continue the preparation, they may slow down or temporarily stop consuming the solution and should 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 from 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, anal discomfort, malaise, vomiting, dyspepsia, hunger, thirst, sleep disorder, headache, dizziness, and rigors. Uncommon or unknown: Dysphagia, discomfort, abnormal liver function tests, allergic reactions including rash, urticaria, angioedema and anaphylaxis, electrolyte disturbances which are more common in patients taking concomitant medication affecting the kidneys, convulsions associated with severe hyponatraemia, transient increase in blood pressure, 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 rehydration may be used. **Pharmaceutical Particulars:** Sachets: Store in the original package below 25°C. Reconstituted solution: Keep covered. May be stored for up to 24 hours below 25oC or in a refrigerator. **Legal Category** UK – Pharmacy only, Ireland – Prescription medicine. **Packs:** One pack of MOVIPREP or MOVIPREP Orange contains a single treatment. **Basic NHS Price:** UK £9.87, Ireland €13.26 **Marketing Authorisation Number:** UK: PL 20142/0005 (MOVIPREP), PL 20011/0006 (MOVIPREP Orange); IE: PA 1336/1/1 (MOVIPREP), PA 1336/1/2 (MOVIPREP Orange). **For further information contact:** Norgine Pharmaceuticals Ltd, Moorhall Road, Harefield, Middlesex, UB9 6NS. Tel. 01895 826606. E-mail: medinfo@norgine.com MOVIPREP® is a registered trademark of the NORGINE® group of companies. Date of preparation/revision: MP/3391/DEC/12.

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References:

1. Worthington J et al. Curr Med Res Opin 2008;24(2):481–488
2. Ell C et al. Aliment Pharmacol Ther 2008;24:1631–42
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Date of preparation: May 2014

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patient survival by log-rank test). Mortality and re-transplant rates were 25.0% and 11.1% in the NS Group respectively compared to 21.2% and 9.3% in the S Group respectively (p>0.05). Steroid pulsing during the perioperative period was an independent predictive factor for shorter graft survival (p=0.009) and Hepatitis C Recurrence (p=0.003). Using multivariate analysis, no other factors were associated with shortened graft survival and increased Hepatitis C Recurrence.

Conclusion: Our study has not demonstrated a beneficial effect of long-term steroids on graft survival and Hepatitis C Recurrence.

ABSTRACT 32 (14S161) POSTER PRESENTATION

Title of Paper: Comparing the effectiveness of Hepa-Mertz mono therapy versus Rifaximin in patients presenting with hepatic encephalopathy.

Author(s): J B M Doyle, N I McDougall, W J Cash.

Department(s)/Institution(s): Liver Unit, Royal Victoria Hospital, Grosvenor road, Belfast, Northern Ireland.

Introduction: Hepa Mertz (L-ornithine-L-aspartate) has been previously utilised in mono therapy in order to prevent episodes of hepatic encephalopathy (HE) in patients with liver cirrhosis. It has been shown to reduce serum ammonia levels in patients presenting with HE, and improve their grade of encephalopathy. Crucially it has been licensed in other European countries for this purpose, but not the UK.

Rifaximin-alpha was been licensed in the UK in February 2013 for the treatment of hepatic encephalopathy. It has been shown to reduce the recurrence and hospitalisation episodes of patients who have had previous episodes of HE, and to reduce the length of stay of patients presenting with HE.

Aims/Background: To assess if rifaximin therapy reduces readmission rates and results in shorter lenghts of stay compared to hepa mertz mono therapy in patients with hepatic encephalopathy.

Method: A retrospective review of 30 consecutive patients treated with hepamerz versus 30 consecutive patients treated with rifaximin was undertaken. All patients were on laxatives. Outcome measures included: Underlying demographics and diagnosis, number of admissions over a 12 month period, average length of stay, 30 day mortality, 6 month mortality and 12 month mortality. Severity of liver disease was recorded with Childs score/UKELD score.

Results: 30 patients were evaluated in each arm. 30 patients had been commenced on hepa-mertz as mono therapy, while a separate 30 patients had been commenced on rifaximin.
The hepa-mertz arm had an average age of 54 and included 21 males. During the 12 month follow-up period the number of admissions for this group was 57, with an average number of admissions of 2 per patient. The average length of stay was 14 days. Average UKELD score in this group was 53.
The rifaximin arm had an average age of 61 and included 23 males. During the 12 month follow-up period the number of admissions for this group was 80, with an average number of admission of 3 per patient. The average length of stay was 11 days. UKELD score in this group was 55.

Conclusions: Rifaximin is now a recognised tool in helping to reduce episodes of HE, and reduces length of stay. Our study did not demonstrate a reduction in the average number of admissions. This may be due to the rifaximin group having both an overall higher average age and average higher UKELD score and contained no patients graded Childs A compared to the hepa-mertz group. Further prospective studies are needed to assess the efficacy and cost-effectiveness of rifaximin.

ABSTRACT 33 (14S165) POSTER PRESENTATION

Title of Paper: Experience of HNPCC Kindreds in a High-Risk Screening Clinic

Author(s): M Walshe[1], M Boyle[1], I Cretu[1], M Farrell[2], J Leyden[1], D Gallagher[2], P Mac Mathuna[1]

Department(s)/Institution(s): GI Unit[1], Oncology Unit[2], Mater Misericordiae University Hospital, Dublin 7

Aims/Background: Proactive screening strategies aim to prevent colorectal cancer by identifying at risk individuals. Identification of HNPCC families, with subsequent risk reduction intervention, has the potential to reduce cancer-related mortality. We report our colorectal neoplasia rate in a HNPCC cohort, managed as part of dedicated high-risk family screening service.

Method: Kindreds fulfilling Amsterdam criteria, and/or having a genetically confirmed diagnosis of Lynch syndrome were identified from a dedicated high-risk colorectal cancer (CRC) screening database. Data regarding genetic tests, history of CRC and colonoscopy-screening detected neoplasia were analysed.

Result: 214 patients from 84 kindreds were identified; 97(45%) male, median age 39yrs, range 8-82yrs.
Gene testing was performed in 66(31%) individuals; 41(19%) tested positive for a mutation known to cause Lynch syndrome, whilst 25(12%) had a negative predictive gene test. Genetic mutations known to cause Lynch syndrome were identified in 24(29%) kindreds. A genetic mutation of uncertain significance was identified in a further 2(2%) kindreds, both in the MLH1 gene.

	Pedigrees with gene identified	Individuals with gene identified
MLH1	10	13
MSH2	10	23
MSH6	4	5
PMS2	0	0
Total	24	41

24 patients were diagnosed with (CRC) prior to referral, of whom 11(42%) had a genetically confirmed diagnosis of Lynch syndrome: 7(27%) with MLH1, and 4(15%) with MSH2 mutations. One patient with a diagnosis of CRC had a negative gene test for the MLH1 mutation identified in his family(ie. sporadic cancer).

Following exclusion of patients with a negative gene test (25) and those with a prior diagnosis of CRC (24), screening data were analysed on the remaining 165(77%) patients. Of this cohort 119(72%) patients had screening by full colonoscopy in our institution. Median age at first screening was 38yrs (range 19-71 yrs). Median follow up period was 8.5yrs. Average number of screening colonoscopies was 2.45. Cancers were detected on screening in 2(2%) patients, at 40yrs and 53yrs. Both cancers were right-sided, and were identified in patients with confirmed MLH1 mutations, who subsequently underwent curative treatment.

10(8%) patients had an advanced adenoma (median age 50yrs, range 37-64yrs), and a further 18(15%) had a simple adenoma (median age 51yrs, range 30-71yrs) detected during the follow up period.

Conclusion: The prevalence of neoplasia on screening colonoscopy, in particular advanced neoplasia, supports the use of colonic screening in HNPCC. However, the age profile of patients with neoplasia would suggest that colonic screening should commence later than is currently described by international guidelines.

ABSTRACT 34 (14S100) POSTER PRESENTATION

Title of Paper: A Survey on patient wellbeing and patient comfort during oesophageal intubations. A multicentre study.

Author(s): M. Brennan, T. Moran, P. Lawlor, L. Barry, M. Treacy, N. Ravi and JV. Reynolds

Department(s)/Institution(s): GI Function Unit, St. James Hospital, University Hospital Cork, University Hospital Galway & Department of Surgery, Trinity Centre for Health Science St. James Hospital, Dublin 8, Ireland

Introduction: Oesophageal intubations are invasive techniques which many patients find quite distressing. These studies require the patient to be alert, be able to swallow liquid boluses and to retain their normal oesophageal function. As a result of this, sedation or oral anaesthetic spray is not routinely administered. This study was compiled in order to obtain specific patient data from Gastrointestinal (GI) Units throughout Ireland by conducting a short survey post patient procedure.

Aims/Background: A Multicentre survey was undertaken from November 2013 until January 2014 on 80 patients (45f Vs 35m) undergoing oesophageal manometry and/or oesophageal 24hr pH/impedance study. The aim of this study was to determine the overall wellbeing of the patient during their investigation.

Method: A survey containing short answer questions was devised and GI units providing a service in GI Physiology testing were asked to participate. The patient was asked to answer either 'Yes' or 'No' to the questions or score the answers to the questions with a value from 0-10 with 10 being the most severe scale of discomfort/anxiety and 0 being the least.

Results: Table (1.1) below shows the results obtained from the multicentre survey.

Total Female Male
Mean Age (years)
49.23 53.58 43.63
Successful intubation rate %
96.3% 95.6% 97.1%
Successful intubation rate in patients
>40years 94.4% 94.4% 94.4%
Successful intubation rate in patients
<40years 100% 100% 100%
Mean anxiety score prior to investigation *
4.73 5.47 3.77
Mean anxiety score post procedure *
1.96 2.26 1.59
Mean discomfort level
4.91 4.93 4.89
Number of patients who would be anxious if studies had to be repeated 32.55 35.56% 28.57%
Number of patients >40years who would be anxious if studies had to be repeated 33.34% 33.34% 33.34%
Number of patients <40years who would be anxious if studies had to be repeated 32% 44.45% 25%
Number of patients who would choose to have an anaesthetic spray administered 61.25% 66.67% 54.29%
Number of patients >40years who would choose to have an anaesthetic spray administered 66.67% 69.44% 61.11%
Number of patients <40years who would choose to have an anaesthetic spray administered 48% 55.56% 43.75%
* On a scale of 0-10 (10 indicating highest rating of anxiety/discomfort) Table 1.1

The reasons given for failed intubations included patient anxiety, nasal sensitivity and previous traumatic Endoscopy experience. With regards to patient anxiety prior to investigation; no option for general anaesthetic, sedation, nasal spray, throat spray, and the fear of the unknown were the main reasons for the high patient anxiety scores.

Conclusion: Appropriately trained GI Physiologists achieved a 96.3% rate of successful oesophageal intubations. Despite this, patient anxiety in anticipation of their procedure is relatively high. With the option of a nasal spray, this survey suggests that patient anxiety levels prior to their investigation would be reduced, thus making the intubation a more pleasant, tolerable and less traumatic experience.

ABSTRACT 35 (14S104) POSTER PRESENTATION

Title of Paper: Treatment, aetiology and HIV testing in patients diagnosed with oesophageal candidiasis

Author(s): Todd P, Loughrey M, Johnston BT

Department(s)/Institution(s): Gastroenterolgy Dept/Belfast Health and Social Care Trust, Tissue Pathology Dept/Belfast Health and Social Care Trust

Introduction: Although oesophageal candidiasis can develop in healthy people, it is much more likely in those who are immunocompromised. Upon diagnosis it is recommended that risk factors should be sought and eliminated. (1)

Aims/Background: It is unclear how many patients diagnosed with it get appropriate treatment, have potential aetiology considered or get tested for HIV. The aim of this audit was to establish how many patients are treated and investigated appropriately following diagnosis.

Method: Data were gathered using NI-ECR and OGD reports for all Belfast Trust patients histologically diagnosed with oesophageal candidiasis in the period of June 2012 – September 2013. They were assessed for; i) whether they were treated, ii) potential aetiology (concurrent antibiotics, inhaled steroids, immunosuppressants, malignancy, diabetes, achalasia, oesophageal stricturing) and iii) whether they were tested for HIV. "Treated" includes treatment recommended to GPs via letter or OGD report, or evidence of anti-fungal prescription on NI-ECR. "Tested for HIV" includes HIV blood test within 6 months after diagnosis or referral to GUM clinic.

Results: 45 cases were included. Of these 33 (73%) were treated, 12 (27%) were not. 18 (40%) had no potential aetiology identified. The most common aetiologies were inhaled steroids (12 cases), immunosuppressants (8 cases), diabetes (5 cases) and oesophageal stricturing (5 cases). 7 patients (16%) were tested for HIV, 38 (84%) were not tested. Of the 7 tested, 1 patient was found positive.

Conclusion: 1) Although most patients were treated for candida, this number could be improved. 2) Only a small percentage of

patients were tested for HIV. 3) We are not good at checking for causative aetiology, including HIV, when oesophageal candidiasis is present.

Reference:
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ABSTRACT 36 (14S108) POSTER PRESENTATION

Title of Paper: Liver transplant survival **Results** for patients followed up at a network centre in Northern Ireland

Author(s): E Clarke (1), J Cash (1), S Bhat (1), J O'Grady (2), N McDougall (1)

Department(s)/Institution(s): Regional Liver Unit, RVH Belfast (1) and Kings College Hospital, London (2).

Introduction: The Regional Liver Unit at the Royal Victoria Hospital (RVH) Belfast operates a network centre jointly with King's College Hospital (KCH) London for the follow up of orthotopic liver transplant (OLT) recipients in Northern Ireland (N.I). Virtually all post-transplant follow-up takes place in Belfast unless surgical intervention or retransplantation is required.

Aims/Background: To determine the outcomes for adult OLT recipients who have the majority of follow up in Belfast.

Method: Details of all OLT recipients attending the Belfast clinic were obtained by cross checking the RVH and NHS Blood and Transplant databases. Relevant data was retrieved from RVH hospital notes.

Results: Between 1988 and December 2012, 255 adult patients (138 male) from N.I underwent OLT (235 transplanted at KCH). There was a progressive rise in OLT recipients (1988-1993 n= 21, 1994-2003 n= 97, 2004-2012 n = 136). The main indications included PBC 20% (n=51), ALD 16.9% (n = 43), PSC 11.8% (n = 30)), acute 9.8% (n=25 - 11 POD), HCC 7.0% (N-=18). Survival at 1 year was 90.9% (210 of 231 patients who had adequate follow up time) and 5 year survival was 80.2% (141 of 176 patients).

Conclusion: Survival data for the NI OLT network centre compares very favourably with overall survival data for UK transplant centres (1yr survival 90.9% v 86.1% in UK, 5yr survival 80.2% v 74.7% in UK - UK Liver Transplant audit data for 1994-2012). This clearly demonstrates good post-liver transplant care can be delivered locally with ongoing support from the transplant centre.

ABSTRACT 37 (14S113) POSTER PRESENTATION

Title of Paper: Red Flag Endoscopy Referrals and Timeframe to Endoscopy

Author(s): McCloskey MC, Brennan D, Glass C, Harding T

Department(s)/Institution(s): Lagan Valley Hospital, Lisburn, Northern Ireland

Introduction: The aim of the red flag referral system is to enable earlier cancer diagnosis. The National Institute of Clinical Excellence (NICE)1 and Northern Ireland Cancer Network (NICAN)2 have published guidance on red flag symptoms which should be assessed urgently by a specialist within two weeks, and is used by gastroenterologists to aid decisions on those patients who require an urgent endoscopy.3

Aims/Background: We aimed to assess the appropriateness and timeframe of red flag endoscopy referrals in accordance with NICE and NICAN guidance.

Method: A total of 48 red flag endoscopy referrals were reviewed in November 2013 from the most recent referrals to Lagan Valley Hospital endoscopy unit. Data was collected including demographic details, source and indication of referral, time frame to endoscopy and endoscopic findings.

Results: Of the 48 referrals reviewed, 25/48 (52%) were male and 23/48 (48%) were female, with age range 42-88 years. 47/48 (98%) of referrals were sourced from general practice and 1/48 (2%) from gastroenterology clinic. The average length of time (days) to endoscopy was 22.7 days. 16/48 (33%) underwent oesophago-gastro-duodenoscopy (OGD), with average waiting time of 12.75 days, and cancer yield 1/16 (6%). 22/48 (45.8%) underwent colonoscopy, with average waiting time of 29.45 days and cancer yield of 3/22 (13%). 5/48 (10%) had both OGD and colonoscopy, with average waiting time of 35 days and cancer yield of 1/5 (20%). 15/48 (31%) of patients had their endoscopy procedure within the recommenced 2 week timeframe. 27/48 (56.25%) of referrals through the red flag system were deemed as appropriate as per NICE/ NICAN guidelines. 16/48 (33%) were deemed as inappropriate, 1/48 (2%) were deemed as having insufficient information, 3/48 (6%) were inappropriately coded as red flag, and 1/48 (2%) had results interpreted inappropriately. 5/48 (10.4%) had a cancer diagnosis, of which 4/5 (90%) had an appropriate referral in accordance with NICE/NICAN guidance, with 2/5 (40%) undergoing endoscopy within the recommended 2 week time frame.

Conclusion: This audit demonstrates that almost half of red flag referrals are inappropriate or have insufficient information, which may have an impact on the fact that the average length of time to endoscopy is longer than the recommended 2 week time frame. Of those with a cancer diagnosis however, the majority had an appropriate referral. This highlights the importance of ensuring red flag referrals are appropriate and contain adequate information, which may have an impact on the time frame to endoscopy and subsequent cancer diagnosis. Further education on the indications for red flag referral, including in the primary care setting, may be warranted.

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ABSTRACT 38 (14S119) POSTER PRESENTATION

Title of Paper: The Prevalence of Osteoporosis and Osteopenia in our Inflammatory Bowel Disease Cohort in St. James's Hospital

Author(s): Muhammad Ateeq Md Jalil, Rachel Flood, Eu Jo Martin Wong, Jun Liong Chin, Nasir Mahmud, Miriam Casey

Department(s)/Institution(s): St James Hospital

Introduction: Osteoporosis and osteopenia are common in patients with inflammatory bowel disease (IBD). Therefore, all at risk patients with IBD should be screen for osteoporosis and osteopenia to allow early initiation of treatment and prevent fractures. We examined the prevalence of osteoporosis and osteopenia in our IBD cohort.

Aims/Background: We examined the prevalence of osteoporosis and osteopenia in our IBD cohort.

Method: We investigated the electronic patient records of 317 patients with IBD in St. James's Hospital. Information regarding dual X-ray absorptiometry (DXA) results, type of IBD, duration of disease, and patient characteristics were obtained.

Results: Of the 317 patients with IBD, only a third of these patients (101/317) had dual X-ray absorptiometry (DXA) to screen for osteoporosis and osteopenia. 53.5% (54/101) patients have Crohn's disease (CD), 38.6% (39/101) with ulcerative colitis (UC) & 7.9% (8/101) with indeterminate colitis (IC). Almost half of all IBD patients were osteopenic (47.5%, 48/101 patients of which 24 CD, 21 UC, 3 IC) while only 13.9% of IBD patients were osteoporotic (14 patients of 5 CD, 6 UC, 3 MC). The median T-score for CD patients were -0.75, UC were -1.25 and MC were -1.15 respectively. Only 20.8% (21/101) had follow up DXA, but all showed improvement of T score & lumbar spine BMD after 2 years treatment. 32.7% (33/101) patients had serum 25-hydroxyl vitamin D3 checked and 8.9% (9/33) were found to be vitamin D deficient.

Conclusion: In summary, a large proportion of IBD patients who had DXA were found to be osteopenic or osteoporotic but a considerable number of IBD patients were not screened.

ABSTRACT 39 (14S122) POSTER PRESENTATION

Title of Paper: **Introduction** of a nurse led venesection program improves adherence to national guideline targets for ferritin and transferrin saturations in Hereditary Haemochromatosis patients

Author(s): J.A. Gray, J McKee, N.I. McDougall, W.J. Cash

Department(s)/Institution(s): Liver Unit, Royal Victoria Hospital Belfast

Introduction: Hereditary haemochromatosis(HHC) is a common condition in Ireland. Treatment involves an initial venesection program(IVP) to deplete iron stores followed by a less frequent maintenance venesection program(MVP). Prior to 2011 the venesection program within our unit was performed on an adhoc basis at ward level and often resulted in failure to reach guideline targets for ferritin and transferrin saturations(EASL) with only 72% achieving target ferritin after IVP.

Aims/Background: To assess adherence to EASL guidelines for ferritin(<50□g/L) and transferrin saturations(<50%) in both IVP and MVP following the introduction of a protocol driven, nurse led venesection program(NLVP) in 2011 and compare the results with historical audit data from our unit recorded in 2007.
Method: Electronic care records were reviewed for all HHC patients who commenced IVP between 1st January 2011 and 31st December 2012 inclusive. Patients who commenced IVP prior to 1st January 2011 were assessed for MVP targets only.

Results: A total of 61 patients commencing venesection in 2011 & 2012 had completed the IVP at time of data collection. All 61(100%) met EASL guidelines for ferritin and transferrin saturations. 166 patients were assessed across all years for MVP. 153 met EASL guidelines. Of the 13 that failed to reach targets 6 had been withdrawn due to advancing age/medical conditions giving a 95.6% target achievement for those with vensections ongoing.

Conclusion: Introduction of a protocol driven, nurse led service has increased quality of care in our HHC cohort with overall ferritin targets improved from 72% to100% in IVP and from 80% to 95.6% in MVP.

ABSTRACT 40 (14S125) POSTER PRESENTATION

Title of Paper: Vitamin D levels in Hereditary Haemochromatosis

Author(s): Grace Harkin,Sinead Kinsella,Terri Mc Veigh,John Lee

Department(s)/Institution(s): Department of Hepatology,Galway University Hospital,Galway

Introduction: Hereditary Hemachromatosis (HH) is a recessive disorder of iron metabolism. Ireland has the highest carrier frequency in the world (1,2). Vitamin D deficiency has been associated with chronic liver disease(5,6) , and is common in Ireland, as a direct consequence of the country's latitude.

Aims/Background: The aim of this study was to investigate the influence of regular venesection on Vitamin D levels in patients with HH.

Method: The study group comprised 45 patients undergoing two-weekly venesection treatment for HH. Bloods were taken for 25-hydroxyvitamin D, PTH, Calcium, and liver function tests at treatment intervals. Statistical analyses were performed using SPSS v21

Results: The study group included 30 male and 15 female patients, with median age of 50years (24-76). There was no statistical difference in mean vitamin D or corrected calcium levels after 12 weeks, but iron and ferritin levels improved significantly (table). Multivariate analysis investigating factors affecting vitamin D levels included week of venesection, calcium, PTH, Iron and ferritin levels. Venesection significantly influenced vitamin D levels in patients treated in winter (p=0.03, logistic regression) and spring (p=0.007), but not in summer(p=0.95) or autumn(p=0.15).

Measurement(Mean(SD)) Week 0 Week 12 P-value

Vitamin D(IU) 40.73 (17.5) 42.44 (22.5) 0.727*
PTH(pg/ml) 32.6 (11.16) 36.8 (17.1) 0.22*
Corrected Calcium(mmol/l) 2.18 (0.16) 2.16 (0.07) 0.508*
Iron(µmol/l) 60.18 (15.9) 48.34 (21.3) 0.01*
Ferritin (median(range))/(µg/l)411 (169-5497) 249 (47-3786) 0.01#
*ANOVA
#Independent Samples Median test

Conclusion: Vitamin D levels may be influenced by venesection in patients with HH, but this effect is modified by seasonal variation

ABSTRACT 41 (14S134) POSTER PRESENTATION

Title of Paper: Transnasal Gastroscopy– A Faster Procedure And Better Tolerated Than Standard Endoscopy In A Feasibility, Safety And Acceptability Comparative Study

Author(s): Julie Regan 1, 4, Susan Lawson 1, 4, Barry Hall 2, 4, Grainne Holleran 2, 4, Maeve Murphy 1, 4, Barry McMahon 3, 4,

Deirdre McNamara 2, 4

Department(s)/Institution(s): 1 Speech and Language Therapy Dept., Tallaght Hospital; 2 Gastroenterology Dept, Tallaght Hospital; 3 MPCE, Tallaght Hospital, 4 Trinity Academic Gastroenterology Group (TAGG)

Introduction: Standard upper endoscopy (SE) is a vital tool in diagnostic and therapeutic gastroenterology. However, it frequently involves sedation which has associated costs and risks. Transnasal gastroscopy (TNG) has the potential to overcome these issues as it does not induce the pharyngeal gag reflex and does not require conscious sedation.

Aims/Background: This study aims to compare the feasibility, safety, duration and tolerance of TNG as a viable alternative to SE.

Method: Patients scheduled for SE were prospectively recruited and invited to undergo a non-sedated TNG procedure. A further group of patients scheduled for non-sedated SE were invited to participate as a control group. The SE procedures were performed using standard protocol with topical application of oral Xylocaine 10–30 mgs and a standard size Olympus gastroscope. TNG procedures were performed using either a Pentax EG-1690K 5.4 mm (N=38) or an Olympus 5.8mm (N=9) transnasal gastroscope which were passed via the nasal floor following application of Instillagel nasally and topical oral Xylocaine 10–30 mgs. Post procedure fasting (1 hour) and recovery advice was the same for both groups. The indication and duration of each procedure were recorded as were any complications. A Visual Analogue Scale (VAS) was used to assess overall patient tolerance and tolerance for each of the following parameters; pain, gagging, choking and anxiety graded on a 0-10 scale. All results were expressed as means and compared with a student T-test using SPSS 20. Significance was set at $p<.05$.

Results: 94 patients (62 males; mean age 53 years, age range 20–85 years) have been recruited to date (TNG=47; SE=47). Main indications were GORD (n=27, 29%), dysphagia (n=22, 24%), epigastric pain (n=17, 20%) and nausea (n=12, 13%). 100% of SE procedures and 89% of TNG procedures (42/47) were completed with intubation to D2 (failed trans-nasal intubation in 5 of 47 TNG studies). There was one complication (mucosal tear) in the SE group and 3 in the TNG group (3 cases of epistaxis). Mean duration of the TNG procedure was significantly shorter (8.76 mins) than SE (10.98 mins) ($p=0.025$). TNG (2.6) was better tolerated by patients than SE (4.3) ($p=0.002$), based on VAS scores. There was a significant advantage for TNG versus SE for choking on intubation (1.8 vs 3.8, $p<0.00$ 95% CI 1.1–3.0), gagging on intubation (2.8 vs 5.2, $p<0.00$ 95% CI 1.2–3.6) and gagging during the procedure (2.3 vs 5.3=, $p<0.00$ CI 1.8–4.2).

Conclusion: Findings suggest that TNG is safe and useful as a tool in diagnostic upper endoscopy. The TNG procedure is significantly quicker than SE and it is better tolerated by patients. Other potential added advantages included improved views, reduced length of stay and fewer complications. Recruitment continues to investigate these areas further.

ABSTRACT 42 (14S137) POSTER PRESENTATION

Title of Paper: An enhanced recovery program following minimally invasive oesophagectomy decreases duration of hospital stay and perioperative morbidity with improved patient outcomes.

Author(s): S. Cushen*, E. Ni Bhuachalla*, P. Carroll#, A. Griffith^, A. Ryan*, T. Murphy#

Department(s)/Institution(s): *Department of Nutrition, University College Cork, ^Department of Anaesthetics, #Department of Surgery, Mercy University Hospital, Cork

Introduction: Enhanced recovery programs (ERP) are multimodal perioperative pathways designed to achieve early recovery and improved outcomes for patients after major surgery. Prospective randomized controlled trials have demonstrated ERP decrease morbidity and hospital stay after colorectal surgery. Oesophagectomy has traditionally been associated with high perioperative morbidity and long hospital stays. Consequently ERP may have a role in improving outcomes post oesphagectomy however prospective studies and consensus guidelines are lacking.

Aims/Background: The aim of the study was to prospectively determine the impact of an ERP on perioperative and patient-reported outcomes post minimally invasive oesophagectomy.

Method: From January 2013 to March 2014 consecutive unselected patients undergoing minimally invasive oesophagectomy (MIO) were enrolled in a standardized multidisciplinary ERP including written patient education with daily treatment targets, pre-emptive analgesia, early structured mobilization and early enteral feeding protocols. Patients were commenced on jejeunostomy feeding day one and were discharged on overnight enteral feeding for one month post surgery. In-hospital/30 day outcomes, patient-reported global quality of life (QOL) scores (EORTC C30) and nutritional outcomes were prospectively collected.

Results: 25 patients underwent a MIO with an in-hospital/30-day mortality of 4%. 76% had an uncomplicated in-hospital stay. Median length of stay was 7 days (range 6-18). All patients were tolerating oral diet at discharge and no clinically significant weight loss occurred at 30 days (mean weight loss 3.7%). 30-day re-admission rate was 8%. Global mean QOL scores were not significantly reduced at 30 days compared to baseline (75 versus 69; $p=0.3$)

Conclusion: ERP after MIO is associated with reduced hospital stay, decreased perioperative morbidity, low readmission rates and improved nutritional and patient-reported outcomes.

ABSTRACT 43 (14S142) POSTER PRESENTATION

Title of Paper: Use Of Scoring System in prioritizing Upper Gastrointestinal Bleeding in a General Hospital

Author(s): Ambreen Ali Sheikh, Umar Kabir, Gerard Clarke

Department(s)/Institution(s): Department Of Medicine and Gastroenterology

Introduction: Upper Gastrointestinal bleeding (UGIB) is one of the most common causes of emergency admissions. Clinically, the presence of hematemesis, melena, or lab findings to support acute UGIB within a 10 day historical period1, are essential in formulation of the diagnosis of UGIB. It is very important to determine the hemodynamic status of the patient to establish whether admission is warranted or not.

Aims/Background: The Blatchford scoring system works as a beneficial tool in guiding the management of such patients, right from addressing the need for admission to providing a rationale for urgent endoscopic intervention.

Method: A retrospective study determining whether the Blatchford Scoring System is used in risk stratification of patients who present with UGIB to Portiuncula hospital, as it is the standard of care

prescribed by the NICE guidelines. We checked medical notes of patients presented to the A/E with UGIB with in a period of 7 months from 1/03/13 to 30/09/13. This study included 37 patients based on the inclusion criteria that hematemesis, melena, or lab results suggestive of UGIB (low haemoglobin) should be their presenting complaint. We analysed their records and established whether or not any scoring system was used. Then using the parameters of the Batchford Scoring system, we stratified the patients and evaluated whether best practice was followed by addressing whether high risk patients had endoscopy with in 24hrs, and whether the low risk group was clearly identified and early discharge arranged.

Results: The audit revealed that there was no recorded evidence of a Scoring system being used to stratify the risk of patients presenting with UGIB. Out of the 37 patients, 67% presented with haematemesis, and 19% with malena. 90% of the patients presented with Non Variceal bleeding. 16 of the patients were medical and 21 were surgical admissions. 11 Low risk patients were admitted to hospital and offered endoscopy whereas 8 high risk patients did not receive urgent endoscopy (with in 24hrs), and 7 did not have endoscopy.

Conclusion: All high risk patients need to have endoscopic evaluation with in 24hrs, and variceal bleeds need urgent intervention if suspected. Introduction of the Blatchford scoring system in the Emergency department, is a probably cost effective and a standard approach, as per standards, in order to accurately risk stratify the patients presenting with UGIB.

ABSTRACT 44 (14S146) POSTER PRESENTATION

Title of Paper: The correlation of wireless video capsule endoscopy and other radiological imaging in the investigation of suspected and established small bowel Crohn's disease

Author(s): Paul Moore, Andrew O'Cionnaith, Lisa O'Byrne, Grainne Holleran, Barry Hall, Deirdre McNamara

Department(s)/Institution(s): Departments of Gastroenterology and Clinical Medicine, Tallaght Hospital & Trinity College Dublin

Introduction: Background : In recent times there have been significant advances in both the radiological, CT and MRI Enterocolysis (CTE / MRE) and the endoscopic, video capsule endoscopy (CE) investigation of small bowel disease. The optimal complimentary and appropriate use of various new evolving and standard diagnostic modalities remains to be established. In particular, their role in identifying small bowel Crohn's disease remains unclear. Early identification of ileal Crohn's disease is desirable to guide treatment and impact on long-term outcome.

Aims/Background: Aim: To compare the diagnostic performance of CE and radiological imaging in detecting small bowel Crohn's disease in the local population and to correlate the findings of CE with other various imaging modalities.

Method: A retrospective analysis was undertaken of a database of patients who underwent capsule endoscopy from 2009 to 2013 at Tallaght Hospital. Those patients who underwent CE for known histologically-confirmed or suspected Crohn's disease were identified. This cohort was cross-referenced with the Hospital Radiology Report system "Keogh" for the same period. Patient demographics, radiological procedures, CE and radiology findings were recorded. The diagnostic yield and correlation coefficient was calculated for radiological tests compared to CE.

Results: In all, 263 patients, 155 female (59%), mean age 41 years, had a CE for known (n=29, 11%) or suspected (n=234, 89%) Crohn's disease. In all 110 (42%) had active disease on CE. In only 96 (37%) patients additional radiological tests were available for comparison, 73 (76%) and 23 (24%) in positive and negative CE cases. Of 28 CTE's, 28 SBFT's and 17 Abdominal CT's performed in positive CE subjects only 37 (51%) also reported evidence of active Crohn's disease, overall correlation coefficient ☐ = 0.49, 95% CI 0.37-0.61. SBFT was the least sensitive test, 32% (9/28), while CTE and Abdominal CT's had similar diagnostic yields of 64% (11/17) and 61% (17/28). Correlation was better among patients without active Crohn's disease, with 20 of 23 radiological tests, 7 CTE's, 7 SBFT's and 9 Abdominal CT's also being reported as normal, correlation coefficient ☐ = 0.87, 95% CI 0.72-1.0. The incremental diagnostic yield for CE in patients with suspected or known Crohn's disease in our cohort compared to radiological investigations was 34%, CE 76% and all Radiology 42%.

Table 1: Diagnostic yield according to test.

Number (%)	CE	CTE	CT-Abd	SBFT
Positive	73 (76%)	18 (51%)	11 (42%)	11 (31%)
Negative	23 (24%)	17 (49%)	15 (58%)	24 (69%)
Total	96	35 (36%)	26 (27%)	35 (36%)

Conclusion: Conclusion: Despite its poor diagnostic yield and the advent of new diagnostic modalities SBFT remains a frequently employed test in CD. Notwithstanding the inherent bias in our study, the findings suggests the correlation between CE and standard and targeted small bowel radiology is at best moderate, with CE having a higher diagnostic yield. CE should be considered in all subjects with suspected Crohn's disease.

ABSTRACT 45 (14S147) POSTER PRESENTATION

Title of Paper: GI bleeding in the modern era - A 3-year review at Tallaght Hospital

Author(s): Paul Moore; Grainne Holleran; Barry Hall; Deirdre McNamara

Department(s)/Institution(s): Departments of Gastroenterology and Clinical Medicine, Tallaght Hospital & Trinity College Dublin

Introduction: Gastrointestinal bleeding is a common clinical condition accounting for up to 13% of Gastroenterology referrals. It frequently requires hospitalization with subsequent intervention and is associated with significant morbidity and mortality. Determining the origin of bleeding can be a challenge. Newly available modalities in both gastroenterology and radiology are available to address obscure bleeding cases.

Aims/Background: a) To examine the role of endoscopic and radiological investigations in a cohort with GI bleeding. b) To assess the diagnostic performance of available radiological and endoscopic techniques in cases of GI bleeding, including obscure bleeding.

Method: A Retrospective analysis was undertaken of patients admitted with Gastrointestinal bleeding at Tallaght Hospital from 2010-2013 via HIPE (Primary discharge diagnosis – Malaena, Haematemesis, Gastrointestinal haemorrhage or IDA due to bleeding). Discharge summaries were reviewed and patients were

excluded if they were <18 yrs or had no evidence of bleeding. All radiological and endoscopic investigations were identified from cross-referencing with "Keogh" Radiology, Capsule Endoscopy (CE) and Unisoft Endoscopy Reporting Systems. Outpatient investigations were included if prompted by the index admission. Patient demographics, procedures and positivity rates for the various modalities were recorded.

Results: In all, 418 patients were identified from HIPE, 106 (25%) were excluded following discharge review. Of the 312 remaining cases the majority were male 176 (56%) with a mean age of 59 years (Range 18-97). In all 294 (94%) presented with overt bleeding vs 18 (6%) with occult bleeding. Of note 18 (6%) underwent no investigation for bleeding. Of the 294 who had tests, 163 (55%) had either a colonoscopy or OGD and 122 (41%) had both and 39 (13%) proceeded to have additional endoscopic tests, CE and/or Enteroscopy. In all 110 (37%) had a specialized radiological test. After any investigation, 122 (41%) had negative tests with no etiology found. While 77 (26%) had obscure GI bleeding defined as a negative gastroscopy and colonoscopy. In this obscure cohort, only 26 (34%) had 2nd line GI Investigations and disregarding standard CT, only 27 (35%) had a specialized radiological test. Overall 66 (22%) remained obscure despite all investigations. The frequency of investigations by type and positivity rate is illustrated in table 1. Diagnostic yield was highest for standard endoscopy at 48% OGD and 28% Colon whilst also significant for CE (31%), Enteroscopy (50%) and Angiography (50%).

Table 1.

Table 1 cont'd

Table 1.	OGD	Colon	Entero-scopy	Capsule	CT	Fluoroscopy
Number	245	162	10	36	70	19
+ve Test	118	46	5	11	18	2
Positivity	48%	28%	50%	31%	26%	11%

Table 1 cont'd

	CT	CT/MRI	Nuclear	Angiography	CE
Number	27	5	1	8	8
+ve Test	6	0	0	4	0
Positivity	22%	0%	0%	50%	0%

Conclusion: Obscure GI bleeding remains common (26%) and the diagnosis often remains elusive despite advanced endoscopic and radiological tests. The diagnostic yield for many commonly employed less specific modalities is poor and suggests changes to the diagnostic paradigm are appropriate.

ABSTRACT 46 (14S149) POSTER PRESENTATION

Title of Paper: Early morning emergency endoscopy lists: An appropriate use of valuable resource?

Author(s): O Foghlu G, Shuhaibar M, Farnes Z, Harewood G, Patchett SE, Murray FE.

Department(s)/Institution(s): Gastroenterology Department, Beaumont Hospital/ RCSI, Dublin 9

Introduction: Prompt urgent endoscopy is appropriate in patients presenting with suspected upper gastrointestinal bleeding. In September 2013 an early morning bleeder list initiative "Bleeder List Program -BLP" commenced prior to routine endoscopy times. This service was provided by senior gastroenterology registrars supported by consultant gastroenterologists in emergency cases.

Aims/Background: This study aimed to analyse the Bleeder List Program (BLP) performance over a period of six months particularly in relation to inclusion criteria and outcomes.

Method: All endoscopies performed on the BLP were analysed, using EndoRAAD reporting system. The procedure indications and findings were recorded. We also analysed patient demographics and pre-procedure haemoglobin.

Exclusion criteria:
Patients scheduled for routine endoscopy, patients with prolonged hospitalisation for other co-morbidities and those who were inpatient at the time of data analysis were excluded from the evaluation.

Results: A total of 455 in-patients had underwent OGDs over the six month period (09/09/13-31/03/14). Of those 124 (27.3%) patients were scheduled on the "BLP". The mean age was 64 years with no gender difference.

The commonest indications submitted for OGD were anaemia 33%, melaena 15% and abdominal pain 10.5%. Risk stratification using Blatchford/ Rockall bleeding scores were not utilized in any patient referral. The average haemoglobin before endoscopy was 11.6g/dL and 10.4 g/dl in males and females respectively. Only 9 (6.5%) patients required therapeutic gastroscopy of the total 88% in patient OGDs performed on the BLP.

Conclusion: Findings of this evaluation illustrated that the "Bleeder List Programme" could be optimised by selecting patients more judiciously by applying Rockall/ Blatchford scores to avoid non-urgent cases utilizing extra (BLP) time. A pro-forma request form designed from this audit results may help in patient stratification and case prioritisation.

ABSTRACT 47 (14S152) POSTER PRESENTATION

Title of Paper: Did an early bleeder list program initiative impact on patients' hospital length of stay?

Author(s): Farnes Z, O Foghlu G, Shuhaibar M, Harewood G, Murray FE, Patchett SE

Department(s)/Institution(s): Gastroenterology Department, Beaumont Hospital/ RCSI, Dublin 9

Introduction: There is a bed crises in Irish hospitals, with a 5.7 day average length of stay (LOS) reported in 2012. Previous data from our centre demonstrated a mean LOS for gastrointestinal bleed at 3.2 days in 2011.
Aims/Background: Our unit commenced an early morning Bleeder List Program (BLP) in an attempt to reduce patient hospital stay. The aim of our study is to evaluate the impact of this program on LOS.

Method: In this audit of the "Bleeder List Programme" we reviewed all endoscopies, using Endo-RAAD and PIPE systems. We assessed referral source, indication, outcome, length of stay and follow up plans upon discharge.

Exclusion criteria:

Patients scheduled for routine endoscopy/ out-patients, patients with prolonged hospitalisation for other co-morbidities and those who were inpatient at the time of analysis were excluded from the audit.

Results: Endoscopy referral were coming from in patient wards, Acute Medical Assessment Unit (AMAU) and the Emergency Department in 56%, 38.3% and 5.7% of cases respectively. None of the requests had a relevant Blatchford or Rockall score. A total of 141 procedures were carried out (OGD 124 and 17 sigmoidoscopies) with only 9 (6.3% of total procedures) therapeutic endoscopies. The average (A)LOS of the patients within the audit was 7.57 days. The ALOS for < 50 years of age was 5.07 days, 50 – 65 years 6.97 days and over 65 years 11.29 days. The ALOS of those that underwent therapeutic endoscopy was 6.44 days compared to 8.33 days for the others. Follow up endoscopy was recommended in 50 (35.7%) of the total endoscopies performed. 46.8% of patients that underwent endoscopy had an LOS of 5 days or less.

Conclusion: Early morning BLP impact on average LOS can be optimized further with implementation of patient risk stratification criteria to utilize of resources in an economic manor.

ABSTRACT 48 (14S153) POSTER PRESENTATION

Title of Paper: Validation of Donor Risk Index in Orthotopic Liver Transplantation, an Irish National Study

Author(s): Ahmed Abu Shanab, Zaid Heetun, Bahman Honari, Naeem Ullah, Elgaily El Rayah, Daniel Schmidt, Masood Iqbal, Diarmaid Houlihan, P.Aiden Mc Cormick

Department(s)/Institution(s): Liver Unit, St.Vincent's University Hospital, Dublin, Ireland

Introduction: Continuous scoring systems for analysing donor risk index (DRI) have been developed recently. Despite increased need for liver allografts, we adopt high selection of donor criteria in our programme.

Aims/Background: We aimed to validate DRI and identify its potential use in Ireland.

Method: Data was collected from our national liver transplant unit from January 1, 2001 to December 31, 2011 with two and half years of follow up. Data of 483 transplants were analysed, including DRI, other donor, transplant and recipient factors. The outcome was graft failure-free survival and DRI score was categorized as low (≤1.6), medium (1.61-2) and high (>2). Different DRI categories were evaluated with separate Kaplan-Meier curves.

Results: Of all 483 transplants, (14%) were listed as superurgent and (1.2%) cases had split partial graft. Median graft free survival was 5.64 years with 13% had re-OLT. More than half of donors were male and 43% of all donors were < 40 years. The cause of death was secondary to cerebro-vascular accidents in two thirds of donor deaths where 91.7% were allocated regionally from Ireland with mean cold ischemic time 9.2 hours. The average DRI was 1.4 with less than 5% had DRI >2. Kaplan Meier curves showed significant discrimination by the DRI categories, either with or without inclusion of emergent cases, in respect to failure-free survival with p value of 0.025 and 0.001 respectively.

Conclusion: DRI is generally low in our programme as we do not accept donation after cardiac death (DCD). High DRI was predictive of poorer graft survival.

ABSTRACT 49 (14S156) POSTER PRESENTATION

Title of Paper: Surveillance Endoscopy Compliance with Guidelines: Glass still only half full

Author(s): Joyce A, Shahin A, Ahmed Z, Buckley M, Smyth C, Farrell RJ.

Department(s)/Institution(s): Department of Gastroenterology, Connolly Hospital Blanchardstown, RCSI, Dublin 15.

Introduction: A significant proportion of patients' are recalled too early or unnecessarily for surveillance endoscopies compounding already long wait times for symptomatic patients

Aims/Background: To ensure that all surveillance endoscopy procedures for Barretts's oesophagus, colon adenomas, family history of colorectal cancer (CRC) and chronic IBD comply with current BSG guidelines.

Method: 121 patients listed for upper and lower surveillance endoscopy for the period November 2012 to February 2014 had their chart reviewed in this single-centre retrospective audit. Procedures that did not comply with BSG CRC (2010) and Barretts oesophagus guidelines were reviewed by 2 Consultant Gastroenterologists

Results: 38 patients were listed for upper endoscopy surveillance (25 Barrett's oesophagus) and 83 patients were listed for colonoscopy surveillance (37 polyp surveillance; 33 CRC family history surveillance; 10 IBD surveillance and 3 miscellaneous. Although, compliance with guidelines for CRC family history and Barrett's oesophagus surveillance was high at 91% and 80%, respectively, 6/25 (24%) patients listed for Barrett's surveillance did not have histological evidence of Barrett's oesophagus and were removed from the surveillance list. Compliance with polyp surveillance and IBD guidelines was poor at 49% and 50%, respectively. While 78/121 patients were compliant with guidelines (65%) and surveillance intervals remained unchanged in 62/121 patients (51%), 35/121 patients had their surveillance intervals extended (29%) and a further 22/121 patients (18%) were removed from surveillance

Conclusion: Almost half our surveillance patients were either listed for inappropriately short surveillance intervals or should not have been on surveillance lists. Closer adherence to guidelines and booking surveillance intervals based on histology results rather than endoscopy findings could significantly improve surveillance compliance for polyp, IBD and Barrett's oesophagus patients. From July 2014 we will only list patients for prospective surveillance endoscopies at our unit who are on a consultant-vetted, server-based, endoscopy surveillance register.

ABSTRACT 50 (14S157) POSTER PRESENTATION

Title of Paper: First year's experience of the National Colorectal Cancer Screening programme at Connolly Hospital Blanchardstown

Author(s): Ann Joyce, Ammar Shahin, Zuhair Ahmed, Maire Buckley, Claire Smyth, Richard Farrell

Department(s)/Institution(s): Department of Gastroenterology, Connolly Hospital Blanchardstown and RCSI, Dublin 15

Introduction: Following the launch of BowelScreen® by the Irish National Cancer Screening Service (NCSS) Connolly Hospital commenced CRC screening colonoscopies in May 2013 based on faecal immunohistochemical testing (FIT) in adults aged 60-69 yrs.

Aims/Background: Following the launch of BowelScreen® by the Irish National Cancer Screening Service (NCSS) Connolly Hospital commenced CRC screening colonoscopies in May 2013 based on faecal immunohistochemical testing (FIT) in adults aged 60-69 yrs.

Method: All Bowel Screen patients were identified from our EndoRAAD endoscopy reporting system using their unique NCSS number (COR ID). Data extracted from EndoRAAD included sedation levels, caecal intubation rate, mean caecal withdrawal time, polyp detection and suspected tumour diagnosis. A diagnosis of adenoma or colorectal carcinoma was confirmed by histology.

Results: 134 patients (69 male, 65 female) underwent screening colonoscopy between May 2013 and March 2014 at our hospital. The caecal intubation rate was 96.3%. Three patients were referred for CT colonography (2.2%) and two required repeat colonoscopy. Median (interquartile range) Midazolam dose was 4 mgs (3-10mgs), median Pethidine dose was 25mgs (25-50mgs) and median Fentanyl dose was 75mgs (50-100mgs). The mean caecal withdrawal time was 18.2 minutes. The polyp detection rate was 62% (83/134) with an adenoma detection rate of 57% (76/134). Sessile serrated polyps were detected in 8 patients (5.9%). Twenty-five patients (18.6%) had an adenoma > 1cm in size. Two adenomas had high grade dysplasia (1 removed endoscopically and 1 removed surgically). Detected adenomas were completely removed at the index colonoscopy in 94% (78/83); two patients required two further colonoscopies to clear the colon and three required sigmoidoscopies. Eight patients (6%) had colorectal cancer: six have had surgery and 2 have had adjuvant chemotherapy (3 stage 1, 1 stage 11a, 2 stage 11b, 1 stage 111b and 1 stage 4). One patient had a bleed post biopsy requiring a 2 unit blood transfusion.

Conclusion: The initial experience of the BowelScreen® programme at our centre reflects international experience with FIT-based screening with a 6% cancer detection rate and high advanced adenoma detection and removal rates.

ABSTRACT 51 (14S158) POSTER PRESENTATION

Title of Paper: Prevalence and Epidemiology of Autoimmune Hepatitis and Primary Biliary Cirrhosis across the South-Eastern Regional Health Board.

Author(s): Zaid Heetun, Noreen Maher, Angela Buggy, Pauline Carroll, Abdur Rahman Aftab, Garry Courtney
Department(s)/Institution(s): St Luke's Hospital, Kilkenny

Introduction: Autoimmune Hepatitis (AIH) and Primary Biliary Cirrhosis (PBC) are rare autoimmune conditions with unknown prevalence in the Irish population.

Aims/Background: To evaluate the prevalence and epidemiology of those two conditions.

Method: This study was conducted in St Luke's General Hospital (SLGH). SLGH was chosen as it is the referral center for liver diseases in the South-East covering a catchment area of approximately 500 000 individuals. From the hepatology database we identified all patients diagnosed with AIH and PBC from 2001 to 2013. We followed all patients through January 2014. Patient demographics, date of diagnosis and outcome were obtained from chart review.

Results: There were 61 and 49 patients diagnosed with AIH and PBC respectively. In the AIH group, there were 53 females (86.9%) and mean age at diagnosis was 56.5 years compared to 46 females (93.9%) and mean age at diagnosis of 57.0 years in the PBC group. In our follow-up, 8 (13.1%) and 6 (12.2%) patients had died in the AIH and PBC groups respectively. 2 patients (3.3%) with AIH progressed to liver transplantation compared to one (2.0%) with PBC. There were no statistical differences between the two groups. The incidence rate for AIH was 1.01 per 100 000 population per year and remained stable during the study period compared to an incidence rate of 1.40 per 100 000 population per year and halved during the study period for PBC. The prevalence rate for AIH and PBC were 12 and 10 per 100 000 population respectively. In addition most cases of AIH were diagnosed in spring (34.3%) compared to other seasons and the least number of PBC cases (8.1%) were diagnosed in autumn.

Conclusion: This is the first study documenting incidence and prevalence of AIH and PBC in the Irish population. We report that although there are no differences in patients' demographics for AIH and PBC, the incidence and seasonal variations of those two diseases are different. In particular, there is a peak of AIH diagnosis in spring. This has not previously been reported. This may be related to increase in viral infections in this time period.

ABSTRACT 52 (14S164) POSTER PRESENTATION

Title of Paper: What is the colonoscopy polyp yield from an average risk cohort screened outside the National Screening programme?

Author(s): M Walshe, I Cretu, M Boyle, J Leyden, L O'Brien, P MacMathuna.

Department(s)/Institution(s): GI Unit, Mater Misericordiae University Hospital, Dublin 7.

Aims/Background: National colorectal cancer (CRC) screening is now being rolled out for persons aged 55-74yrs using FIT (faecal immunochemical test) as the initial screening test. To date, the observed polyp yield has been high. Our High Risk family clinic, in common with general experience, includes individuals with perceived rather than actual high risk who fall into a similar average risk category. In real life, many average risk individuals have screening colonoscopy. Here we present our experience of colonoscopic screening of patients deemed to be in the average risk group.

Method: Patients referred for screening were identified from a dedicated colon screening database and characterised as high (incl. HNPCC), moderate, or average risk based on family history CRC. We excluded high and medium risk patients, and focussed on the outcomes of the average risk group. In particular, we focussed on polyp yield in those who had undergone colonoscopy. Polyps were classified as advanced adenoma (AA) or simple adenomas (SA), based on established criteria.
Result: 438 average risk individuals were identified, 161(37%) male, 277(63%) female, median age 45 yrs (range 19-75yrs). 204(47%) had a screening colonoscopy; 79(39%) male, 125(61%) female. Median age at colonoscopy was 50yrs (range 20-75yrs). The polyp yield is outlined below:

Reference
1. Resolor® Summary of Product Characteristics.

Conclusion: The total polyp yield was significantly greater in patients >55yrs compared to those <55yrs; p=0.014. Our data supports the lower age limit of 55yrs for the Irish national CRC screening programme.

Age	<55yrs n=127	>55yrs n=77	Total n=204	*P value*
Advanced adenoma	4(3%)	7(9%)	11(5%)	*0.11*
Simple adenoma	16(13%)	17(22%)	33(16%)	*0.08*
No Adenoma	107(84%)	53(69%)	160(79%)	*0.014*

ABSTRACT 53 (14S169) POSTER PRESENTATION

Title of Paper: ERCP in very elderly: outcome in patients over 80 years of age

Author(s): I Cretu, B Kelleher, S Stewart, Gayle Bennett, P MacMathuna, J Leyden

Department(s)/Institution(s): Gastrointestinal Unit, Mater Misericordiae University Hospital

Introduction: ERCP is an important procedure for the management of pancreato-billiary disease. The demand for ERCP is increasing in the elderly. There are limited data on the outcome of these complex procedures in this group of patients.

Aims/Background: Audit of ERCP outcomes in patients over 80 years of age

Method: Patients who underwent ERCP in our institution over a two year period - January 2012 to December 2013 - were identified from the electronic endoscopy database.
Retrospective data were collected, using a standardised data collection form, for procedures performed in 2012 from a combination of endoscopy reports/discharge summaries, radiology and laboratory reports.
Outcomes for patients referred from other institutions were assessed, where possible, using discharge documentation.
Subsequently, a prospective audit, collecting the same data, was performed in 2013. For patients transferred from other institutions, the referring teams were contacted to obtain the relevant information within 1 week of the procedure. Categorical data was analysed using Fisher's exact test.

Results: A total of 296 ERCPs were performed in patients >80 years, mean age was 83.2 years, 56 % female. These accounted for 24.8% of the ERCPs performed during the 24 month period. Twenty two (7.4%) procedures were performed in patients > 90 years.
The main indications for ERCP were choledocholithiasis (56%) and malignancy (23%).
The cannulation rate was, 88.5% with a completion rate 82.1%.
Procedures performed: sphincerotomy (39.2%), balloon trawl (57.7%), CBD stenting (49.3%), PD stenting (2.3%), lithotripsy (3.3%), and pre-cut sphincterotomy (3%, of which 89% were successful). CBD stone clearance rate was 91 %. Procedure complexity: 44% grade 2 and 54% grade 3.

The immediate complication rate was available for all patients and complete data on ERCP-related complications (immediate and delayed) were available on 233 (78.7%) of the patients. The overall complication rate in this group was 5.8% - pancreatitis 1.8%, infection 1.3%, cardiopulmonary 0.9 %, impacted lithotripsy basket 0.9%, bleeding 0.9%. There was no statistical difference in cannulation and complication rates in patients >80yrs and those <80yrs.
The estimated 30-day mortality rate was 2.3%; no deaths were attributed to the procedure.

CBD cannulation was unsuccessful in 34 cases. A PTC was performed in 14(41.1%) of these cases, repeat ERCP was successfully in 6(17.8%) and surgery was performed in 2(5.9%). A conservative/palliative approach adopted for 11(32.3%) of the patients and one patient was transferred back to the referring hospital for further management (2.9%).

Conclusion: ERCP in the elderly carries a high degree of success, without an increase in recognised ERCP-related complications.

ABSTRACT 54 (14S172) POSTER PRESENTATION

Title of Paper: The determination of prognosis and disease progression in patients with established cirrhosis

Author(s): Galvin Z, Dillon A, Lowry D, Russell J, Stewart S

Department(s)/Institution(s): Mater Misericordiae University Hospital

Introduction: Cirrhosis is a common chronic disease and is associated with significant morbidity and mortality. It is a dynamic process that evolves from early cirrhosis without portal hypertension to end-stage decompensated disease. Appropriate classification of a patient on the cirrhosis spectrum is important from the point of view of prognosis and management.

Aims/Background: To evaluate some of the non-invasive fibrosis-scoring tools and to establish which, if any, might be useful in determining the risk of clinical disease progression in patients with compensated cirrhosis

Method: Consecutive compensated cirrhotic patients attending the outpatient department over a two year period were recruited for the study. Each patient had a baseline visit and follow-up visits at regular intervals. Blood testing, transient elastography and psychometric testing was performed at each visit. The study endpoints were the development of ascites, hepatic encephalopathy, bleeding varices or death.

Result: Of 124 patients, 11 patients decompensated/had a liver-related death during the study (median follow up 15.4months). On univariate analysis liver stiffness measurement (LSM), PHES score, bilirubin, AST, creatinine, AST/ALT ratio, APRI, Fib4, ELF score, MELD and CPS were associated with death/decompensation ($p<0.05$) and bilirubin and LSM remained significant on multivariate analysis ($p<0.05$). A LSM cut-off threshold 26.3kPa gave a sensitivity of 81.8% and a specificity of 66.7% for detecting clinical outcomes. A bilirubin cut-off threshold 25.5µmol/L gave a sensitivity of 80.0% and a specificity of 84.7% for detecting clinical outcomes.

Conclusion: We found that in a compensated, cirrhotic population of mixed aetiology, the risk of decompensation/death was significantly associated with liver stiffness and bilirubin. With greater numbers it should be possible to develop a composite prognostic score using LSM and serum markers.

ABSTRACT 55 (14S176) POSTER PRESENTATION

Title of Paper: Dried blood Spot Testing for Hepatitis B and C in the Chinese Community living in Northern Ireland

Author(s): Annelies McCurley, Neil McDougall

Department(s)/Institution(s): NI Hepatitis Clinical Network and Regional Liver Unit, Royal Victoria Hospital, Belfast

Introduction: The epidemiology of hepatitis B and C in Europe is changing, with migration causing significant increases in prevalence rates. Northern Ireland still has a very low prevalence of viral hepatitis, with an average of 80 -100 HBV and 100 -120 HCV cases being diagnosed every year. Certain groups however are at higher risk of infection including those born in high or intermediate endemic areas.

Aims/Background: The aim was to set up a single viral hepatitis community screening event to offer testing to members of the Chinese community in Belfast and determine the prevalence of HBV and HCV in those tested.

Method: Members of the Belfast Chinese Community were invited to attend a Hepatitis B&C awareness and testing session held in the Chinese Welfare Centre. All those attending for testing were educated regarding the advantages and disadvantages of screening through a presentation (translated) and literature. Dry blood spot (DBS) testing was used as an alternative to venous sampling to try and encourage participation.

All patients (and their GPs) were informed of results by letter. Those with positive HBsAg or positive HCV antibody individuals were contacted by letter and also by telephone with the assistance of an interpreter and asked to attend a hospital clinic. Those who tested HBsAg negative and HBcAb positive were advised to attend their GP surgery for follow up HBV serology and HBV DNA. HIV testing was offered to all those with a positive result.

Results: 97 individuals expressed an interest in coming forward testing but 29 (30%) could not be screened as they were not registered with a GP in Northern Ireland. Of those that attended the event 55 individuals were tested (62% female, mean age 47, range 22 -67).
13 (24%) individuals tested HBsAg negative and HBcAb positive, - suggesting previous infection. Five patients (9%) individuals tested positive for chronic viral hepatitis – 4 were HBsAg positive and 1 was HCV PCR positive. All 5 subsequently attended a hepatology clinic for follow-up.
49 (89%) of those presenting for testing reported they had never been vaccinated against HBV.

Conclusions: DBS testing of a sample of the Chinese community living in a low prevalence area of the UK can detect chronic viral hepatitis in 9%. In addition, one third of those requesting screening were not registered with a GP and therefore could not be detected by current NHS services. This suggests that the NHS need to consider setting up screening services for ethnic communities even in low prevalence areas of the UK.

ABSTRACT 56 (14S101) POSTER PRESENTATION

Title of Paper: Identifying Achalasia subtypes using High Resolution Manometry – An early experience.

Author(s): Moran T+, Brennan M+, Lawlor P+, Macarthy F++, Ravi N*, Reynolds JVR*.

Department(s)/Institution(s): +GI Function Unit, St James's Hospital, Dublin. ++Department of Gastroenterology, St James's Hospital, Dublin. *Department of Surgery, Trinity Centre for Health Sciences, St James's Hospital, Dublin.

Introduction: High-resolution manometry (HRM) has proven to be a very effective tool in detecting impaired sphincter function. The metric used in HRM to detect abnormal OG junction relaxation is the integrated relaxation pressure (IRP). The IRP is the equivalent of LOS relaxation pressure in conventional manometry. One of the most interesting developments with HRM has been the classification of achalasia into distinct subtypes, something which is difficult to do with standard manometry. The classifications are based not only on LOS impairment, but also on the dominant feature of the distal oesophageal pressurisation after swallowing. The subtypes are: Type I Classic Achalasia, with little or no oesophageal pressurisation, Type II Achalasia with compression, showing oesophageal pressurization with little or no dilation of the oesophagus and Type III Achalasia with spastic contractions. Studies have shown that type II has the best outcome for treatment with pneumatic dilatation (PD) or Laparoscopic Heller's Myotomy (LHM) than type I or III with type III considered the most difficult to treat, due to the spastic nature of the contractions.

Aims/Background: Our aim was to establish the different Achalasia subtypes presenting to our physiology unit.

Method: 104 patients (57male, 47female) underwent HRM in the GI Physiology Unit at St James's Hospital, Dublin. Using the definitions recommended by the Chicago Classification scheme for HRM, we categorised the patients according to Achalasia subtype.

Results: A total of 15 patients (14%) had a manometry pattern consistent with Achalasia. The table illustrates the break down of subtype encountered

Achalasia Sub-Types Type I
(2 male) Type II
(4 male, 7 female) Type III
(1 male, 1 female)
n 2 11 2
Mean LOS Pressue (mmHg) 23.5 33.5 38.9
Mean LOS Length (cms) 4 3.3 4
Mean IRP (mmHg) 17 28.1 39
Mean distal amplitude (mmHg) 0 28 60
% Pan oesophageal pressure 0 100 100

Conclusion: We can conclude that there are distinct and recognizable subtypes in Achalasia. Type II appears to be the most common sub-type in our cohort, demonstrating pan-oesophageal pressurization in the oesophageal body. Achalasia type III is distinguishable from type II by the presence of rapid and premature oesophageal contractions, not seen in type I or II. These early findings are encouraging as we endeavour to study the outcome of treatment on the various subtypes going forward.

ABSTRACT 57 (14S106) POSTER PRESENTATION

Title of Paper: Endoscopy is associated with excellent patient satisfaction and positive experience.

Author(s): Zaid Heetun, Sujeevan Maheswaran, Mohmand Khan, Fatima Azad, Mary Hackett-Brennan, Mary O'Sullivan, Genevieve Corrigan, Garry Courtney, Abdur Rahman Aftab

Department(s)/Institution(s): St Luke's Hospital, Kilkenny

Introduction: There is no data on patient satisfaction and experience following day-case endoscopic procedures among Irish Hospitals. We evaluated same at our institution.

Method: From the 1st Nov 2013, 105 randomly selected patients were given a 21 point questionnaire, with Likert-scale questions on the day of their procedure. They were asked to complete the survey the following day and post in a pre-paid envelope. The questionnaire was designed by medical, surgical and nursing staff and aimed to address several factors in relation to patient satisfaction and

experience regarding endoscopy. Part of the questions were taken from the mGHAA-9 (modified Group Health Association of America - 9) Questionnaire.

Results: 54 patients returned the questionnaire (response rate 51.4%). There were 31 females (57.4%) and the mean age was 55 years. There were 19 gastroscopies, 5 flexible sigmoidoscopies and 30 colonoscopies. No patients (0%) had been waiting for more than a year for their procedure. The majority of patients (81.5%) had received information leaflets and 75.9% reported that the information was presented in a clear and easily understandable manner. Interestingly 5 (9.3%) patients were unsure what procedure they had undertaken. On the day-ward 74.1% of patients had spoken to both a nurse and doctor pre-procedure. In contrast only 18.5% reported speaking to both health professionals in the endoscopy unit pre-procedure. Most patients (>87%) were satisfied that they were adequately informed of the procedure, the risks and the results. 12 patients (22.2%) had signed their consent forms in the endoscopy procedure room. 94.4% of patients rated their experience as very good or good. Only 2 patients (3.7%) reported they would never have an endoscopy again. There were 13 (24%) unfavorable responses and long waiting time and pain during procedures accounted for 61.5% of those. Lack of information (2), lack of sedation (2) and lack of privacy (1) accounted for the rest of patients' complaints.

Conclusion: Our results demonstrate that most patients are satisfied with their endoscopic procedure and had a positive experience. This survey also highlighted short-comings in terms of number of patients signing their consent forms in the endoscopy unit and the long waiting time prior to the procedure which will be rectified.

ABSTRACT 58 (14S109) POSTER PRESENTATION

Title of Paper: Audit: Unsuccessful colonoscopies and eventual patient outcome in a District General Hospital

Author(s): S Paremal, A McGowan, C Apakama, A Jayaprakash

Department(s)/Institution(s): Department of Gastroenterology, Wansbeck General Hospital, Ashington, UK

Introduction: Failure in colonoscopy occur in up to 20% of cases. Repeat or alternative investigation is appropriate depending on clinical circumstances.

Aims/Background: We performed a review of failed colonoscopies to ascertain reasons for failure to assess eventual patient outcomes following failed colonoscopy.

Method: This is a retrospective analysis of 94 incomplete colonoscopies performed between March and July 2011 at Northumbria Healthcare Trust, which were identified from the endoscopy software.

Results: 1352 colonoscopies were performed during the study period with a failure rate of 6.9% (94/1352); significantly less than in other audits conducted elsewhere in the country. Male Female ratio was 33:61 and median age was 71 years (range 22- 98). Iron deficiency anaemia (30%) and change in bowel habit (29%) were the commonest indications for colonoscopy. Major causes for incomplete colonoscopy were, poor bowel preparation (21%, 20/94), obstructing tumour (14/94), patient discomfort (13.8%, 13/94), tight angulation (13.8%, 13/94), difficult loops (12.7%, 12/94). Majority (78.3%,29/37) of the patient who had tight angulation and looping were female. In 75% of the cases (71/94) an alternative investigation was carried out which is well above national average. CT pneumocolon was the commonest alternative investigation chosen (63.3% 45/71). 13 patients underwent repeat colonoscopy, of these, 3 (23%) were again incomplete and all of them were performed by different operator. 23 cases were not reinvestigated of which, in 11 (48%), indication was thought to be weak. Among the reinvestigated patients, only 21% (15/71) were done within 2 weeks after failed colonoscopy. New cancer detection rate on reinvestigation was (4.2%, 3/71).

Conclusion: Significant improvements that were made in the colonoscopy teaching and practice since the 2004 Bowel audit is reflected in this audit by lower failure and better reinvestigation rates. Proportion of patient discomfort and looping causing failure has significantly come down since the Bowel audit. Careful patient selection with appropriate indication and closer attention to bowel preparation and instruction could improve the colonoscopy failure rates even further.

ABSTRACT 59 (14S130) POSTER PRESENTATION

Title of Paper: Patients on urgent waiting list: how urgent are?

Author(s): Mohamed G, Monged A, Buckley M

Department(s)/Institution(s): Gastroenterology Department, Mercy University Hospital

Introduction: Scheduling of endoscopy lists is crucial for efficient running of endoscopy unit .There are consequence for hospital if it is not able to perform urgent endoscopy within 4 weeks.

Aims/Background: The aim of this study to assess the number of patients waiting for urgent endoscopy and to check their fulfillment to the specific criteria for urgent gastroscopy and colonoscopy.

Method: The study included patients were referred by consultant physician and surgeons for urgent endoscopy between November 2013 and February 2014. The questionnaire used included personal information, referring doctor, indication and type of endoscopy and criteria for urgent upper GI endoscopy according to NICE guidelines and lower GI endoscopy according to HSE criteria.

Results: Eighty one patients were on urgent endoscopy waiting list .Forty two of them (51.85%) did not fulfill the criteria for urgent endoscopy. Of 32 patients waiting for gastroscopy, 62.5 % were not urgent .Of 49 patients waiting for colonoscopy, 44.89% were not urgent. Forty three patients were referred by surgical team, 69.76 % were not urgent. Thirty eight patients were referred by medical team, 31.57 % were not urgent.

Conclusion: More than 50% of patients waiting for urgent endoscopy did not meet the criteria for urgent endoscopy and could be removed from the urgent waiting list. Protocols should be in place to ensure that patients been put on an urgent waiting list fulfill the criteria for urgent endoscopy. New referral criteria and protocols were developed at Mercy university hospital.

ABSTRACT 60 (14S139) POSTER PRESENTATION

Title of Paper: Postal consent for gastrointestinal endoscopy: a patient based analysis

Author(s): Zeyd Sako (1), Karen Hartery (1), Majd B Protty (2), Danny G. Cheriyan (1), Gavin Harewood (1), Stephen Patchett (1), Frank Murray (1)

Department(s)/Institution(s): (1) Beaumont Hospital, Dublin,

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GBIE.COL.13.0704 Date of preparation: July 2013

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(2) University Hospital of Wales, Cardiff, UK

Introduction: Increasing demands on endoscopy services have demanded that gastroenterologists streamline the process from referral to consenting. Frequently patients may not have been seen by a gastroenterologist prior to their procedure. We have recently introduced a new system to improve the quality of the informed consent prior to endoscopy. Despite these changes, it is important to remember that endoscopy requires "informed" consent. This means that the patient understands the nature of/reason for the proposed procedure and are given time to deliberate and ask appropriate questions.

Aims/Background: To assess patient opinion with regard to the postal consent forms.

Method: 137 outpatients referred for diagnostic gastrointestinal endoscopy were surveyed prospectively over a 2-week period. Patients were asked to complete a questionnaire in the endoscopy waiting area. This included patient demographics, education level obtained and information about procedure being performed. They were asked about how helpful the information given in post about the procedure was.

Results: 53% of the patient cohort were males. 67% had a previous endoscopic procedure. The majority of patients found information regarding taking prep (88%), medicine to be stopped (74%), description of procedure (91%) and after-care (83%) helpful. However despite appropriate information being forwarded to all patients, 27% of patients were not aware of the indication for their procedure, 11% believed that there were no risks associated with it and 15% reported not receiving any information in the post.

Conclusion: Our survey shows that postal consent process provides acceptable and comprehensible information to our patients. Whilst most patients were happy with the consenting process, a significant proportion appears to be poorly informed about the details of the procedure. Further reference to optimize patients understanding will be needed in the future.

ABSTRACT 61 (14S151) POSTER PRESENTATION

Title of Paper: The role of disease course and outcomes in a prospective IBD population cohort from the early 1990's in identifying IBD phenotype.

Author(s): Shuhaibar M, O'Morain C on behalf of the Irish EC-IBD (part of the European Collaborative study on inflammatory bowel disease) group.

Department(s)/Institution(s): Department of Gastroenterology, Adelaide and Meath Hospital, AMNCH/ TCD

Introduction: Inflammatory bowel disease course vary from one patient to another and hence prognosis.

Aims/Background: Evaluating disease course and outcomes in a prospective population cohort may help in identifying disease phenotype and possible prognostic indicators for the future of IBD management in Ireland

Method: A homogenous IBD population cohort from the Greater Dublin area diagnosed between 1991and 1992 was followed over 19 years. Patients completed study questionnaire that helped to identify disease phenotype at diagnosis, risk factors, disease severity, medical and surgical therapies as well as hospitalization rates.

Results: 76 UC and 42 CD patients were included. In the CD group, 81% were diagnosed <40 years of age, majority were females (64%). Appendectomy history appeared as a risk factor for terminal ileum CD which was diagnosed in 36% of the cohort whereas 39% had penetrating, fistulazing CD.
In the UC group, 67% of cases were diagnosed < 40 years of age with left sided colitis in the majority and 18% had pan-colitis. Surgical rates were high in the first5-10 years of diagnosis for both groups and hospitalisation was higher for CD than UC. 61.5% of CD patients had surgery compared to 23.4% of the UC group. The commonest procedures were terminal ileal resection, right hemicolectomy and total colectomy for CD and UC respectively. Ex-smoking was identified in 20% of UC patient at time of diagnosis

Conclusion: This Irish IBD population cohort identified disease course and treatment outcomes over 19 years since initial diagnosis. Females with CD under the age of 40 years with history of appendectomy had severe disease course and required surgery. UC disease course was relatively mild to moderate. More severe cases were identified in older males and ex- smokers.

ABSTRACT 62 (14S162) POSTER PRESENTATION

Title of Paper: Mesenteric Panniculitis - an uncommon radiological and clinical diagnosis, a retrospectice study

Author(s): Dr N Iqbal, Dr E Phelan, Dr V Kale, Dr I Khan, Dr N Breslin, Prof D Mc Namara, Prof W C Torregiani, Dr. B Ryan

Department(s)/Institution(s): Department of Gastroenterology and Radiology AMNCH.

Introduction: Mesenteric Panniculitis (MP) is a rare idiopathic chronic fibrosing inflammatory disease that affects the adipose tissue of the mesentery of the small intestine and colon.Various nomenclature has been used to describe this disorder which likely represent the different points in the natural history of the underlying process, with adipocyte necrosis (mesenteric lipodystrophy) evolving into a chronic inflammatory state (mesenteric panniculitis), and finally to fibrosis (sclerosing mesenteritis).
Pathophysiologically, these processes may affect the integrity of the gastrointestinal lumen and mesenteric vessels by a mass effect. It predominantly affects men between the fifth and seventh decades of life and may result in a variety of gastrointestinal and systemic manifestations, including abdominal pain, nausea and vomiting, diarrhoea, weight loss, and fever.
Its aetiology remains obscure, although several mechanisms have been suggested including previous abdominal surgery or trauma, autoimmunity, paraneoplastic syndrome, ischemic injury, and infection etc.
MP has been reported in association with a number of presumably autoimmune conditions, including Riedel thyroiditis, primary sclerosing cholangitis, retroperitoneal fibrosis autoimmune hemolytic anemia, minimal change nephropathy, systemic lupus erythematosus, and relapsing polychondritis.
One series described an association with elevated serum IgG4 and/or autoimmune pancreatitis in some patients, suggesting a possible role for IgG4-related immunopathologic processes in its pathogenesis.
A possible autoimmune aetiology is also supported by a clinical response to immunomodulatory medications including glucocorticoids, azathioprine and cyclophosphamide.

Aims/Background: The aim was to identify the all cases of MP diagnosed in our institution over the past 5 years. Secondly to perform a retrospective review of all the charts to establish the patient's demographics, what diagnostic work up was carried out and what if any associated medical conditions were identified.

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Remicade® 100mg Powder for Concentrate for Solution for Infusion (infliximab) *Prescribing Information (Refer to full SPC text before prescribing Remicade (infliximab))* **Indications:** *Rheumatoid Arthritis (RA)*: Remicade, in combination with methotrexate (MTX), is indicated for the reduction of signs and symptoms, as well as the improvement in physical function, in adult patients with active RA when the response to disease-modifying anti-rheumatic drugs (DMARDs), including MTX, has been inadequate, and in adult patients with severe, active and progressive disease not previously treated with MTX or other DMARDs. In these patient populations, a reduction in the rate of the progression of joint damage, as measured by X-ray, has been demonstrated. *Adult Crohn's Disease (CD)*: Remicade is indicated for the treatment of moderately to severely active CD in adult patients who have not responded to, or are intolerant of, a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; and fistulising active CD in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment (including antibiotic, drainage and immunosuppressive therapy). *Paediatric Crohn's Disease (CD)*: Remicade is indicated for the treatment of severe, active CD in children and adolescents aged 6 to 17 years who have not responded to conventional therapy including a corticosteroid, an immunomodulator and primary nutrition therapy; or who are intolerant to or have contraindications for such therapies. *Ulcerative Colitis (UC)*: Remicade is indicated for the treatment of moderately to severely active UC in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies. *Paediatric Ulcerative Colitis (UC)*: Remicade is indicated for treatment of severely active UC, in children and adolescents aged 6 to 17 years, who have had an inadequate response to conventional therapy including corticosteroids and 6-MP or AZA, or who are intolerant to or have medical contraindications for such therapies. *Ankylosing Spondylitis (AS)*: Remicade is indicated for the treatment of severe, active AS, in adult patients who have responded inadequately to conventional therapy. *Psoriatic Arthritis (PsA)*: Remicade is indicated for the treatment of active and progressive PsA, in adult patients when the response to previous DMARD drug therapy has been inadequate. Administration should be in combination with MTX or alone in patients who show intolerance to MTX or for whom MTX is contraindicated. A reduction in the rate of progression of peripheral joint damage in patients with polyarticular symmetrical subtypes of PsA has been measured by X-ray. *Psoriasis (PsO)*: Remicade is indicated for the treatment of moderate to severe plaque PsO in adult patients who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, MTX or PUVA. **Dosage and administration**: To improve the traceability of biological medicinal products, the trademark and the batch number of the administered product should be clearly recorded in the patient file. Remicade should be administered intravenously, infused and supervised by physicians experienced in the diagnosis and treatment of RA, CD, UC, AS, PsA and PsO. Remicade should be administered intravenously over a 2 hour period. All patients administered Remicade should be observed for at least 1 to 2 hours post infusion for acute infusion-related reactions by appropriately trained healthcare professionals. *Shortened infusions in non-adult indications*: In carefully selected adult patients who have tolerated at least 3 initial 2-hour infusions of Remicade (induction phase) and are receiving maintenance therapy, consideration may be given to administering subsequent infusions over a period of not less than 1 hour. If an infusion reaction occurs in association with a shortened infusion, a slower infusion rate may be considered for future infusions if treatment is to be continued. Shortened infusions at doses >5 mg/kg have not been studied. *RA*: 3 mg/kg given as an intravenous infusion followed by additional 3 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. *Adult moderately to severely active CD*: 5 mg/kg given as an intravenous infusion followed by an additional 5 mg/kg infusion 2 weeks after the first infusion. If a patient does not response after 2 doses, no additional treatment should be given. *Adult, fistulising, active CD*: 5 mg/kg intravenous infusion followed by additional 5 mg/kg infusions at 2 and 6 weeks after first infusion. If a patient does not respond after 2 doses, no additional treatment should be given. *UC*: 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. Clinical response is usually achieved within 14 weeks of treatment (3 doses). *AS*: 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 6 to 8 weeks. If a patient does not respond after 2 doses, no additional treatment should be given. *PsA*: 5 mg/kg given as an intravenous infusion period followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. *PsO*: 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. If a patient shows no response after 4 doses, no additional treatment should be given. *Readministration*: Remicade can be readministered within 16 weeks following the last infusion. The safety and efficacy of readministration after a Remicade-free interval of more than 16 weeks has not been established in either CD or RA. The safety and efficacy of readministration in AS, other than every 6 to 8 weeks and in PsA and UC, other than every 8 weeks, has not been established. Readministration with any single Remicade dose in PsO after an interval of 20 weeks suggests reduced efficacy and a higher incidence of mild to moderate infusion reactions when compared with the initial induction regimen. Limited experience from retreatment, using a reduction regimen suggests a higher incidence of infusion reactions, some serious, when compared to 8 weekly maintenance treatment. In cases maintenance therapy is interrupted in any indication, and there is a need to restart treatment, Remicade should be reinitiated as a single dose followed by the maintenance dose recommendations. *Paediatric population*: *CD (6 to 17 years)*: 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. If a patient does not respond by 10 weeks, no additional treatment should be given. *UC (6 to 17 years)*: 5 mg/kg given as an intravenous infusion over a 2-hour period followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. *Available data do not support further infliximab treatment in paediatric patients not responding within the first 8 weeks of treatment*. **Contra-indications:** Tuberculosis or other severe infections such as sepsis, abscesses and opportunistic infections; patients with a history of hypersensitivity to infliximab, other murine proteins or any of the excipients; patients with moderate or severe heart failure (NYHA class IIIB/IV). **Precautions and Warnings**: *Infusion reactions*: *Acute infusion reactions* including anaphylactic reactions may develop during (within seconds) or within a few hours following infusion. If acute infusion reactions occur, the infusion must be interrupted immediately. Emergency equipment, such as adrenaline, antihistamines, corticosteroids and an artificial airway must be available. Antibodies to infliximab may develop and have been associated with increased frequency of infusion reactions. Symptomatic treatment should be given and further Remicade infusions must not be administered. In clinical studies, delayed hypersensitivity reactions have been reported. Available data suggest an increased risk for delayed hypersensitivity with increasing Remicade-free intervals. *Infections*: Patients must be monitored closely for infections, including tuberculosis, before, during and up to 6 months after treatment with Remicade. Exercise caution with use of Remicade in patients with chronic infection or a history of recurrent infection. Patients should be advised of potential risk factors for infections. Suppression of TNFα may mask

Philip Cullinan, Olympus

Howard Simpson, Dr Falk

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Method: This was a retrospective study. Radiology data base (CT Scan) was searched using the search criteria "Mesenteric Panniculitis" and " Misty Mesentery". The charts of these patients are currently being reviewed to establish the clinicopathologic correlations of this disorder. Furthermore the results of follow up scans were reviewed, where available to assess the natural history of this rare condition.

Result: A total of 20 cases were identified from the radiology data base using the above mentioned criteria between 2008 and 2013. There were 13 (65%) Male and 7 (35%) female patients .The mean age was 53.1 +/- 11.6. The clinicopathologic correlates and follow up of these patients is currently being completed.

Conclusion: MP is an uncommon condition. It has been reported to be associated with number of underlying medical conditions. We are currently reviewing our cohort to evaluate the frequency of the putative associated conditions within Irish population.

ABSTRACT 63 (14S166) POSTER PRESENTATION

Title of Paper: Percutaneous Transhepatic Cholangiography: a vital complimentary modality to ERCP for complex biliary disease.

Author(s): B. Murphy[1], I. Cretu[1], P. MacMathuna[1], J.Leyden[1], L.Lawler[2], C.Farrelly[2]

Department(s)/Institution(s): Gi Unit[1], Department of Radiology[2], Mater Misericordiae University Hospital

Introduction: Percutaneous transhepatic cholangiography (PTC) is an integral part of a modern pancreatobiliary service. PTC is a therapeutic intervention, usually performed in two phases, allowing a needle, under an imaging modality to be inserted into the biliary tree in order to allow biliary system decompression often followed by drain internalisation as the second stage.

Aims/Background: Audit of PTC procedures performed following a failed endoscopic retrograde cholangiopancreatography (ERCP) over a 2-year period. Outcomes were compared to current standards of practice: CPG guidelines 2010.

Method: ERCP and PTC reports were retrospectively reviewed and patient outcomes were analysed using the hospital's electronic patient record, over a 2-year period (2012 – 2014).

Results: Overall, 80 PTC interventions were performed on 60 patients within this timeframe: 35 males (56.92%), 25 females (43.08%); average age was 68.56 years.
The main indication for PTC was biliary stricture (80.64%) – of which 94% were malignant: 18 (pancreatic neoplasm), 6 (cholangiocarcinoma), 4 (metastatic colorectal), 3 (gallbladder), 2 (duodenal), 2 (oesophageal), 1 (metastatic gastric), 1 (metastatic pancreatic neuroendocrine), 2 (presumed neoplastic process).

29 of the cases were performed as one-stage procedure: external-internal drain only (11 cases), assessment of current stent patency (7 cases), direct stenting (5 cases), diagnostic PTC (3 cases), stent dilatation (2 cases) and external drain only (1 case).
There were 29 two-stage interventions: external/internal drain insertion followed by stenting (19 cases) and rendezvous ERCP (10 cases).

The post-procedure complication rate overall was 22.5%: unsuccessful procedure 6.25% (5 cases), sepsis 4% (2 cases), bleeding 4% (2 cases), post-procedure biloma 2% (1 case), stent occlusion requiring repeat procedure 8.75% (7 cases) and stent dislodgment 2% (1case).

The 30-day mortality was 8 (10%), 2 attributed to the procedure (1x bleed, 1x sepsis).

ABSTRACT 64 (14S170) POSTER PRESENTATION

Title of Paper: Audit of ERCP key performance indicators in a high volume interventional/biliary endoscopy centre

Author(s): I Cretu, B Kelleher, S Stewart, Gayle Bennett, P MacMathuna, J Leyden

Department(s)/Institution(s): Gastrointestinal Unit, Mater Misericordiae University Hospital

Introduction: Quality assurance and audit have become key components of modern endoscopy practice, with particular focus in recent years on colonoscopy and gastroscopy practice. There is less data on quality outcomes for ERCP.

Aims/Background: To determine ERCP outomces, including complictions, in our institution and to compare these to the quality assurance standards proposed by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

Method: Patients who underwent ERCP in our institution over a two year period - January 2012 to December 2013 - were identified from the electronic endoscopy database.
Retrospective data were collected, using a standardised data collection form, for procedures performed in 2012 from a combination of endoscopy reports/discharge summaries, radiology and laboratory reports.
Outcomes for patients referred from other institutions were assessed, where possible, using discharge documentation.
Subsequently, a prospective audit, collecting the same data, was performed in 2013. For patients transferred from other institutions, the referring teams were contacted to obtain the relevant information within 1 week of the procedure.

Results: A total of 1192 ERCPs were performed -56 % female, 44 %male. The main indications for ERCP were choledocholithiasis (62%) and malignancy (23%). The cannulation rate was, 89.95%, with a completion rate 81.8%.
Procedures performed: sphincerotomy (46.9%), balloon trawl (56.5%), CBD stenting (35.9%), PD stenting (1.9%), lithotripsy (1.65%), and pre-cut sphincterotomy (2.65%, of which 67% were successful). CBD stone clearance rate was 91.5 %. Procedure complexity: 46% grade 2 and 52% grade 3.
Immediate complication rate was available for all patients and complete data on ERCP-related complications (immediate and delayed) were available on 976 (78.7%) of the patients. The overall complication rate in this group was 5% - pancreatitis 1.89%, infection 1.3%, cardiopulmonary 0.7 %, impacted lithotripsy basket 0.07%, bleeding 0.55%.
The estimated 30-day mortality rate was 1.6%; no deaths were attributed to the procedure.
CBD cannulation was unsuccessful in 120 cases (10.05%); PTC was performed in 53(44%) cases, repeat ERCP was successful in 30(25%) cases, 13 (20%) patients underwent surgery and conservative/palliative approach was adopted for 24(11%) patients.

Conclusion: The therapeutic success rate was excellent with a low complication rate. The cannulation, completion and complication rate met the quality assurance standards set by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

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Date of preparation: February 2013 IE/13500

ABSTRACT 65 (14S175) POSTER PRESENTATION

Title of Paper: Ambulatory Liver transplant assessment reduces bed usage without compromising patient safety

Author(s): B Layard, N.I. McDougall, W.J. Cash

Department(s)/Institution(s): Liver Unit, Royal Victoria hospital, Belfast

Introduction: In 2009 all patients with end stage liver disease or other indications for liver transplantation were admitted to our unit for in-patient assessment whilst being considered for listing on the transplant waiting list. In early 2010 an ambulatory assessment service was launched. Initially, selected patients underwent ambulatory assessment and subsequently the majority of assessments are undertaken in the programmed treatment unit.

Aims/Background: To assess the effectiveness and safety of ambulatory liver transplant assessments

Methods: All liver transplant assessments performed from 1st February 2009- 8th August 2009 were included and compared to all liver transplant assessments from 1st February 2012 – 8th August 2012 inclusive. Demographics, underlying indication for transplant, UKELD scores, length of stay (overnights in hospital) and whether patients were listed for transplant or not were recorded.

Results: 31 patients underwent liver transplant in the 2009 group, 20 male. These patients had an average length of stay of 11.55 days in a hospital bed and 9 of the 31 patients were subsequently listed for transplantation (29%). Median UKELD score in this group at the time of assessment was 57.3.
33 patients underwent transplant assessment in the same period of 2012, 18 male. The average length of stay for these patients was 0.25 days (only 1 patient admitted for assessment). 14 patients in this group were listed for transplantation (42%). Median UKELD score in this group was 54.2.

Conclusion: Ambulatory liver transplantation is safe and does not impact negatively on a patient's chances of being listed for liver transplantation. Moreover, there is a significant reduction in the use of hospital beds.

ABSTRACT 66 (14S123) POSTER PRESENTATION

Title of Paper: Double Balloon Enteroscopy: A single centre experience of clinical appro-priateness, safety and diagnostic yield.

Author(s): Conor Grant, Jun Liong Chin, Grace Chan, Nasir Mahmud

Department(s)/Institution(s): St. James's Hosptial

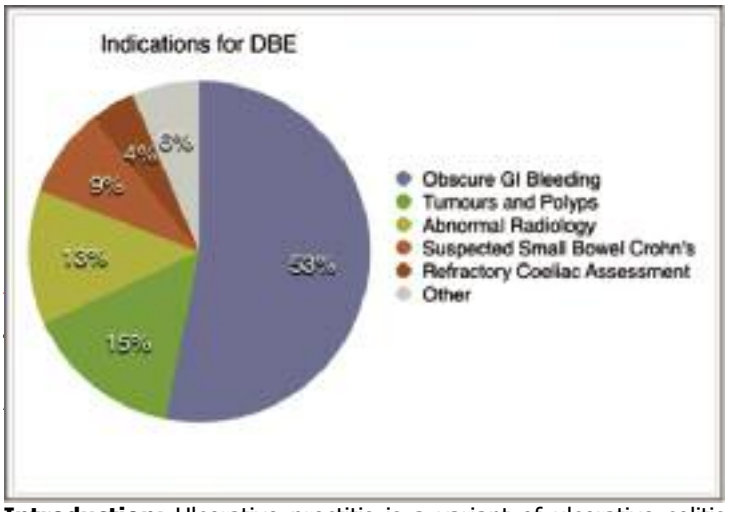
Introduction: Double-Balloon Enteroscopy (DBE) allows examination of the entire small bowel.

Aims/Background: We audited our practice against the British Society of Gastroenterology guidelines on small bowel enteroscopy and capsule endoscopy in adults.

Method: Information regarding indications, sedation used, findings, therapies applied and complications for each DBE procedure performed in our institution was retrieved.

Results: 47 DBEs were performed on 40 patients (25 males and 15 females) in the study period. The mean age was 50±16 years. All of the indications for DBEs were appropriate. The most common indication for DBE was anaemia due to occult gastrointestinal bleeding (53%;25/47). 15% of DBEs were performed for small bowel tumours and polyps while abnormal radiology necessitated 6 DBEs (13%). Almost half of all DBEs (49%; 23/47) were performed for indications, where capsule endo-scopy was initially recommended but had not been carried out. The mean midazolam used was 8.2±2.9mg; pethidine used was 59.3±19.3mg; fentanyl used was 81.3±21.7mcg; and diazepam used was 8.2±3.3mg. The diagnostic yield was low; only 32% (8/25) of patients who had DBE for anaemia and 17% (1/6) of DBEs for abnormal radiology showed significant pathology. Therapeutic interventions include polypectomy in 4 cases, and argon plasma coagulation treatment in 3 DBEs. Complications reported were benzodiazepine toxicity for one patient, minor haemorrhage in three patients, and one case of severe discomfort.

Conclusion: Although DBE was relatively safe with rare complications, it remains a relatively invasive procedure requiring large amounts of sedation.



Introduction: Ulcerative proctitis is a variant of ulcerative colitis anatomically limited to the rectum. Disease course and prognosis particularly in term of refractoriness is varied. Disease extension beyond the rectum in this subset of patients with ulcerative colitis is associated wtih a poor prognosis and has been linked with a increased likelihood of corticosteroid prescription at diagnosis, higher rates of disease relapse and chronic activity, and higher risk of disease hospitalisation in these patients with disease extension.

We sought to evaluate the outcomes of patients at our centre with a diagnosis of ulcerative colitis and evaluate outcomes among patients who had disease extension in comparison to patients with limited rectal disease. We retrospectively analysed endoscopic records using ERAD correlating with histopathology and reviewed disease extent at the time of diagnosis to identify patients with ulcerative proctitis within our Inflammatory Bowel Disease (IBD)

database. Disease course and progression was recorded using follow up endoscopy reports and outpatient clinic correspondance. 173 patients with ulcerative proctitis were included.

ABSTRACT 68 (14S174) POSTER PRESENTATION

Title of Paper: Two Cases of Malignant Melanoma in a Small Cohort of Crohns Disease Patients Receiving Maintenance Adalimumab Treatment

Author(s): Niamh Hogan, Azrin Muslim, Hasan Zaid and Manus Moloney

Department(s)/Institution(s): UL Hospital Group Nenagh

Introduction: Long term immunosuppression is a risk factor both for causing and promoting the growth of malignancy. We report two cases of malignant melanoma in a relatively small cohort of fifty Crohns Disease patients receiving maintenance adalimumab treatment during the period 2000 to 2014 at Nenagh hospital.

Aims/Background: Published data on the role of adalimumab suggests no increase in malignancy in patients on monotherapy although there is an increased risk in patients on combination therapy with an immunomodulator, Osterman et al Gastroenterology. 2014 Apr;146(4):941-949. In the present study we aim to summarise the observed risk factors for malignancy in two Crohns patients receiving adalimumab therapy and relate the temporal aspects of their treatment to the presentation of malignancy.

Method: Case reports and literature review.

Results: Both patients had a history of excess sun exposure. Both patients were heavy smokers which may have an inverse risk association with melanoma. Both patients had difficult Crohns disease and underwent ileocaecal resection and had several courses of corticosteroids prior to commencement of anti TNF therapy. One patient was on combination therapy with an immunomodulator at the time of diagnosis of melanoma, the other patient had a trial of immunomodulator treatment discontinued before starting anti TNF treatment. Both patients required extensive local resection for their melanoma and local lymph node dissection and are now prohibited from receiving anti TNF and immunomodulator therapy. One patient is taking a legal case against the HSE.

Conclusions: The possibility of an increased incidence of malignant melanoma in patients on Anti TNF treatment should be of concern to clinicians and should stimulate further research in this area. The desirability of a routine skin check by a dermatologist as a part of standard work up prior to the commencement of Anti TNF Treatment should be discussed at National and International level in the development of future treatment guidelines.

ABSTRACT 69 (14S154) POSTER PRESENTATION

Title of Paper: ‘’OxyElite Pro” induced fulminant hepatotoxicity: A case report

Author(s): Ahmed Abu Shanab, Naeem Ullah, Diarmaid Hololihan, Masood Iqbal, P.Aiden Mc Cormick, Raphael Merriman

Department(s)/Institution(s): Liver Unit, St.Vincent’s University Hospital, Dublin, Ireland

Introduction: A recent study by Organisation for Economic Co-operation and Development (OECD) showed Ireland had the second highest rates of obesity in Europe and these rates are increasing rapidly. OxyElite Pro is a widely available and marketed as “a fat burner” herbal supplement It is purported to contain several herbal agents such as Rauwolfia Canescens, triiodothyronine and thyroxine hormone, Bauhinia purpurea L, Bacopa monnieri, 1,3-Dimethylamylamine, Cirsium Oligophyllum and caffeine.

Aims/Background: We present a case of a healthy woman who developed fulminant liver failure while taking this herbal supplement for weight loss.

Method: In March, 2013 a previously healthy 34 years old woman presented to her general practitioner (GP) with progressive fatigue, new-onset jaundice and dark urine over the previous three weeks. This was associated with right upper quadrant pain for one day before presentation. Initial laboratory testing by her GP showed an alanine transaminase (ALT) 1347 IU/L, aspartate transaminase (AST) 766 IU/L, alkaline phosphatase (ALP) 135 IU/L, total bilirubin (TB) 83 umol/l.

Results: Liver enzymes had become more elevated with an ALT of 1184 IU/L, TB was 422 umol/l, Alkaline phosphatase of 113 IU/L, . Importantly, the prothrombin time (PT) was elevated at 23.7 seconds (9.6-11.8 sec) with an INR of 2.2. During admission she developed flapping tremors consistent with grade 2 hepatic encephalopathy. The patient underwent trans-jugular liver biopsy which was consistent with moderate to severe acute hepatitis. The patient remained alert, fully oriented, and asterixis resolved after 4 days. The total bilirubin peaked at 872 umol/l and INR at 1.74. Synthetic function continued to slowly improve over the subsequent 4 weeks after which she was discharged.

Conclusion: Attributing hepatotoxicity to a specific ingredient, drug or herbal supplement can be challenging because of new multiple combined ingredients, product variability, and lack of testing to confirm exposure to a product. An awareness of the potential for herbal supplements highlights the need of comprehensive assessment by clinicians evaluating patients with any pattern of liver injury

ABSTRACT 70 (14S110) POSTER PRESENTATION

Title of Paper: When is an Achalasia not an Achalaisa? When it’s an Adenocarcinoma.

Author(s): Lawlor P+, Moran T+, Brennan M+, Macarthy F++, Ravi N*, Reynolds JV*.

Department(s)/Institution(s): +GI Function Unit, St James’s Hospital, Dublin. ++Department of Gastroenterology, St James’s Hospital, Dublin. *Department of Surgery, Trinity Centre for Health Sciences, St James’s Hospital, Dublin.

Introduction: A 74 year old male was referred for High Resolution Manometry (HRM) to investigate ongoing episodes of odynophagia and two episodes of food bolus obstruction. His endoscopy had been unremarkable with normal biopsies. A barium swallow showed a minimal hold-up of contrast and a narrowing at the lower end of the oesophagus consistent with achalasia.

Method: Initial HRM revealed an Achalasia Type II pattern with pan oesophageal pressurization, raised intrabolus pressure (IBP) and dramatic oesophageal shortening. (Fig 1) This type of shortening also had some features in keeping with Type III Achalasia. According

to the Chicago classification of HRM, this pattern may be a variant form of achalaisa, indicative of wall stiffness, possibly as a consequence of an infiltrative disease. As the history and pattern were not classical of achalasia , we recommended repeat OGD to exclude pseudoachalasia. The patient was rescheduled for an urgent OGD +/- Dilation. However, dilation to 11mm proved extremely difficult and the patient was booked for a repeat HRM and EUS. The second HRM showed a more marked pan oesophageal pressurisation holding up around 38-40cms from the nares, and the HRM pattern was consistent with a failed dilation. (Fig 2). EUS was performed the next day, which revealed an adenocarcinoma, 2cms in length across the OGJ junction. The patient is currently undergoing Chemoradiotherapy and is awaiting an Oesophagectomy.

Fig 1 HRM

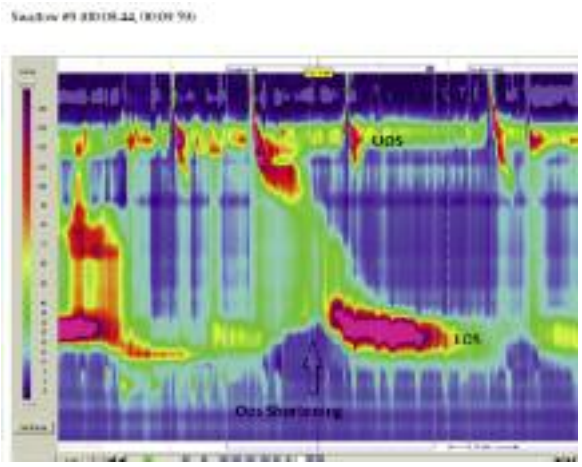
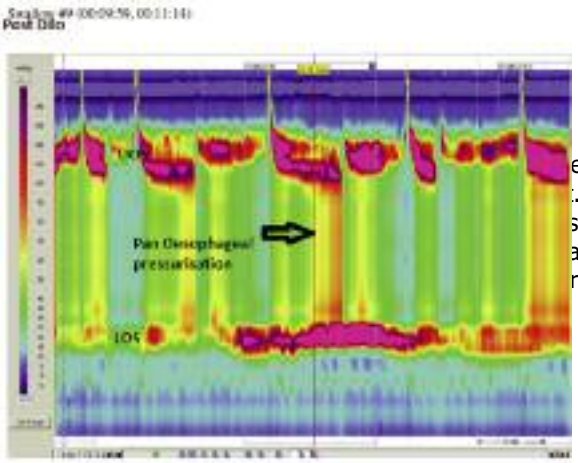


Fig 2
Post Dilo



Conclusio ent would have . If this patier sed manometry ave been visibl r a number of All patients wi

Dr Barry Hall Tallaght Hospital

Dr Edel McDermott SVUH

Dr Shaheel Sahebally, U.L.

Dr Frank McDermott, Conway Institute

Winter Meeting 2013

Dr Johnny Cash of Royal Victoria Hospiotal Belfast

Prof Catherine Nelson-Piercy Speaker

Dr Gavin Harewood Secretary ISG and consultant at Beaumont Hospital Dublin

Dr Glen Doherty SVUH

Dr Tony C.K Tham

Dr Alan Coss Galway Clinic Speaker

Prof Kevin Conlon AMNCH

Dr Geraldine McCormack Midland Hosp Tullamore

Winter Meeting 2013

Dr Claire O'Donoghue

Dr Barbara Ryan

Margaret Cogan, Sword Med

Prof Humprey O'Connor being interviewed by TG4

Claire Flinn, BSCI

Steve Gillman, Manitex

Audience view at ISG

Winter Meeting 2013

L-R: Edel Quinn, Deirdre Kelleher - Sanofi

L-R: David Rossiter, Fergal Kearns, Professor Humphrey O'Connor, Phillip Cullinan, Gareth Halligan - Olympus

L-R: Darren Clarkson, Julie Lenihan, Ray Smith, James Donohue - Hospira

L-R: Dr Hassan Zayed, Dr Hamid Youssef, Margo Keating, Elgaily Gilead Sciences and Dr El Rayah

L-R: Mai Hanlon - Tillotts Pharma, Dr. Noirin Noonan St.James's Hospital

L-R: Fiona Ryan, Caroline Hall - Cook Medical

L-R: Colm Moynihan, Margaret Hogan, Declan Barry, Sinead Foley, Mark Fitzmaurice - Sword Medical

Maureen Kennelly - Vifor Pharma

Winter Meeting 2013

L-R: Hillary Hobbs, Austin Malarkey, John Halpin, Peter Tobin - Ferring Pharmaceuticals

L-R: Michael Dineen, Dr Manus Moloney, Dr Martina Goggin

L-R: Dr Kevin Ward,Prof Einar S. Björnsson, Dr Michael Whelton, Dr Barry O'Connor

L-R: Dr Orla Craig, Dr Suzanne O'Reilly, Dr Karen Hartery

Dr Helen Mohan SVUH

Prof Adam Cheifetz Speaker Harvard University Hospital

Dr Garret Cullen Speaker SVUH

Dr Donal Sheehan CUH

Winter Meeting 2013

L-R: John Fenlon(Astellas), Ciara Egan, Matthew Farrelly (Astellas)

Poster Prize Presentation L-R: Anthony Murphy(Abbvie), Prof. Humphrey O'Connor, Dr Bikrant Barihar Peter Cassidy(Abbvie), Elizabeth Grogan(Abbvie)

L-R: Anthony Murphy, Elizabeth Grogan, Peter Cassidy, Eoin Murphy - Abbvie

L-R: Matthew Farrelly, John Fenlon - Astellas

LR : Margaret Drysdale, Karen Martin - Shire Pharmacueticals

Prof Einar Bjornsson University of Iceland Speaker

Dr Karen Boland, SVUH

Dr Stephen Bligh, Tallagh Hospital

Winter Meeting 2013

Prof. Humphrey O'Connor presenting 3rd poster prize to Khalid Yousif

L-R: Steven Donnellon, Gerarldine Bennett - BSCI

Prof John Reynolds, Dr Karen Hartery
winner of Nutrition Award & Dr Orla Crosbie, CUH

Anne Martina Mulligan, Ann McDermott, Marie Gorman, MSD

Dr Paul Moore AMNCH

Dr Grainne Holleran AMNCH

Dr Vikrant Parihar, AMNCH

Dr Mohd S Ismail, Drogheda

Winter Meeting 2013

Prof John Reynolds Chair of IrSPEN

Dr Jon Shaffer, Salsford UK Speaker

Dr Orla McCormack, SJH

Dr Orla Crosbie, CUH

Dr Daniel Schmidt SVUH

Dr Rana Haider Naas

Dr Susanne O'Reilly, SVUH

Prof Jacob Izbicki University of Hamburg Speaker

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Uses: Targaxan® is indicated for the reduction in recurrence of episodes of overt hepatic encephalopathy in patients ≥ 18 years of age.

Dosage and administration: Adults 18 years of age and over: 550 mg twice daily, with a glass of water, with or without food for up to 6 months. Treatment beyond 6 months should be based on risk benefit balance including those associated with the progression of the patients hepatic dysfunction. No dosage changes are necessary in the elderly or those with hepatic insufficiency. Use with caution in patients with renal impairment.

Contraindications: Contraindicated in hypersensitivity to rifaximin, rifamycin-derivatives or to any of the excipients and in cases of intestinal obstruction

Warnings and precautions for use: The potential association of rifaximin treatment with Clostridium difficile associated diarrhoea and pseudomembranous colitis cannot be ruled out. The administration of rifaximin with other rifamycins is not recommended. Use with caution in patients with severe (Child-Pugh C) hepatic impairment and in patients with MELD (Model for End-Stage Liver Disease) score > 25. The effectiveness of oral oestrogenic contraceptives could be decreased after Rifaximin administration. It is recommended to take additional contraceptive precautions, in particular if the oestrogen content of oral contraceptives is less than 50 µg.

Pregnancy and lactation: Rifaximin is not recommended during pregnancy. The benefits of rifaximin treatment should be assessed against the need to continue breastfeeding.

Side effects: Common effects reported in clinical trials are dizziness, headache, depression, dyspnoea, upper abdominal pain, abdominal distension, diarrhoea, nausea, vomiting, ascites, rashes, pruritus, muscle spasms, arthralgia and peripheral oedema. Other effects that have been reported include: Clostridial infections, urinary tract infections, candidiasis and pneumonia. Blood disorders e.g. Anaemia, Thrombocytopenia. Anaphylactic reactions, angioedemas, hypersensitivity. Hypo and hypertension. Pyrexia. Liver function tests abnormalities.

Licensing and Legal category: Legal category: Prescription only

MA number: PA 102/29/1.

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Ireland

Adverse events should be reported to Medical Information at Norgine Pharmaceuticals on +44 1895 826606.

Reference:

1. Bass NM *et al.* N Engl J Med 2010;362:1071–81.

NORGINE

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*For adult patients with moderately to severely active ulcerative colitis (UC)**

*For adult patients with moderately to severely active Crohn's Disease (CD)**

*HUMIRA is indicated for treatment of moderately to severely active Crohn's disease in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or who are intolerant to or have medical contraindications for such therapies. HUMIRA is indicated for the treatment of severe active Crohn's disease in paediatric patients from 6 years of age who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies. HUMIRA is indicated for treatment of moderately to severely active ulcerative colitis in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine or azathioprine, or who are intolerant to or have medical contraindications for such therapies.

Full prescribing information is available upon request from AbbVie Limited, Block B, Lilley Valley Office Campus, Quarrywood, Co Dublin, Ireland. | Legal Category: POM | Marketing Authorisation Numbers: EU/1/08/458/001-005, EU/1/03/256/007-010. Marketing Authorisation Holder: AbbVie Limited, Maidenhead, Berkshire SL6 4XE, UK.

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HUMIRA