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Irish Society of Gastroenterology

Winter Meeting

21 - 22 November 2014
Ballsbridge Hotel
Dublin

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Presentation: Film-coated tablet containing rifaximin 550 mg.

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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.

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Reference:

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

NORGINE

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Date of preparation: May 2014.

Welcome Message from the President Professor Humphrey O'Connor

Dear Colleagues and Friends,

It is that time of year again when the ISG gets together for our last meeting of the year, this time at the Ballsbridge Hotel in Dublin. I am confident that this meeting will provide a unique weekend of immersion in Gastroenterology with an academic programme which incorporates brilliant overseas presenters allied to some of the cream of home talent. The key aim again is education and with it better patient outcomes.

For this meeting we have varied our days by going for a full day on Friday and ending with a half day on Saturday. Having the Ireland v Australia match following the ISG was an irresistible combination.

We start off on Friday morning with 3 top class free papers. We had almost 100 abstract submissions, from which we have selected 11 for oral presentation and 74 posters. The standard was very impressive and the final selection was quite difficult. Many thanks to our review panel for their deliberations.

The first scientific session is on one of the most important topics affecting Human Health at this time – The Human Microbiome. University College Cork are world leaders in this field and this fact is reflected in the choice of speakers. The second session of the morning focuses on Pancreatic Cystic Lesions which often create a clinical conundrum.

The early afternoon has excellent free papers, quality in Colonoscopy, interim results from bowel screen and key information from the Dutch Pancreatitis Study Group on the current role of ERCP in Pancreaticobiliary Disease. A lot of emphasis is rightly placed on inflammatory bowel disease at meetings such as ours, but there are other inflammations that can affect the GI tract and we need updates on those as well. Hence the final session on Friday concentrates on some more unusual inflammations and should be fascinating.

The first session on Saturday morning is devoted to nutrition in association with IRSPEN and deals with the contentious subject of Bariatric surgery. This is followed by an important session on Irritable Bowel Syndrome, by far and away the most common problem we meet in clinical practice and the one where treatment progress seems slow. The line-up of speakers is world-class.

The final session of the meeting starts with the remaining free papers and then concentrates on Gastrointestinal Bleeding. The talks cover Variceal, Occult and Non Variceal bleeding and bring together terrific expertise from East and West.

With all that done there is certainly a need for lunch and the match.

Enjoy the ISG!

With very best wishes,

Humphrey O'Connor
President ISG
Consultant Gastroenterologist

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

ISG Winter Meeting
Ballsbridge Hotel Dublin, 21st and 22nd November 2014
Programme

Friday 21st November

09.00 **Oral Free Papers 1 - 3**

09.30 **Session 1 - The Human Microbiome**

Prof Paul O'Toole, Professor of Microbial Genomics, University College Cork
Title: ***The microbiome at the extremes of life***

Prof Colin Hill, Professor of Microbial Food Safety, University College Cork
Title: ***Microbiome - based therapies for nosocomial infections***

Prof Ciaran Kelly, Professor of Medicine, Harvard Medical School, Boston
Title: ***Faecal Microbial Transplantation***

11.00 **Coffee break, poster viewing and meet the Industry**

11.30 **Session 2 - The Clinical Dilemma of Pancreatic Cystic Lesions**

Oral Free Paper 4

Prof Ann Marie Lennon, Assistant Professor of Medicine, Johns Hopkins University of Medicine, Baltimore
Title: ***Diagnosis and evaluation of Pancreatic Cysts***

Dr Niall Swan, Consultant Histopathologist, SVUH Dublin
Title: ***The Pathology of Pancreatic Cystic Lesions***

Mr Justin Geoghegan, Consultant Hepatobiliary and Transplant Surgeon, SVUH, Dublin
Title: ***Pancreatic Cystic Lesions - Classification and Management***

13.15 **Lunch, Poster Viewing and meet the Industry**

14.15 **Oral Free Papers 5 - 7**

14.45 **Session 3 - Colon Cancer Screening**

Prof Roland Valori, Consultant Gastroenterologist, Royal Hospital Gloucester
Title: ***The Perfect Colonoscopy***

Dr Alan Smith,
Director of Performance Improvement, SDU
Title: ***The Irish Experience - Early Results from Bowel Screen***

15.45 **Session 4 - ERCP**

Dr Nicolein Schepers, Dutch Pancreatitis Study Group, St. Antonius Hospital, The Netherlands
Title: ***ERCP and Pancreatico Biliary Disease - The Dutch Experience***

16.15 **Coffee break and meet the Industry**

16.35 **Session 5 - Unusual Gut Inflammation**

Prof Roger Chapman, Group Head, John Radcliff Hospital, Oxford
Title: ***IgG4 Related Disorders***

Prof Jeffery A Alexander,
Professor of Hepatology, Mayo Clinic Minnesota
Title: ***Eosinophilic Oesophagitis***

Prof Ciaran Kelly, Professor of Medicine, Harvard Medical School, Boston
Title: ***NonCoeliac Enteropathies and Microscopic Colitis***

Saturday 22nd November

08.00 **Astellas Satellite Meeting with Prof Ciaran Kelly**

09.00 **Session 6 - Nutrition Lecture**

Oral Free Papers 8

Mr Diarmuid Duggan,
Senior Dietician, Bons Secours Hospital Cork
Title: ***Dietary Implications of Bariatric Surgery and Micronutritional Sequelae***

Mr Colm O'Boyle,
Consultant Bariatric Surgeon, Bons Secours Cork
Title: ***Metabolic Surgery for Morbid Obesity - Front Line or Last Resort?***

10.15 **Session 7 - Irritable Bowel Syndrome - Our Biggest Problem ?**

Prof Ted Dinan, Head of Department Psychiatry, University College Cork
Title: ***Brain - Gut - Microbiota Axis : Implications for IBS***

Prof Peter Whorwell, Professor of Medicine and Gastroenterology, University Hospital South Manchester
Title: ***IBS - NonPharmacological Management***

Prof Eamon Quigley, Chief, Division Gastroenterology and Hepatology, Methodist Hospital, Texas Medical Centre, Houston
Title: ***Why Pharmacological Therapy of IBS has been such a Minefield***

11.45 **Coffee break and meet the Industry**

12.15 **Oral Free Papers 9 - 11**

12.45 **Session 8 - Gastrointestinal Bleeding**

Prof Peter Hayes, Professor of Hepatology, Royal Infirmary, Edinburgh
Title: ***Management and Prevention of Variceal Haemorrhage***

Prof Cristiano Spada, European Endoscopy Training Centre, Catholic University of Rome
Title: ***Occult GI Bleeding***

Prof Francis Chan, Dean Faculty of Medicine, The Chinese University of Hong Kong
Title: ***Non Variceal Bleeding***

14.15 **Close of Meeting and Lunch**

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*1. Whorwell PJ, Altringer L, Morel J, et al. Am J Gastroenterol. 2006;101:1581–1590. 2. O'Mahony L, McCarthy J, Kelly P, et al. Gastroenterology. 2005;128:541–551. **Among Gastroenterologists who recommended a brand of probiotic in a Wolters Kluwer 2011 survey.

Information for Healthcare Professionals

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Irish Society of Endoscopy Nurses

21 November 2014, Ballsbridge Hotel, Dublin

Time	Chair	Speaker	Topic
08.30-09.00		Registration	
09.00-09.10	Mary Hackett Brennan	Sean Connolly	Welcome to Dublin
09.10-10.20	Leah Palado & Mary Hackett Brennan	Prof. Hugh Mulcahy Consultant Gastroenterologist	Management of IBD from a medical & a patient's perspective from the Centre of Colorectal Disease, St. Vincent's Hospital Dublin
		Denise Keegan IBD Clinical Nurse Specialist	A patient's experience with IBD (Speakers sponsored by Tillotts)
10.20-11.10	**COFFEE**		
11.10-12.00	Leah Palado & Mary Shea	Mary Hackett Brennan & Elaine Egan	ISEN going forward and into the future
12.00-12.30	Elaine Egan	Prof. Paud O'Regan Consultant Gastroenterologist South Tipp General	Foreign Body Retrieval
12.30-13.00	Mary Shea	Elaine Egan Staff Nurse South Tipp General	The introduction of Capnography monitoring in Endoscopy
13.00-14.00	**LUNCH**		
14.00-14.40	Mary Hackett Brennan	Celine Conroy	News
14.40-15.10	Elaine Egan	Caroline Connelly	Decontamination
15.10-15.40	Leah Palado	Joanna Rea Blathnaid Nolan	Poster presentation, at the ESGENA conference in Vienna this Autumn
15.40-16.00	Mary Hackett Brennan	Deirdre Clune	Education update, questions and answers & raffle

Honorary Officers and Board Members:

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Consultant Gastroenterologist

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1962-1964	Professor Oliver Fitzgerald (R.I.P.)

Biographical Sketches

Prof. Paul O'Toole
Professor of Microbial Genomics, UCC

Following research and academic positions in Sweden, Canada, New Zealand and the US, Paul O'Toole is now Professor of Microbial Genomics at University College Cork, Ireland. His main research theme is the genomics and metagenomics of gastrointestinal bacteria with emphasis on human-associated species and host interaction, particularly commensal lactobacilli. His latest research examines the composition and function of the gut microbiota, its dependence on diet, and its relationship to health, ageing and well-being. A particular aim is to develop novel foods and food ingredients to programme the intestinal microbiota towards promoting health in older persons. Research in his lab is supported by Science Foundation Ireland, Dept. Agriculture Fisheries and Marine, the Health Research Board, the EU (FP7) and the US NIH.

Dr Ciarán P Kelly
Professor of Microbial Genomics, UCC,

Ciarán P Kelly, MD, is Professor of Medicine at Harvard Medical School, Director of Gastroenterology Training and Medical Director of the Celiac Center at Beth Israel Deaconess Medical Center, Boston, Massachussets. Dr. Kelly earned his medical degree from Trinity College in Dublin, Ireland where he was a Foundation Scholar and recipient of numerous academic awards. He is an American Gastroenterology Association Fellow and a Fellow of the American College of Gastroenterology. Dr Kelly has longstanding clinical and research interests in intestinal infection and inflammation. He has been involved in patient care and research in Clostridium difficile infection for more than 20 years and leads an NIH-funded research program on the immune response to C. difficile infection and on potential C. difficile vaccines and other immune-based treatments. His interest in the pathophysiology, diagnosis and management of celiac disease is also longstanding and, as Medical Director of the Celiac Center at BIDMC, which he founded in 2004, he heads clinical, research and educational programs in celiac disease. Dr Kelly is the author of numerous clinical and basic research book chapters, invited reviews.

Prof Colin Hill
Professor of Microbial Food Safety in the Microbiology Department of University College Cork, Ireland.

Main interests are in infectious disease, particularly in defining the mechanisms of virulence of foodborne pathogens and in developing strategies to prevent and limit the consequences of microbial infections in the gastrointestinal tract. He is also a Principal Investigator in the Alimentary Pharmabiotic Centre in Cork, a large research centre devoted to the study of the role of the gut microbiota in health and disease. Awarded a D.Sc by the National University of Ireland in 2005 in recognition of his contributions to research. Elected in 2009 to the Royal Irish Academy. Awarded the Metchnikoff Prize in Microbiology (2010) and in 2010 was elected to the American Academy of Microbiology. Published more than 375 papers and 14 patents. President of ISAPP since 2012.

Dr Anne Marie Lennon
Assistant Professor of Medicine
Johns Hopkins University School of Medicine.

Dr Lennon is the Director of the Multidisciplinary Pancreatic Cyst Clinic and an attending gastroenterologist at The Johns Hopkins Hospital. She received her medical degree from the Royal College of Surgeons in Ireland in 1996. In addition, Dr. Lennon has obtained a Ph.D degree from The National University of Ireland. She completed an internal medicine residency in Dublin and at the Cleveland Clinic, followed by a Gastroenterology Fellowship in Edinburgh, Scotland. She then completed a two year Advanced Endoscopy Fellowship in endoscopic ultrasound and ERCP at Johns Hopkins. She is certified in General Internal Medicine and Gastroenterology by the Joint Royal Colleges of Physicians Training Board (JRCPTB) of the United Kingdom and is a fellow of the Royal College of Physicians of Ireland. Dr. Lennons major interests are the workup and management of patients with pancreatic cysts, pancreatic cancer or pre-cancerous lesions and the role of endoscopic ultrasound in the diagnosis of pre-cancerous and cancerous lesions.

Prof Roland Valori
Consultant Gastroenterologist,
Royal Hospital Gloucester

Professor Valori has been a Consultant Gastroenterologist since 1989, initially in London and subsequently in Gloucester. He undertook various lead roles in postgraduate education and management before becoming National Clinical Lead and subsequently National Clinical Director of the Endoscopy service of England. He was appointed lead adviser to the national Bowel Cancer Screening Programme in 2008. In these roles he has led a transformation of the endoscopy service by developing and implementing aquality assurance framework focused on the experience of the patient. At the heart of this framework is a peer review accreditation process that has achieved a step wise change in the quality of care of patients having an endoscopy.

Prof Roger Chapman
Group Head,
John Radcliff Hospital, Oxford

Roger Chapman was born in South Wales and attended a Grammar school in Cardiff. He lives in Oxford and is married to a Doctor with 4 grown up children, one of whom is an intensive care doctor in Perth, Australia.

He qualified from St Bartholomew's Hospital, University of London in 1974, and trained in liver disease, firstly as a registrar in the Liver Unit in Southampton, and then as a lecturer on the Liver Unit at the Royal Free Hospital in London, from 1976 to 1981 under the supervision of Prof Sheila Sherlock, obtaining an MD on "Iron Metabolism in Liver Disease" in 1981.

He moved to Oxford as senior registrar in 1981, becoming a consultant at the John Radcliffe Hospital in 1986. He spent an "off service year" year as a visiting scientist at the University of Washington in Seattle in 1983-4.

Whilst at the Royal Free he developed an research interest in liver disease associated with Inflammatory Bowel Disease which he has continued to this day. He has published 4 books, over 60 book chapters and 200 original articles mainly in the field of autoimmune liver disease, viz Primary Sclerosing

Cholangitis (PSC), Primary Biliary Cirrhosis (PBC) and latterly IgG4 related disease.
He is a founding member (in 1992) of the International Autoimmune Hepatitis Group (IAHG) producing position papers in the field of Autoimmune Hepatitis. More recently he has been involved in the foundation of the International PSC Study Group (2009) facilitating collaboration between different international centres researching into PSC and the foundation of British Autoimmune Liver Disease study Group (2010). He is one of the authors of the current European (EASL) guidelines for "Cholestatic liver diseases" and the first author of the recent North American (AASLD) guidelines on the "Management of Primary Sclerosing Cholangitis".
Roger is medical advisor/consultant to Perspectum Diagnostics Ltd (not an employee).
In 2014, Roger was awarded a Fellowship of the American Association for the Study of Liver Diseases(AASLD).

Dr Jeffrey A. Alexander
Professor of Hepatology,
Mayo Clinic Minnesota.

Dr Jeffrey A. Alexander has been practicing medicine for 32 years. Dr. Alexander graduated from the Wayne State University School of Medicine in 1982. He practices medicine in Rochester, MN and specializes in Gastroenterology and Hepatology. Dr. Alexander is affiliated with Mayo Clinic Health System-New Prague, Federal Medical Center and Mayo Clinic Hospital-Rochester Methodist Campus. He speaks English, French, German, Chinese and Spanish.

Hospital Affiliations: Mayo Clinic Health System-New Prague, Federal Medical Center, Mayo Clinic Hospital-Rochester Methodist Campus
Specialties: Gastroenterology, Hepatology

Mr Justin Geoghegan
Consultant Hepatobiliary
and Transplant Surgeon, SVUH, Dublin.

Mr Justin Geoghegan Is an Consultant Hepatobiliary and Transplant Surgeon attached to St Vincents University Hospital Dublin. He is one of four hundred and sixty nine physicians delivering medical services within the area of Dublin 4 county. Mr Justin Geoghegan achieved his title of Bachelor of Medicine and Bachelor of Surgery from University College Dublin with eight hundred and fourty eighth physicians finished in 1982. Mr Geoghegan also completed specialist training for General Surgeon fourteen years ago.

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

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

Professor Quigley received his medical degree from University College Cork in Cork, Ireland; completed internal medicine residency in Glasgow, Scotland; and did GI fellowship training at the Mayo Clinic and the University of Manchester in England. He served as the Chief of Gastroenterology at the University of Nebraska from 1991 to 1998 and as Dean of the Medical School in Cork, Ireland from 2000 to 2007.

Prof. Peter Hayes
Professor of Hepatology,
Royal Infirmary, Edinburgh.

Prof Peter Hayes Graduated from Dundee University , MB ChB with Honours and trained in Dundee, Kings College Hospital and the Royal Infirmary of Edinburgh.
Appointed Senior Lecturer in Medicine in 1989 and Professor of Hepatology 1998. Research interests include portal hypertension, liver transplantation and viral hepatitis and more recently non-alcoholic fatty liver disease.
Author on more than 300 research publications.
Was recently president of the British Association for the Study of the Liver.

Prof. Francis CHAN Ka Leung
Professor of Medicine at the
Chinese University of Hong Kong.

He is an internationally renowned expert in nonsteroidal anti-inflammatory drug (NSAID)-induced gastrointestinal injury and its prevention. His research work on the relationship between Helicobacter pylori and NSAIDs has driven the Maastricht Consensus to develop guidelines on the prevention of NSAID-related ulcer. Professor Chan is the first in academic history who has published 6 first-authored original research articles in The New England Journal of Medicine and The Lancet. (2007/2008)

Mr Colm O'Boyle
Consultant Bariatric Surgeon,
Bons Secours Cork

Mr Colm O'Boyle qualified from Trinity College Dublin in 1990. He trained in Dublin, Galway, The Leeds General Infirmary, Hull Royal Infirmary and The Royal Adelaide Hospital in Australia prior to becoming Lead Clinician for Upper Gastrointestinal surgical Services at Hull Royal Infirmary in 2002. He was appointed as Consultant General Surgeon to the Bon Secours Hospital, Cork and Senior Clinical Lecturer in Surgery to UCC in January 2008. He is the Council Member representing Ireland on the Association of Laparoscopic Surgeons of Great Britain &

Ireland. He is a member of the International Federation for the Treatment of Surgical Obesity and the British Obesity and Metabolic Surgical Society. He has been performing laparoscopic bariatric surgery since 1998. He has co-edited a book entitled 'Weight Loss Surgery, A Comprehensive Medical Team Approach'.

Prof Peter Whorwell
Professor of Gastroenterology,
University Hospital South Manchester.

Over the years Professor Whorwell has had a particular interest in the functional gastrointestinal disorders and now directs the South Manchester Functional Bowel Service and Neurogastroenterology Unit. This unit undertakes research into the clinical, epidemiological and pathophysiological aspects of these conditions as well as caring for large numbers of these patients from all over the UK. It also undertakes a wide-ranging programme of research into new treatment options including pharmacological, dietary and behavioural approaches. Professor Whorwell has published over 300 papers and chapters in his fields of interest and serves on a number of national and international advisory panels and working parties.

Dr Alan Smith
Director of Performance Improvement, SDU

Dr Smith is a 1992 medical graduate from University College Dublin and is dual EU certified in both General Practice and Public Health Medicine.

He began his public health career in Ireland (1999-2003) with the Health Protection Surveillance Centre. He subsequently went on to work for Departments of Public Health in the former North-Eastern Health Board, the Eastern Regional Health Authority and the Department of Health and Children in the Division of the Chief Medical Officer.

In the UK (2003-2007) he was employed by the Health Protection Agency (HPA), Centre for Infections a world leader in the field of health protection. During this time he worked at local, regional and national levels within the HPA organisation. He worked across a number of divisions including the respiratory, gastrointestinal, STI, blood borne virus, healthcare associated infections and vaccine preventable disease divisions. He also spent time on secondment to the UK Department of Health, Immunisation Division. His primary role was to provide clinical and epidemiological advice to the Department of Health and the Joint Committee on Vaccination and Immunisation (JCVI) about existing and emerging immunisation programmes. His role also included the provision of briefings to Ministers, the Chief Medical Officer and senior colleagues in relation to vaccine preventable disease programmes including HPV vaccines. He has published widely in a number of peer reviewed journals including the Lancet (Infectious Diseases), Vaccine and the BMJ.

He is currently Director of Performance Improvement with the Department of Health Special Delivery Unit.

Mr Diarmuid Duggan
Senior Dietician, Bons Secours Hospital Cork.

Mr Diarmuid Duggan, BSc Sport and Exercise Science, PgDip Dietetics, Ma in Cognitive & Behavioural Therapy, Senior Dietitian, Bon Secours Hospital, Cork

Mr Duggan is a senior dietitian with extensive experience in advising patients on all aspects of obesity surgery. He is a member of the Irish Nutrition & Dietetic Association (INDI), associate member of the Academy of Nutrition and Dietetics (AND), the AND's weight management interest group, and the AND's bariatric surgery interest group. He has a particular interest in the cognitive and behavioural processes that influence food choice and intake and sees the triage of exercise, nutrition, and cognitive and behavioural interventions as key to successful outcomes in weight management.

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 Gavin Harewood
Consultant Gastroenterologist
Beaumont Hospital, Dublin

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

He was subsequently appointed as a Consultant Gastroenterologist in the Mayo Clinic and developed a subspecialty interest in endoscopic ultrasound, health economics and clinical outcomes research. In 2006, he was appointed to his current Consultant post in Beaumont Hospital where he leads endoscopic ultrasound activities and serves as the lead Clinical Trainer in the Endoscopy Department. He also served as the Secretary for the Irish Society of Gastroenterology until 2014. In 2009, Dr Harewood completed a MBA Degree in Health Economics through the UCD Smurfit School of Business. He has authored more than 100 publications in the peer-reviewed medical literature, many dealing with the importance of resource utilisation and economics in healthcare.

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.

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.

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"

Prof Ted Dinan
Head of Department Psychiatry,
University College Cork

Prof Dinan is a medical graduate from UCC and obtained his PhD in Pharmacology from the University of London. He is a Fellow of the Royal Colleges of Physicians and Psychiatrists and a Fellow of the American College of Physicians. Before returning to Cork, Ted was Chair of Clinical Neurosciences and Professor of Psychological Medicine at St. Bartholomew's Hospital, London. Prior to that, he was a Senior Lecturer in Psychiatry at Trinity College Dublin. His main research interests are in the biology of depression and functional bowel disorders. He is a Principal Investigator in the Neurogastroenterology and Bacterial Metabolites cores of the Alimentary Pharmabiotic Centre, University College Cork.

Dr Glen Doherty
Consultant Gastroenterologist
St. Vincent's Hospital, Dublin

Glen grew up in Northern Ireland and graduated in Medicine at Trinity College Dublin in 1998. He was awarded his PhD by NUI in 2006 and completed his gastroenterology training in Ireland followed by an advanced IBD fellowship at Beth Israel Deaconess Medical Center and Harvard Medical School, Boston. Since 2010 he has worked as a consultant 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 Subhasish Sengupta
Secretary ISG, Consultant Gastroenterologist
Our Lady of Lourdes Hospital, Drogheda

Dr Subhasish Sengupta works as a Consultant Gastroenterologist at Our Lady of Lourdes Hospital, Drogheda. Dr Sengupta graduated from Calcutta University, India and subsequently obtained his MRCP (UK) in 2000. He successfully completed his Specialist Registrar training (CCST) in Gastroenterology mainly working in Mater Misericordae and Beaumont University Hospitals Dublin in 2007. His 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.

Dr Niall Swan
Consultant Histopathologist,
SVUH Dublin

Dr Swan is a 1991 graduate of RCSI, where he worked under both Prof John Fielding and Prof Stephen Doyle. He commenced his histopathology training in SVUH and then moved to Boston in 1996 to complete a residency in anatomic pathology and a subsequent fellowship in cytopathology, both at Boston University School of Medicine and the Mallory Institute of Pathology. He was appointed to the faculty as an assistant professor in the Department of Pathology and Laboratory Medicine at Boston University and as an attending staff pathologist at Boston Medical Center and returned to Ireland in 2003 to a consultant histopathologist post at Tallaght Hospital and Naas General Hospital. He moved to his current position at SVUH in 2011 where he is the lead pathologist for the National Surgical Centre for Pancreatic Cancer.
His clinical and research interests include pancreatic cancer, inflammatory bowel disease, laboratory quality assurance, amyloidosis, and colorectal cancer.

Oral Presentations – Winter Meeting 2014

Ref	Author	Paper	Day & Time	Title of Paper
14W147	Miss Aine Balfe	1	Fri, 9.00am	Exploring transcriptional signatures associated with regional variation and the luminal interface in health and ulcerative colitis.
14W154	Dr.Mary Hussey	2	Fri, 9.10am	Long term assessment of clinical response to Adalimumab therapy in refractory Ulcerative Colitis
14W133	Dr David Gibson	3	Fri. 9.20am	Anti TNF therapy switches on CD39+ FoxP3 Tregs resulting in symptomatic and endoscopic remission in IBD
14W 188	Dr Aman Yadav	4	Fri. 11.30am	C-Reactive Protein: A rapid and cost effective marker of acute Pancreatis Severity
14W125	Mr Stephen McCain	5	Fri. 14.15pm	Outcomes following non-resectional management of resectable colorectal cancer in the unfit patient
14W141	Dr Omar El-Sherif	6	Fri. 14.25pm	Significant interindividual variability in Telaprevir exposure in patients undergoing anti-HCV therapy - need for “real world” PK studies to identify vulnerable populations
14W151	Ms Karen Cassidy	7	Fri.14.35pm	Does awareness of the dangers of excess alcohol consumption alter the drinking habits of third level students in Ireland
14W182	Ms Katie O'Sullivan	8	Sat. 9.00am	STAT3 is a potential mediator of obesity-associated oesophageal adenocarcinoma
14W166	Dr. Aaron Doherty	9	Sat.12.15pm	Mortality in Liver Transplantation: our experience so far
14W174	Dr Marion Rowland	10	Sat.12.25pm	Clinically Significant Liver Disease Reduces Life Expectancy in Cystic Fibrosis
14W168	Dr Grainne Holleran	11	Sat.12.35pm	The Natural History of Small Bowel Angiodysplasia

Dr Nicolein Schepers
Dutch Pancreatitis Study
Group, St. Antonius Hospital, The Netherlands

Nicolien Schepers, MD, is a PhD candidate and research coordinator for the Dutch Pancreatitis Study Group (www.pancreatitis.nl). She is appointed as a fulltime researcher to perform clinical studies on acute pancreatitis, including multicenter randomized trials. The Dutch Pancreatitis Study Group is a collaboration between surgeons, gastroenterologists, radiologists and intensive care physicians interested in pancreatitis. Nicoliens’ research focuses on interventions and treatment strategies in acute pancreatitis, in particular biliary pancreatitis. Her clinical interest lies in gastroenterology and pancreaticobiliary diseases.

Prof Cristiano Spada
European Endoscopy Training Centre,
Catholic University of Rome

Completed faculty of Medicine & Surgery in Rome. Lecturer in Gastroenterology and Endoscopy 2013/14. Training in general Surgery 2014/15. Widely published in Gastroenterology & Endoscopy journals

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ABSTRACT 1 (14W147) ORAL PRESENTATION

Title of Paper: Exploring transcriptional signatures associated with regional variation and the luminal interface in health and ulcerative colitis.

Author(s): Aine Balfe, Grainne Lennon, Aonghus Lavelle, Kate Killick, Cathy Spillane, Gordon Blackshield, Helen Earley, Neil Docherty, Calvin J. Coffey, Desmond Winter, Ronan P. O´Connell

Department(s)/Institution(s): School of Medicine and Medical Science, University College Dublin

Introduction: While transcriptional analysis has been fundamental in the current understanding of Ulcerative Colitis (UC), a number of concerns regarding global gene expression analysis (GGEA) remain. These include accounting for colonic regional variation and the use of tissue containing heterogenic cell populations.

Aims/Background: This study aimed to address these concerns by investigating transcriptional signatures associated with loco-regional changes in health and UC and directly at the luminal interface.

Method: GGEA was performed on mucosa biopsies from patients with active UC and healthy controls at four colonic locations (Caecum, Transverse, Left, Rectum). Real-time PCR was used to validate these findings and investigate transcriptional profiles directly at the luminal interface. Epithelial cells were isolated by EDTA calcium chelation and purity was confirmed by flow cytometry.

Results: Clustering analysis revealed loco-regional segregation between the colon and rectum in healthy controls and based on inflammatory status rather than region in UC. A unique transcriptional signature was found to be associated with health and none, moderate and severe inflammation in UC. Isolated mucosal epithelial cells display an altered transcriptional profile compared to that of its relevant mucosa (Table1).

Table 1. Changes in the expression of a number of selected genes assessed by rt-PCR in patients with actively acute UC compared to healthy controls, in isolated crypt epithelium and mucosa biopsies.

Gene Symbol	Description	Fold Change	
		Epithelial Cells	Mucosa
DEFA5	defensin, alpha 5, Paneth cell-specific	-11.2*	202.7**
DEFA6	defensin, alpha 6, Paneth cell-specific	-17.9*	88.0**
REG3A	regenerating islet-derived 3 alpha	-10.9*	292.5**
TFF1	trefoil factor 1	-4.2*	5.9**
TLR2	toll-like receptor 2	-10.3*	4.4**
TLR4	toll-like receptor 4	-13.3*	1.5*
BAX	BCL2-associated X protein	-3.3**	-1.1
MUC2	mucin 2, oligomeric mucus/gel-forming	2.3*	1.1
TFF3	trefoil factor 3 (intestinal)	-12.9**	-2
TIMP1	TIMP metallopeptidase inhibitor 1	1.4	10.5**
CHST5	carbohydrate (N-acetylglucosamine 6-O) sulfotransferase 5	-1.2	-2.7**
CASPASE 3	caspase 3, apoptosis-related cysteine peptidase	-9.4**	-1.6*
CASPASE 7	caspase 7, apoptosis-related cysteine peptidase	-6.1**	-1.7**
DEFB1	defensin, beta 1	-71.7**	-6.7**
DMBT1	deleted in malignant brain tumors 1	2.9	22.9**
FasL	TNF superfamily, member 6	-17.3*	-1.2
LCN2	lipocalin 2	15.5**	74.2**
MMP9	matrix metallopeptidase 9 (gelatinase B, 92kDa gelatinase, 92kDa type IV collagenase)	5.9*	4.0*
RETNLB	resistin like beta	-21.5*	-3.8**
SLC16A1	solute carrier family 16, member 1 (monocarboxylic acid transporter 1)	-9.9**	-6.2**

p value ≤0.05 **p value ≤0.01
Genes in bold represent genes that display a different transcriptional pattern in epithelial cells compared to mucosa biopsies.

Conclusion: This study presents a thorough characterisation of the transcriptional signature associated with both health and UC across the colon. It has highlighted the need for the use of appropriate control groups/tissue and performing transcriptional analysis in single cell populations. The observed variations in gene expression between the mucosa and epithelial population may have a profound effect for studies on the host-microbiota crosstalk and on treatment strategies that focus on mending epithelial barrier function in IBD.

ABSTRACT 2 (14W154) ORAL PRESENTATION

Title of Paper: Long term assessment of clinical response to Adalimumab therapy in refractory Ulcerative Colitis

Author(s): M Hussey[1], R Mc Garrigle[2], U Kennedy[2], G Holleran[1], D Kevans[2], N Breslin[1], B Ryan[2], N Mahmud[2], D McNamara[1]
Department(s)/Institution(s): 1.Department of Gastroenterology, Adelaide and Meath Hospital, Trinity College Dublin, 2. Department of Gastroenterology, St. James' Hospital, Trinity College Dublin

Introduction: The role of anti-TNF agents, in particular Infliximab in fulminant colitis has been well established. Adalimumab, a fully humanised monoclonal antibody, was licensed for use in refractory moderately active Ulcerative Colitis (UC) in April 2012. Available outcome data from clinical practice is limited.

Aims/Background: To evaluate the clinical response to Adalimumab in an Irish cohort of ulcerative colitis patients.

Method: Patients with UC treated with Adalimumab were identified from Inflammatory Bowel disease (IBD) databases at St. James' and Tallaght hospital from 2007. A retrospective chart review was undertaken. Demographic and clinical data were recorded including a Mayo score and CRP where available. All patients received standard induction subcutaneous therapy (160mg/80mg/40mg) followed by maintenance 40mg every other week. Response was assessed by changes in both clinical and biochemical parameters at 6 and 12 month follow up. Dose adjustments, including reduction in frequency to weekly or increasing the dose to 80mg was considered a dose escalation and was recorded. Where possible, reasons for discontinuation and adverse events were noted.

Results: In total 52 patients treated with Adalimumab for UC were identified between the two centres. Of these 65% (n=34) were male and the mean age was 45 years (range 23-72). In terms of disease extent the majority, 65% (n=34) had left sided disease with 31% (n=16) and 4% (n=2) having pancolitis and proctitis respectively.

The majority commenced Adalimumab due to loss of response to immunomodulator therapy (n=45, 87%) while the remaining 13% (n=7) had previously been on Infliximab. In all 6% (n=3) had previous surgery. The mean disease duration was 8 years (range 1-29 years). At baseline 85% (n=44) of patients had moderate disease activity with the remaining 15% (n=8) having mild disease. The mean CRP at baseline was 13.5mg/l. The mean duration of treatment was 18.5 months (range 4-95 months). In total 6 and 12 month follow up data was available in 46 (88%) and 36 (69%) subjects. Overall there was a statistically significant improvement in mean partial Mayo score on follow up; baseline=6, 6 months =2 ($p<0.0001$, 95% CI 2.99-4.55), 12 months=2 ($p<0.0001$, 95% CI 2.74-4.46). In all 27 (59%) and 17(46%) were in remission (partial mayo score ≤2) at 6 and 12 months respectively. Of note 25% (n=13) required dose escalation during follow up. While mean CRP improved to 7.4 at 12 months from baseline, this did not reach statistical significance. In all Adalimumab was discontinued by 7 patients, 5 (10%) due to a loss of response, 4 (80%) within 6 months of commencing therapy, the remaining 2 (4%) due to adverse events, neutropaenia and recurrent infections.
Conclusion: Our study suggests Adalimumab is a highly effective and safe long term therapy for moderately active UC resistant to other treatment modalities. While this data is encouraging, further work is required on patient selection and to determine the impact of treatment on both natural history and quality of life.

ABSTRACT 3 (14W133) ORAL PRESENTATION

Title of Paper: Anti TNF therapy switches on CD39+ FoxP3 Tregs resulting in symptomatic and endoscopic remission in IBD

Author(s): Gibson DJ, Elliott L, McDermott E, Tosetto M, Keegan D, Byrne K, Martin ST, Cullen G, Mulcahy HE, Ryan EJ and Doherty GA

Department(s)/Institution(s): Centre for Colorectal Disease, St Vincent's University Hospital

Introduction: Regulatory T cell (Treg) dysfunction has been implicated in the pathogenesis inflammatory bowel disease (IBD). There are limited studies of how numerical and functional changes in Treg can impact treatment response.

Method: A prospective study of consecutive patients commencing anti-TNF (aTNF) therapy with infliximab (IFX) or adalimumab (ADA) was performed. Serial labs were drawn prior to treatment initiation and at early (3-6 months) and late (9-12 months) time-points. Treatment response was defined as symptomatic and endoscopic remission. Peripheral blood FoxP3 and Tr1 Treg populations were quantified by flow cytometry.

Results: 47 patients (UC n=22,CD n=25) were recruited; 16 patients were defined as responders and 13 non-responders. There were no significant differences in baseline Treg populations between responders and non-responders. Following treatment, CD39+FoxP3 Tregs increased significantly in responders (CD39+Treg /Total CD4+CD25brightCD127lowFOXP3 Treg; 8% 19% and 22.5% at baseline, early and late time-points, $p<0.001$), but not in non-responders. Conversely a significant reduction in CD4+CD45RA-CD49b+LAG3+ Tr1 cells was observed only in responders (median 3.8%, 0.9 and 0.7% of CD4+ T cells at baseline, early and late time-points, $p<0.001$). Responders were significantly less likely to have sub-therapeutic drug levels (IFX $p=0.049$, ADA $p=0.006$). Sub-therapeutic drug levels were also associated with lower frequency of CD39+FoxP3 Tregs ($p=0.016$) and lower IL-17A levels ($p=0.04$).

Conclusion: Increased CD39+Tregs, associated with therapeutic drug levels, are observed with clinical and endoscopic remission in IBD. This reinforces the role of Treg in establishing and maintaining remission in IBD and highlights their potential for disease modification, through modulation of IL-17.

ABSTRACT 4 (14W188) ORAL PRESENTATION

Title of Paper: C-Reactive Protein: a rapid and cost effective marker of acute pancreatitis severity

Author(s): Aman Yadav, Sarah Rafferty, Jawad Rasool, John Keohane, Subhasish Sengupta

Department(s)/Institution(s): Gastroenterology Department, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Introduction: Early prediction of severity of Acute Pancreatitis (AP) will aid in stratifying patients into low and high-risk groups and in turn will lead to prompt intensive treatment resulting in improvement of the outcome. CRP is a marker of inflammation and is high in patients with AP.

Aims/Background: The aim of the study was to assess if CRP levels taken 48 hours after admission can predict the severity of AP

Method: In this retrospective study, we identified all patients with a diagnosis of AP from the HIPE data between 1st January 2012 and 31st December 2013. From chart review patient age, gender, presenting complaint, aetiology, date and time of admission, Length of Stay (LOS), serum amylase levels on admission and CRP levels at 48 hours after admission were recorded. Only patients on whom CRP data at 48 hours was available were included in the study.

Results: Of 128 patients diagnosed with AP, 99 (77.34%) met the inclusion criteria (Male: 54, Female: 45, Mean age: 54.04+/- 16.78 years). The mean LOS for all patients was (7.45 +/- 4.5) days. The mean LOS for patients with CRP>150 (9.85+/-4.57) days was significantly higher than patients with CRP<150 (4.81+/-2.47) days with p value <0.0001. CRP at 48 hours positively correlated with LOS of patients (R = 0.72) and thereby predicted severity of AP.

Conclusion: CRP levels at 48hrs post admission can help in early prediction of disease severity with CRP levels >150 almost doubling the length of stay in hospital.

ABSTRACT 5 (14W125) ORAL PRESENTATION

Title of Paper: Outcomes following non-resectional management of resectable colorectal cancer in the unfit patient

Author(s): Peter Henderson, Dorothy Johnston, Stephen McCain, Kevin McElvanna

Department(s)/Institution(s): General Surgical unit, Royal Victoria Hospital, Belfast

Introduction: Colorectal cancer is the fourth most common cancer in the UK and the second most common cause of cancer death. Management options include surgical resection, neo-adjuvant and adjuvant medical therapy and palliation for symptom control. The treatment is influenced by the stage of the disease at presentation, the patients' fitness for surgery and the patients choice.

Aims/Background: The aim of this study was to assess the outcome of patients who underwent non-resectional management of potentially resectable disease due to their unfitness for surgery.

Method: Between January 2006 and January 2014, 975 patients were discussed at the colorectal cancer multi-disciplinary meeting at The Royal Victoria Hospital in Belfast. Charts were reviewed retrospectively and patients were followed up until time of death or for those still alive until the 1/08/2014. Data collected included patient demographics, site of tumour, stage of tumour , reasons for non-resection, palliative surgical procedure performed, medical management and cause of death as written on the death certificate. Cause of death was then categorised into death secondary to advanced colorectal cancer, underlying co-morbidities or other.

Results: 146 patients were managed non-surgically. 30 of these patients had potentially resectable disease but were deemed unfit for surgery. 15 patients were male and 15 were female. 12 patients had rectal cancer (6 males and 6 females) and 18 had colon cancer. Their median age was 84 and ranged from 69-94. 8 patients were alive at follow up, 9 patients died due to progressive colorectal cancer and 13 died secondary to their underlying medical co-morbidity. 6 patients received radiotherapy for symptom control and one patient underwent chemotherapy. 5 of the patients who had radiotherapy had rectal cancer. 2 patients underwent surgical intervention with one emergency loop ileostomy and one elective loop colostomy. Two patients underwent elective stent insertion. For those patients who passed away the mean survival was 321 days.

Conclusion: This study demonstrates the importance of careful MDT assessment of patients with medical co-morbidities and a new diagnosis of colorectal cancer. Non-resectional management is acceptable in selected patients given the high morbidity and mortality associated with the resection of colorectal cancer. Palliative surgical procedures may be required with time and therefore non-resectional patients should be followed up carefully to assess for potential complications This may enable surgery or endoscopic procedures to be performed in an elective rather than an emergency basis.

ABSTRACT 6 (14W141) ORAL PRESENTATION

Title of Paper: Significant interindividual variability in Telaprevir exposure in patients undergoing anti-HCV therapy - need for "real world" PK studies to identify vulnerable populations

Author(s): El-Sherif O (1), Dilly Penchala S (2), Else L (2), McKiernan S (1), Khoo S (2), Norris S (1)

Department(s)/Institution(s): 1. Department of Hepatology, St. James's Hospital; 2. Department of Molecular & Clinical Pharmacology, University of Liverpool

Introduction: The addition of Telaprevir (TVR) to Pegylated Interferon and Ribavirin for the treatment of chronic hepatitis C genotype 1 infection has resulted in a significant increase in the rates of sustained virologic response (SVR). However, triple therapy is associated with more side effects, and certain groups such as those with cirrhosis are less responsive to therapy. It is unclear whether interindividual pharmacokinetic variability affects treatment outcome.

Method: TVR pharmacokinetics was determined in patients undergoing treatment for HCV genotype 1 infection receiving TVR based triple therapy. Patients underwent intensive (rich) PK sampling at steady-state following the administration of 1125mg of Telaprevir bid with food. Samples were collected at 0,1,2,4,6,8,10 and 12 hours post dose, and TVR and its R-diastereomer (VRT-127394) were measured in plasma using a validated HPLC-MS/MS assay. One hundred and sixty eight samples from 21 patients (17 treatment naïve, 4 non-responders; 15 male; 2 cirrhotic) were analysed. The mean age was 41.9+7.9yrs, and mean baseline viral load was log105.66+1.12. The majority of patients (85%) were IL-28B non-CC. TVR area-under-the-curve-time concentration curves (AUC) were compared between cirrhotics and non-cirrhotics, patients achieving a rapid virological response (RVR) vs no RVR, and those with anaemia [Haemoglobin (Hb) < 10 vs >10 g/dl] using an independent samples t-test. The relationship between Telaprevir exposure and Hb decline (by week 2), or liver stiffness were assessed using Pearson correlation

Results: TVR AUC ranged from 17,960-56,009 ng*hr/mL, and mean TVR AUC was lower in patients with cirrhosis (20,323 +/- 3341 ng*hr/mL) compared to non-cirrhotics (35,661 +/- 9888 ng*hr/mL), $p = 0.046$. There was no significant difference in TVR exposure between RVR and non-RVR patients. Mean TVR AUC was higher in patients with Hb decline below 10g/dl, although this was not statistically significant. Furthermore, there was no significant correlation between TVR AUC and Hb decline by week 2, or liver stiffness.

Conclusion: TVR AUC is significantly lower in patients with cirrhosis, and this may partly account for the reduced SVR rates reported. These data also demonstrate the significant interindividual variability in TVR exposure in patients undergoing anti-HCV therapy, and highlight the need for "real world" PK studies in HCV patients to identify vulnerable populations.

ABSTRACT 7 (14W151) ORAL PRESENTATION

Title of Paper: Does awareness of the dangers of excess alcohol consumption alter the drinking habits of third level students in Ireland

Author(s): Karen Cassidy (1), Edel Walsh (1), Orla Crosbie (2)

Department(s)/Institution(s): School of Economics University College Cork (1), Dept of Hepatology, CUH (2)

Introduction: The level of alcohol consumption in Irish society continues to be problematic and Irish adults binge drink more than adults in any other European country. this results in ongoing medical and social consequences and adds significantly to the burden of Irish healthcare costs.

Aims/Background: The main aim of this project was to evaluate third level student's perceptions of alcohol related health problems and drinking behaviours.

Method: Data was collected from 105 first year students at UCC during 2014. SPSS was used to analyse the collected data.

Results: 54% of respondents were male, the mean age was 20.1 years (range 17-50) years. 96% of students consumed alcohol, spending on average 20 euro (range 0-190) per week on alcohol. Males consumed more drinks than females on a night out and younger students tended to drink more than older students. 39% admitted to going out with the intention of getting drunk, knowing that it would affect their daily duties on the next day. When asked what might influence a reduction in alcohol consumption; 29% gave participation in sport, 21% an increase in the price of alcohol, 19% exams, 14% a reduction in income, only 9% would reduce consumption due to an awareness of the medical consequences and 7% gave other reasons.

Conclusion: These results indicate that individuals do not act rationally when it comes to their level of alcohol consumption. Students on a night out will often drink over six drinks, defined by

the HSE as binge drinking and most drink far larger quantities. This suggest that individuals do not take into consideration the long term health consequences associated with these short term effects, but are more influenced by the price of alcohol and a reduction in income.

ABSTRACT 8 (14W182) ORAL PRESENTATION

Title of Paper: STAT3 is a potential mediator of obesity-associated oesophageal adenocarcinoma

Author(s): K.E. O' Sullivan, W. Gao, U Fearon, J. Lysaght, J.N. O' Sullivan, J.V. Reynolds

Department(s)/Institution(s): Institute of Molecular Medicine, St James's Hospital, Dublin 8, Ireland 1. Department of Translational Medicine, St Vincent's University Hospital

Introduction: A large body of evidence has implicated the STAT (Signal Transducer and Activator of Transcription) family and particularly the ubiquitously expressed STAT3 protein in the pathogenesis of a number of malignancies.

Aims/Background: An increasing body of epidemiological evidence has linked obesity and it's associated pro-inflammatory state with the development of oesophageal cancer however the molecular mechanisms underpinning this association remain unknown. This study examines the association between obesity and pSTAT3 signaling in oesophageal adenocarcioma both in vivo and in vitro.

Method: OE33 cells were treated with ACM from obese and non-obese patients (n=3 per cell line) for 0, 5, 10, 15, 20, 25 and 30 minutes respectively. PhosphoSTAT3 quantification was performed on (Tyr705) Assay whole cell lysate kit (MesoScale Discovery). Oesophageal Tissue Microarrays were constructed comprising 154 patients with oesophageal adenocarcinoma. Immunohistochemical staining for pSTAT3 and IL-6R was performed.

Results: Treatment of OE33 cells with ACM resulted in a significant increase in pSTAT3. Obese ACM resulted in a significantly greater increase in pSTAT3 than non-obese ACM at after 10 minutes ($p=0.04$). There was a positive correlation between IL-6R and pSTAT3 intensity ($p<0.0001$, $r=0.6$) and percentage positivity in the stromal compartment ($p<0.0001$, $r=0.3$) of OAC tumor specimens. Survival analysis revealed a protective effect with increased pSTAT3 expression in the epithelial compartment of adenocarcinoma specimens (HR 0.74, $p=0.02$).

Conclusion: We have demonstrated that ACM treatment results in upregulation of pSTAT3 expression in an oesophageal adenocarcinoma cell line. Furthermore, there is greater upregulation in patients who are obese. Immunohistochemical analysis has revealed a protective effect associated with pSTAT3 in the epithelial compartment of oesophageal adenocarcioma tissue. Findings suggest that STAT3 is a potential mediator in obesity-associated oesophageal adenocarcinoma and that inhibition is a potential therapeutic target.

ABSTRACT 9 (14W166) ORAL PRESENTATION

Title of Paper: Mortality in Liver Transplantation: our experience so far

Author(s): Doherty A, O'Reilly S, Cooney A, Houlihan DD

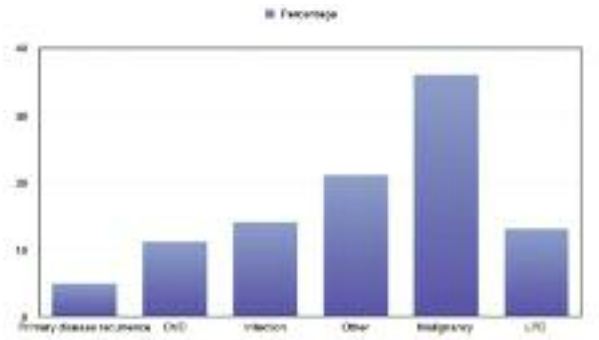
Department(s)/Institution(s): Liver Unit, St Vincent's University Hospital

Introduction: The Irish Liver Transplantation Unit opened in January 1993, and has transplanted a total of 751 patients to date. It is well recognised that malignancy, infection and cardiovascular disease are more common causes of death in transplant cohorts than in the general population. It is theorised that much of this may be secondary to immunosuppressive therapy.

Aims/Background: To determine if occurrence of these diseases/events is related to the underlying indication for transplant.

Method: This is a retrospective study spanning the period January 1993 to July 2014. Data on all liver transplant patients who died one year or more after transplantation was collected. Patient name, sex, date of birth, indication for transplant and cause of death were recorded. Where possible, we used electronic patient records such as dictated letters, radiology and pathology, to establish specific diagnoses, where the cause of death was recorded as 'multiorgan failure' or 'sepsis'. We excluded those who died within one year of transplantation, as the majority of these deaths are related to post operative complications.

Results: Two-hundred and eighteen patients (29%) have died post-transplant, 103 within the first year. One hundred and fifteen patients died more than one year post-transplant. Of this cohort, 36% died from malignancy, 5% from recurrent primary disease, 14% from infection, 11% from cardiovascular disease, 13% from lymphoproliferative disorder and 21% from other/unknown causes. Primary malignancies included angiosarcoma, mesothelioma, and renal cell carcinoma.



Conclusion: The high incidence of malignancy, cardiovascular death, and sepsis may lend credence to eventual withdrawal of immunosuppressive drugs. The evidence may also support the instigation of a primary prevention programme, such as smoking cessation amongst the cohort, and secondary preventions such as routine screening programs and treatment of hypertension or hypercholesterolaemia. It is interesting to note that there appears to be a higher mortality rate among those patients with autoimmune disease as their underlying indication for transplant. We hypothesise that this is because these patients are on higher doses of immunosuppression and therefore more likely to develop sepsis or malignancy, however a prospective study will need to be done to validate this theory.

ABSTRACT 10 (14W174) ORAL PRESENTATION

Title of Paper: Clinically Significant Liver Disease Reduces Life Expectancy in Cystic Fibrosis

Author(s): M. Rowland1 J. Dummond,1 C. Gallagher,3 P. Mc Nally,2 AM Broderick,2 P. Greally,4 D. Slattery,5 LE. Daly,6 NG Mc Elvaney,7 R. Ó Laoide,3 B. Bourke,1,2 on behalf of the Irish Cystic Fibrosis Liver Dis

Department(s)/Institution(s): 1School of Medicine and Medical

Science University College Dublin, 2 Our Lady's Children's Hospital Crumlin, Dublin, 3 St Vincent's University Hospital Elm Park, Dublin, 4 The National Childrens's Hospital

Introduction: Cystic Fibrosis (CF) is the commonest fatal inherited disease of Caucasians. Liver disease (CFLD) is an uncommon complication in CF, with no well-defined diagnostic criteria or effective treatment. Retrospective data suggests that CFLD represents a worse phenotype and reduces life expectancy in CF.1, 2

Aims/Background: To prospectively determine if liver disease increase mortality in CF

Method: All children under 18 years were invited to participate in national cohort study of CFLD and had in-depth clinical and nutritional assessments in 2007 and 2012. Liver disease status was classified using North American Cystic Fibrosis Foundation (NACFF) criteria as: No evidence of liver disease (NoLD), Non-specific liver disease (NSCFLD) and clinically significant liver disease (CFLD)

Ta

	Clinically Significant Liver Disease (CFLD)	Non-Specific Liver Disease (NSCFLD)	No Liver Disease (NoLD)	p
	n %	n %	n %	
Prevalence of CFLD	35 (6.7%)	119 (22.8%)	367 (70.4%	
Dead	11 (31.4%)	10 (8.4%)	7 (1.9%)	
Alive	24 (68.6%)	109 (91.6%)	360 (98.1%)	0

Results: 521 children were enrolled in 2007; mean age 9.XX SD 52% Male, mean follow-up 4.01 years SD1.05. The prevalence of liver disease and the outcome in 2012 is presented in Table 1. In a logistic regression model CFLD (Odds Ratio 5.05 95%CI 2.2-11.3) and poor pulmonary function (Odds Ratio 16.3 95%CI 3.7-70.9) were independent risk factors for mortality. Increasing age or gender did not predict mortality. A diagnosis of CFLD before the age of 10 years appears to predict more severe disease.

Conclusion: Clinically significant liver disease reduces life expectancy in CF.

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ABSTRACT 11 (14W168) ORAL PRESENTATION

Title of Paper: The Natural History of Small Bowel Angiodysplasia

Author(s): Grainne Holleran, Barry Hall, Niall Breslin, Deirdre McNamara

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

Introduction: Small bowel angiodysplasias (SBA) account for 50% of small bowel sources of obscure gastrointestinal bleeding (OGIB). They are known to bleed recurrently and small bowel lesions are thought to have a worse prognosis than lesions elsewhere. SBAs are difficult to treat endoscopically, and currently available medical treatments are relatively ineffective at reducing re-bleeding. There is little known about the natural history of SBA which is needed to guide treatment decisions and counsel patients on prognosis.

Aims/Background: To describe the natural history of a cohort of patients with SBA

Method: Patients with SBA were identified from our capsule endoscopy database. Information including; demographics, clinical history, medication use, number and location of SBAs, treatments, haemoglobin levels, RCC transfusion requirements and mortality rate was collected retrospectively. A re-bleeding episode was defined as a drop in haemoglobin of >2g/dL, with or without overt bleeding. Logistic regression analysis and cox survival analysis were performed to identify factors associated with re-bleeding.

Results: We identified 86 patients with SBA, in whom a total of 274 SBAs were detected. Overall 61% (n=52) presented with occult bleeding and 39% (n=34) had obscure overt bleeding. Of these, 54% (n=47) were female, and the average age was 71.6 years (range 40-92). The majority (69%, n=59) had multiple lesions, with an average of 2.76 (1-18) SBAs per patient, and the most common location was the jejunum, accounting for 65%. Of the 86 patients, follow-up information was available in 65% (n=56). There was a significant increase in haemoglobin level from 10.05g/dL (3.7-14.7) to 11.94g/dL (8.9-15), p<0.001 (95% CI -2.61- -1.18) after a mean follow up of 31.9 (6-62) months. Re-bleeding episodes occurred in 80% (n=45), with an average of 2.91 re-bleeding events per person (range 1-15). The mean interval between diagnosis and the first re-bleeding event was 10.7months (1-53). Of the group overall, 70% (n=40) required RCC transfusions during follow up, with a median number of 10 units (range 2-64) transfused per patient, and 67% required at least one hospitalisation due to a re-bleeding episode, with an average of 1.8 admissions per person. With regard to specific treatments, 57% (n=33) underwent DBE and APC, 33% (n=19) were treated with a long-acting somatostatin analogue, and 5% (n=3) required surgical resection. In total 3.5% (n=2) died as a direct consequence of bleeding from SBAs. On logistic regression analysis, the presence of multiple lesions and valvular heart disease were predictive of a re-bleeding episode, with p values of 0.048 and 0.034 respectively.

SBA Patients	N=56
Specific Treatments:	
APC	N=33
Octreotide	N=19
Surgery	N=3
Re-bleeding: 80%	**N=45**
Hospital admissions	N=38 (84%)
RCC transfusions	N=40 (89%)
Mortality	N=2 (4.4%)

Conclusion: This study is the first to describe the natural history in a large cohort of patients with SBA. It has identified that SBA in isolation, is an emerging condition not recognised previously due to the inability to fully visualise the entire small intestinal mucosa. We have shown the significant impact of the condition on patients, with high rates of re-bleeding, persistent anaemia and an overall mortality rate of 3.5%, despite the use of currently available medical and endoscopic therapies.

ABSTRACT 12 (14W100) POSTER PRESENTATION

Summer Meeting 2014

Elizabeth Grogan, AbbVie, Prof Humprey O'Connor and Dr Aine Balfe

Margaret Ann Connaughton, St. Vincent's University Hospital Dublin being presented with 3rd Oral, prize by Cora Gannon

Lina Zgaga Trinity College Dublin being presented with 2nd Oral, prize by Cora Gannon

Eoin Murphy of AbbVie, Prof Humprey O'Connor and Zita Galvin receiving First Poster Prize

Tess Cooke of Norgine, Prof Humprey O'Connor, Prof Colm O'Morain, Brenda Scannell and Robert Felton of Norgine

Neil Power of Abbvie, Prof Humprey O'Connor and Dr Margaret Walshe

Pinewood Healthcare World Cup TV Winner
L-R Liza Waters of Naas General and Katie Tobin of Pinewood Healthcare

Cara Dunne oral paper on Cancer screening

Summer Meeting 2014

Thomas Fitzgerald Oral Presentation on Pancreatic Tumours

Paul Lynch and Gavin Harewood chairing session with
Sinead Smith who received First Oral Prize on Molecular Genetics

Stephen Attwood speaking on “Barretts”

Nick Shaheen speaking on “Barretts”

Marie O’Sullivan speaking on Nutrition

James Neuberger speaking on PBC

Graham Foster speaking on Hep C

Dermot O'Toole speaking on “Barretts”

Title of Paper: Esophageal Adenocarcinoma – a case of rare metastases Afaq Zaman Khan

Author(s): Afaq Zaman Khan, Iqbal Z Khan, Danyal Zaman Khan, Major Assad Khan

Department(s)/Institution(s): Florida Hospital Orlando, Royal College of Surgeons Ireland, Mayo Clinic Castlebar. Army Medical College, Rawalpindi

Introduction: The link between esophageal carcinoma and metastasis to skeletal muscles is extremely rare. Only 6 cases have been reported in medical literature so far. Metastasis to skeletal muscles represents less than 1% of all hematogenous spread from solid tumors. Inspite of skeletal muscles being well vascularised, the rarity of metastasis may be secondary to proteases and other inhibitors blocking tumor invasion. The most frequent metastatic locations in skeletal muscles are the diaphragm, rectusabdominis, deltoid, psoas major,thigh muscles, intercostal, glutei and spinal muscles. The most common primary tumors are melanoma, thyroid, breast, colon, uterus, and lung carcinoma. Treatment options include observation, excision, radiotherapy and chemotherapy. This case report highlights multiple asymptomatic muscle metastases. It also elucidates the advantage of PET scan over a CT scan in identifying metastatic lesions. Prognosis remains poor secondary to advanced presentation of the disease.

Aims/Background: The usual metastases of esophageal carcinoma are to the liver, lungs, bone, and adrenal glands. To our knowledge this is the first reported case of metastasis to erector spinae from adenocarcinoma of esophagus. Treatment modality is not yet well defined.

Method: Literature review was done using Pubmed. Only six cases were reported in the literature regarding the metastasis of esophageal carcinoma to the skeletal muscles. Duration of search was from 1985-2014.

Results: Local invasion of skeletal muscles from an adjoining adenocarcinoma is a well recognized entity. However, only 4 previous papers have documented distant metastasis to skeletal muscles. Ours is the first established case of involvement of gluteal muscles. CT guided biopsy can provide histopathological confirmation with high degree of accuracy.

Conclusion: This case report highlights the possibility of metastases to the skeletal muscles from primary esophageal carcinoma. However the incidental finding of both these pathologies occurring together in the same patient raises the question – is the increasing incidence of muscle metastasis secondary to a change in disease pattern or a result of improving imaging modality? With an increase in use of PET scans more of the rare metastatic lesions will be surfacing. The important question would be establishing an optimal treatment modality in these advanced cancers.

ABSTRACT 13 (14W101) POSTER PRESENTATION

Title of Paper: Towards a scoring system For evaluation of Lower gastrointestinal bleeding In the Pre-hospital setting

Author(s): O'Reilly S, Doherty G, Menzies D, Bury G

Department(s)/Institution(s): St Vincent's University Hospital Endoscopy Department/Emergency Department

Introduction: It is estimated that between 20 and 33% of gastrointestinal haemorrhages are from the lower GI tract. Lower GI bleeding can be defined as bleeding from the gastrointestinal tract distal to the ligament of Treitz. While two well established and validated scoring systems exist for evaluation of upper GI bleeding, no such score has been proposed for bleeding from the lower GI tract.

Aims/Background: 1. To review the presentation, procedures, laboratory results and lengths of stay for patients presenting to the emergency department in St Vincent's University Hospital within a given timeframe. 2. To propose a hypothetical score on the basis of these results, with a view to creating a pilot study for such a score in the future. 3. To establish what proportion of patients are bypassing their GP and going straight to the emergency department, either via ambulance, or private transport, with lower GI tract bleeding.

Method: Data over a two year period (January 2012-January 2014) obtained from the MAXIMS emergency department electronic system used in St Vincent's University Hospital was examined. I created a database looking at a wide variety of parameters: age, sex, chronic liver disease, chronic renal disease, cardiovascular disease, use of anticoagulant/antiplatelet agents or NSAIDs, previous diagnosis of haemorrhoids, previous GI bleed, previous abdominal surgery, alcohol use, inflammatory bowel disease, diverticular disease and vital signs at presentation. I also looked at what endoscopic procedure, if any, the patient went on to have and I established whether or not they had any imaging, and what the findings were.

Results: Out of 193 patients, 50 were ultimately found to meet inclusion criteria. Of these, five were unstable. 26 patients were transported by ambulance, and nine in total attended their GP first. 29 (58%) patients were admitted,18 of whom underwent endoscopic investigation. Only 43% had a length of stay greater than 24 hours. Average length of stay for those over 60 years of age was 6.65 days, versus 4.45 days in those younger than 60. Patients on an anticoagulant or antiplatelet were more likely to have a significant drop In their haemoglobin (<8g/dL or >2g/dL drop from baseline). 26/50 had cardiovascular disease. Two of the 50 were found to have colorectal cancer.

Bright red blood per rectum	1
Age >60	1
Anticoagulant	1
Antiplatelet	1 point for each agent
Previous GI Bleed	1
Recent bowel surgery (within 2/52)	1
BP <90/60	1
HR >100	1
Hb <8g/dL, or drop of >2g/dL from previous	2

C…g literature, and highlights once again the absence of a validated scoring system for lower GI bleeds. Only 10% of patients in this cohort were unstable GI bleeds. Over half never underwent an endoscopic examination, and almost 43% were discharged the same day. Many of these patients could have been evaluated as an outpatient, if there was a scoring system for evaluation of their symptoms to aid decision making. A prospective, pilot study needs to be completed to validate this. I have proposed such a scoring system for pilot use, based upon validated literature and my own

findings. A score of 3 points or more warrants emergency department referral. At the discretion of the physician, those with a score of less than this should be referred for urgent endoscopy as an outpatient, or review in gastroenterology clinic. Potentially,a similar system could be implemented for use as a 'treat and discharge' strategy for advanced paramedics.

ABSTRACT 14 (14W102) POSTER PRESENTATION

Title of Paper: Endoscopic Surveillance of Patients with Inflammatory Bowel Disease; an audit of compliance with guidelines.

Author(s): E. McDermott, B. Neary, D. Keegan, K. Byrne, C. Flanagan, G. Cullen, H. Mulcahy, G. Doherty.

Department(s)/Institution(s): St Vincent's University Hospital

Introduction: Patients with Inflammatory Bowel Disease (IBD) have an increased risk of bowel cancer. Thus it is recommended that they receive endoscopic surveillance (1).

Aims/Background: To assess our compliance with international guidelines.

Method: Patients diagnosed with IBD between 1/1/2000-31/12/2002, who would therefore be eligible for screening as per guidelines, were identified from the prospectively maintained IBD database. Only patients with a St Vincent's University Hospital number were included. Patients with Crohns disease who had surgery, and would therefore not be eligible for screening, were excluded. Patients were cross-referenced against the electronic endoscopy, pathology and letters systems. Results were recorded in Microsoft excel.

Results: 322 patients were identified. 167 were excluded as above, thus 155 were assessed. Of these 155 patients, 63 had an endoscopy, 16 had an endoscopy in St Vincent's private, 71 were not actively attending the unit (had not attended hospital services within 2 years), 3 had a completion proctectomy (therefore did not require surveillance) and 2 had no endoscopy. In the group who received an endoscopy the median number of biopsies was 12 and median prep was good. Per protocol analysis shows that 63 of 65 eligible patients received an endoscopy (97%).

Conclusion: We have excellent compliance with endoscopic surveillance guidelines. Biopsy numbers have room for improvement (though the value of random biopsies is controversial and we are moving towards an alternative form, i.e. chromoendoscopy). It was not possible in this audit to assess whether surveillance intervals are being adhered to and this could be reviewed in future audits.

ABSTRACT 15 (14W103) POSTER PRESENTATION

Title of Paper: Appropriateness of GP referrals to Gastroenterology (GI) Clinic of patients with Iron Deficiency Anaemia(IDA): Implications for GI outpatient services and the concept of "direct access" endoscopy

Author(s): Yousif K, Elsafi G, O'Mahony S

Department(s)/Institution(s): Department of Gastroenterology in Cork University Hospital

Introduction: IDA is a common reason for referral to Gastroenterology (GI) out-patient services. We carried out this audit because of two on-going concerns: (1) Many patients referred to our service were not truly iron-deficient, and thus did not require endoscopic evaluation, and (2) GPs, strongly encouraged by the last Minister for Health, are now commonly requesting "direct access" OGD and colonoscopy.

Aims/Background: To audit prospectively the appropriateness of GP referrals to our GI outpatients of patients with Iron Deficiency Anaemia (IDA).

Method: We evaluated 47 referrals from November 2012 to June 2013. A patient was judged to be iron deficient based on Hb, MCV and ferritin. Those patients assessed as being not iron deficient were referred back to their GP. Further investigation of patients with IDA conformed to the Guidelines published by the British Society of Gastroenterology (BSG) in 2011.

Results: Of 47 patients referred to our service with anaemia, only 23 (49%) had IDA. Most (89%) were over 50, and 55% were female. All patients were screened for coeliac disease. 14 patients (60%) had both gastroscopy and colononoscopy. 8 patients had CT abdomen or CT colonography. In the majority of patients (59%), no cause for IDA was found. In the remainder, IDA was thought to be caused by: aspirin/NSAID use (9%); presumed menstrual blood loss (9%), haemorrhoidal bleeding (9%); oesophagitis/hiatus hernia (5%); duodenal ulcer (5%); and angiodysplasia (5%). No case of GI cancer was detected.

Conclusion: Just over half of all GP referrals to our service for evaluation of IDA are inappropriate. We now screen all such referrals: if the patient does not have iron deficiency, the referring GP is written to and advised that GI investigations are not required, and the patient is not assessed by our service. This audit shows that provision of "direct access" endoscopy (particularly colonoscopy) would result in many inappropriate procedures. Patients undergoing endoscopy should be seen first at a GI clinic. GPs need education in diagnosis of IDA and the BSG guidelines need wider dissemination.

ABSTRACT 16 (14W106) POSTER PRESENTATION

Title of Paper: A prospective 52 week mucosal healing assessment of small bowel Crohn's disease as detected by capsule endoscopy

Author(s): B Hall1, G Holleran1, JL Chin2, S Smith1, B Ryan1, N Mahmud2, D McNamara1

Department(s)/Institution(s): 1. Department of Gastroenterology, Adelaide and Meath Hospital, Dublin 2. Department of Gastroenterology, St James's Hospital, Dublin

Introduction: Mucosal healing is increasingly recognised as an important treatment goal in Crohn's disease (CD). Data from colonic disease shows improved long-term outcomes in patients achieving mucosal healing and deep remission. Little is currently known of this with regard to active small bowel CD, which is increasingly diagnosed using modern imaging techniques.

Aims/Background: To prospectively assess small bowel mucosal healing and deep remission rates in a cohort of symptomatic small bowel CD patients following 52 weeks of medical therapy.

Method: Patients attending our IBD service with active CD requiring either immunomodulator or biologic therapy were invited to participate. Baseline and 52 week assessments included capsule endoscopy (SBCE), Harvey Bradshaw Index (HBI), quality of life questionnaires, C-reactive protein & faecal calprotectin analysis. The capsule endoscopy Crohn's disease activity (CECDAI) index was used to assess the severity of small bowel CD. Rates of clinical response (as defined by a normalization of C-reactive protein, faecal calpotectin and HBI), mucosal healing (the absence of visible

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References:
1. OLYSIO Summary of product characteristics. Available at www.medicines.ie.
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ulcerations on SBCE) and deep remission (mucosal healing and clinical remission) were calculated. Results at baseline & week 52 were compared using two-tailed Wilcoxon analysis, p <0.05 considered significant.

Results: In all, 71 patients were screened over 15 months, 28 (39%) were deemed unsuitable; failed patency examination (39%), declined (50%), no change in therapy (11%). Of the 43 subjects who underwent baseline SBCE, 22 (51%) were female, the median age was 38 years (range 19-63) and 16 (37%) were smokers. In all, 37 (86%) had ileo-colonic disease with 6 (14%) having ileal disease only. In total, 19 (44%) had previous surgery. Overall 108 SBCE were performed on the 43 patients, 39 (90%) demonstrated active ileitis at baseline with 28 (65%) undergoing 52 week assessment. At week 52, 15 (54%) had achieved clinical remission. Quality of life parameters had also improved from baseline (p<0.0001 95% CI -0.74 to -0.34). Of note, 12 (42%) subjects achieved both mucosal healing and deep remission at week 52 which was statistically significant (p<0.0001 95% CI -0.62 to -0.22). Of note, stricturing disease was associated with persistent symptomatic and mucosal disease (OR 6.000 p=0.0613 95% CI 0.9187 to 39.1859). There was also a trend towards less mucosal healing in older patients (OR 2.0 p<0.52) and smokers (OR 2.5 p<0.31) although neither parameter reached statistical significance.

Conclusion: Our study shows SBCE is a safe and effective means of assessing small bowel treatment response. Complete mucosal healing is achievable in small bowel CD with rates similar to published colonic data. Stricturing disease phenotype is a poor prognostic indicator for clinical and mucosal response. Early diagnosis and treatment of small bowel CD may decrease the risk of stricture development and subsequent need for surgery.

ABSTRACT 17 (14W107) POSTER PRESENTATION

Title of Paper: Progressive Attitudes but Heterogeneity among Irish Gastroenterologists in the Treatment of Severe Alcoholic Hepatitis

Author(s): Audrey Dillon, Diarmaid Houlihan, Stephen Stewart

Department(s)/Institution(s): Mater Misericordiae University Hospital, St Vincent's University Hospital

Introduction: Patients with Severe Alcoholic Hepatitis (SAH) have a significant mortality but their management is heterogeneous.

Aims/Background: The aim was to ascertain the degree of heterogeneity in the management of SAH amongst Irish gastroenterologists and determine attitudes to the role of liver transplantation in selected patients.

Method: A one-page survey at the ISG Summer 2014 meeting.

Results: 20 consultants and 21 SpRs responded. 18 (43.9%) had a hepatology sub-speciality interest. Transjugular liver biopsy was available to 29 (70%) but only 14 (34%) used biopsy in less than half of cases to diagnose SAH. For assessment, 39/41 (95%) of respondents used the Maddrey's Discriminant Function, with 19 (49%) also using the Glasgow Alcoholic Hepatitis Score, and 7 (18%) also using the Lille score. All respondents used nutritional supplementation with 85% using nasogastric feeding. 38(93%) used corticosteroids if no contraindication. 23(56%) reserved pentoxifylline for patients with steroid contraindications, while 9(22%) used it in addition to steroids and 3(7.5%) used it exclusively. N-Acetyl-Cysteine was used regularly by 4 (9.8%) and occasionally by 12 (29%). 30 (73%) recorded difficulty in access to intensive care unit (ICU) treatment. Psychosocial supports were only available to half the gastroenterologists and were: Alcoholic Nurse Specialist (20(48%)), Alcohol Counsellor (13(32%)) and Psychiatrist (18(44%)). 20(49%) of the respondents would like to refer all SAH patients to a tertiary hospital. 37(90%) were willing to submit data to a national registry. 33(80%) of respondents thought it appropriate to refer well-selected patients with SAH for consideration for transplantation.

Conclusion: This survey shows that there is great heterogeneity in the diagnosis, assessment and treatment of SAH in Ireland. Access to transjugular liver biopsy, psychosocial supports, and ICU care is sub-optimal. Real-life outcome data may be generated though the recorded willingness to contribute to a national outcomes registry. There is a progressive attitude to the consideration of liver transplantation in well-selected patients with SAH.

ABSTRACT 18 (14W108) POSTER PRESENTATION

Title of Paper: A Century of SeHCATs: Utilisation and outcomes of the selenium homotaurocholic acid test (SeHCAT) in Belfast.

Author(s): Hall PSJ, Turner GB

Department(s)/Institution(s): Department of Gastroenterology, Royal Victoria Hospital, Belfast Health and Social Care Trust

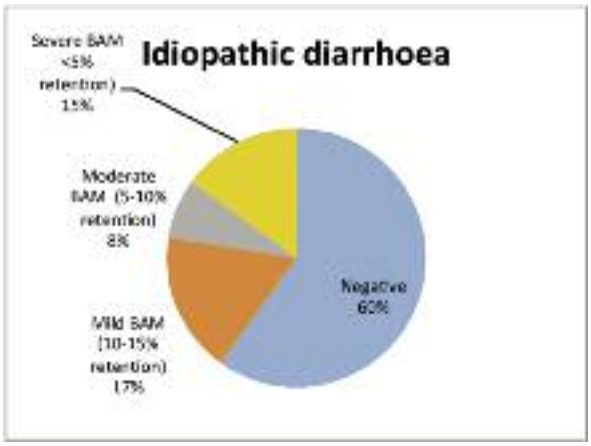
Introduction: Bile acid malabsorption (BAM) accounts for over 25% of patients with diarrhoea predominant irritable bowel symptoms. In addition, interruption of enterohepatic recirculation of bile acids in the terminal ileum (TI) may cause diarrhoeal symptoms in patients with surgical resections, Crohn's disease, radiation damage or ischaemia. The SeHCAT scan objectively measures bile acid retention allowing identification of BAM.

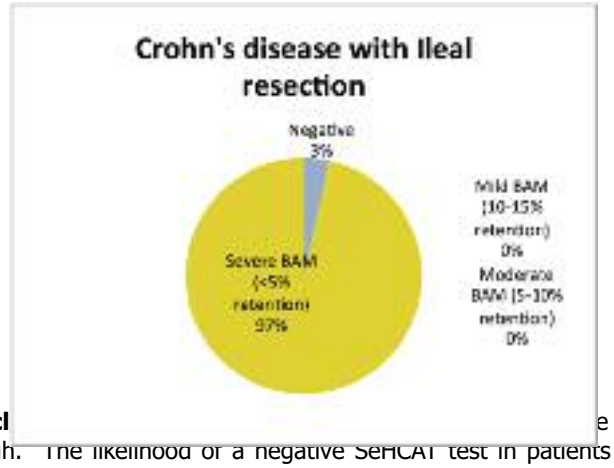
Aims/Background: Evaluate SeHCAT use in Northern Ireland.

Method: Retrospective identification of patients from a hospital radiology database correlated with clinical records.

Results: One hundred patients attended for a SeHCAT between June 2010 and August 2014. Tests performed have risen from 4 in 2010, to 51 in the first eight months of 2014. Testing was performed in all cases for diarrhoeal symptoms: Idiopathic diarrhoea (40%), post cholecystectomy (15%), Crohn's with ileal resection (29%), other ileal resection (8%), previous abdomino-pelvic radiation therapy (4%) and Crohn's disease without resection (4%). We found positive tests for BAM in 40% (16/40) patients with idiopathic diarrhoea, 60% (9/15) patients with post-cholecystectomy diarrhoea and 97% (28/29) patients with Crohn's disease and ileal resection. All 28 of these Crohn's resections had severe BAM (<5% retention at one week).

	Positive BAM	Negative BAM	Total patients
Idiopathic diarrhoea	16	24	40
Post cholecystectomy	9	6	15
Ileal resection – Crohn's	28	1	29
Ileal resection – Ischaemia/lymphoma	4	4	8
Post radiotherapy	4	0	4
Crohn's – no resection	1	3	4





Concl e yield is high. The likelihood of a negative SeHCAT test in patients with Crohn's and ileal resection appears very low. Larger studies are required but our results suggest some patient groups could benefit from empirical trial of therapy rather than SeHCAT scanning.

ABSTRACT 19 (14W110) POSTER PRESENTATION

Title of Paper: Distance from treating hospital and colorectal cancer survivors' quality of life: a gendered analysis

Author(s): Audrey Alforque Thomas, Pamela Gallagher, Alan O'Ceilleachair, Alison Pearce, Linda Sharp, Michal Molcho

Department(s)/Institution(s): NUI Galway, Dublin City University, University College Cork, National Cancer Registry Ireland

Introduction: How far colorectal cancer patients live from medical services is associated with their clinical outcomes. Increasing distance to a hospital or to their general practitioner is associated with later stage at diagnosis of colorectal cancer, lower likelihood of receiving treatment, reduced likelihood of attending a specialist centre, and shortened survival. The association of remoteness from hospital with clinical outcomes is well-documented; however, the association with patient-reported outcomes is less well understood. A recent study of long-term colorectal cancer survivors in Australia showed a negative relationship between remote residence and cancer-specific QoL, but remoteness was not the focus of their study. More research investigating how distance to hospital is related to colorectal cancer survivors' quality of life (QoL) is needed.

Aims/Background: Distance from residence to hospital has been associated with clinical outcomes for colorectal cancer patients. However, little is known about the association of remoteness with quality of life (QoL) for colorectal cancer survivors. We examined the relationship between distance from hospital and colorectal cancer survivors' QoL, with a specific focus on gender.

Method: Colorectal cancer survivors in Ireland who were more than 6 months post-diagnosis completed the European Organisation for Research and Treatment of Cancer QLQ-C30, measuring global health status (GHS) and physical, role, cognitive, social, and emotional functioning. Bootstrap linear regression was used to evaluate the association between remoteness and QoL scales, controlling for demographic and clinical variables. Separate models were generated for the full sample, for women, and for men.

Results: The final analytical sample was 496 colorectal cancer survivors; 186 women and 310 men. Living remote from treating hospital was associated with lower physical functioning (coefficient -4.38 [confidence interval -8.13, -0.91]) and role functioning (coeff. -7.78 [-12.64, -2.66]) among all colorectal cancer survivors. In the separate gender models, remoteness was significantly associated with lower physical (coeff. -7.00 [-13.47, -1.49]) and role functioning (coeff. -11.50 [-19.66, -2.65]) for women, but not for men. Remoteness had a significant negative relationship to GHS (coeff. -4.31 [-8.46, -0.27]) for men.

Conclusion: Aspects of QoL are lower among colorectal cancer survivors who live far from their treating hospital. There are gender differences in how remoteness is related to QoL domains. The results of this study suggest that policy makers, service providers, and health care professionals should consider the specific QoL needs of remote colorectal cancer survivors, and be attuned to and prepared to address the differing needs of men and women.

ABSTRACT 20 (14W111) POSTER PRESENTATION

Title of Paper: Improving attendance at a regional hepatitis clinic in Northern Ireland: Is SMS the answer?

Author(s): O Devlin, A McCurley, WJ Cash, NI McDougall

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

Introduction: 'Did not attend' (DNA) rates at viral hepatitis clinics are notoriously high and at our clinic have been as high as 36% (Aug 2013). The use of short message service or texting (SMS) reminders has been proposed as a solution.

Aims/Background: To audit the use of SMS reminders as a means of reducing clinic DNA rates

Method: DNA rates were monitored from Jan-Sept 2013, this was used as control data for comparison. In Jan 2014 we introduced a text message reminder service and the subsequent DNA rate was monitored. Questionnaires and random sampling (to confirm accuracy of mobile numbers held on PAS) were used to obtain patient feedback on texting.

Results: The DNA rate from January-September 2013 was 27% (standard clinic had 45-50 appointments booked). After implementation of SMS reminders, the DNA rate was 25% for Jan 2014. A questionnaire in early 2014 of 113 patients showed that 57% did not receive a text reminder. Subsequent clinic visits were used to actively update mobile numbers with improvement in DNA rates reaching 7% in April 2014. Overall DNA rate with SMS improved to 22% in the period January-September 2014. In September 2014, sampling of those who attended revealed we had the correct mobile number for 94% with one patient having changed their number but not notifying the hospital.
Conclusion: SMS technology is an effective means of improving clinic attendance rates. However hospital data on mobile numbers

is frequently outdated and needs to be actively managed if it is to be used for SMS clinic reminders.

ABSTRACT 21 (14W113) POSTER PRESENTATION

Title of Paper: Misattribution to the virus of psychosocial and cognitive dysfunction in hepatitis C: Select psychosocial contributors identified.

Author(s): Damien Lowry, Teresa Burke, Zita Galvin, John Ryan, John Hegarty, Stephen Stewart, John Crowe.

Department(s)/Institution(s): Mater Misericordiae University Hospital Liver Centre; University College Dublin School of Psychology; St. Vincent's University Hospital Liver Unit.

Introduction: Chronic hepatitis C (CHC) is associated with health related quality of life (HRQoL) and cognitive impairments, even in mild disease. Recent evidence demonstrating hepatitis C virus (HCV) neurotropism has strengthened a neuropathophysiological hypothesis for this. However, sample heterogeneity has been shown to confound study outcomes.

Aims/Background: A uniquely homogeneous cohort of Irish women, following an iatrogenic HCV outbreak, offers a rare opportunity to control for HCV chronicity and the virus' purported impact on HRQoL and cognition.

Method: A multi-site, three-group, cross-sectional design was employed. Non-cirrhotic, iatrogenically-infected women, developing either acute or chronic infection were recruited from prospective tertiary care liver clinics and the community. Well matched healthy-controls were also recruited. All participants completed a psychosocial survey and were asked to complete a subsequent comprehensive neuropsychological test battery.

Results: Significantly distressed psychosocial symptom profiles were observed in those with an iatrogenic HCV exposure history, which was independent of viral chronicity. CHC and cleared-HCV cohorts were not differentiated from each other. Two distinct subgroups, demarcated along 'impaired' versus 'non-impaired' global-HRQoL reports were clearly identified and logistic regression analysis identified depressed mood and cognitive fatigue, rather than viral status, as statistically significant predictors of group membership. Compared with matched controls, significant cognitive impairments were not observed in either HCV cohort.

Conclusion: Our findings provide strong evidence of non-viral factors accounting for HRQoL impairment in CHC and they also appear to question existing reports of cognitive dysfunction in mild HCV disease. Depressed mood and cognitive fatigue appear to be critical psychosocial mediators of reduced HRQoL and we hypothesise that metabolite abnormalities reported in HCV samples may also be confounded by these factors, given the associated literature.

ABSTRACT 22 (14W114) POSTER PRESENTATION

Title of Paper: Long term follow-up of Crohn's Disease patients resistant to anti-TNFa agents treated with ustekinumab

Author(s): Z Heetun, D Keegan, K Byrne, G Cullen, H Mulcahy, G Doherty

Department(s)/Institution(s): Center of Colorectal Disease, St Vincent's University Hospital, School of Medicine and Medical Research, University College Dublin.

Introduction: Ustekinumab is a fully human monoclonal antibody against p40 subunit of IL 12/23. It has been shown to be effective in Crohn's disease patients with poor response to infliximab.

Aims/Background: To evaluate long-term clinical remission rates and complications in patients treated with ustekinumab.

Method: A single center retrospective observational study. Ustekinumab was used for Crohn's disease refractory to immunomodulator therapies and at least two anti-TNF? agents. All patients received standard induction (90 mg subcutaneously weekly for 4 weeks) and maintenance therapy was initiated in patients with a clinical response. Clinical response was defined by physician's global assessment combined with decision to continue therapy. Clinical response was assessed throughout treatment and at last follow-up (up to 30th July 2014).

Results: 12 patients (7 males (58%); mean age 40 years; mean follow-up 19 months) had received ustekinumab during our study period. 46% of patients had also received certolizumab as a third anti-TNFa agent. 92% had previous surgical resections. At long term follow-up, 8 patients (67%) were on maintenance ustekinumab. 3 patients (25%) were in complete remission (CR; symptom free) and 5 (42%) were in partial remission (improvement in symptoms). Dose escalation was required in one patient in the PR group. 4 patients had steroid dependant disease pre-ustekinumab and 2 were taken off steroids in the CR group and 2 in the PR group were on a reduced steroid dose. Ustekinumab was discontinued in 4 patients due to lack of efficacy (2 after induction and 2 after 11.6 and 22.2 months). No adverse events were recorded and no patients discontinued ustekinumab due to drug side-effects.

Conclusion: In this real-life cohort, two-thirds of patients with Crohn's disease refractory to anti-TNFa therapy demonstrated sustained clinical improvement on ustekinumab. Ustekinumab use was not associated with opportunistic infections and was well tolerated by patients. Subcutaneous ustekinumab is therefore an effective therapeutic option in IBD patients who fail licensed therapies.

ABSTRACT 23 (14W115) POSTER PRESENTATION

Title of Paper: Alicaforsen retention enema induces long-term remission in patients with ulcerative colitis.

Author(s): Zaid Heetun, David Gibson, Denise Keegan, Kathryn Byrne, Garret Cullen, Hugh Mulcahy, Glen Doherty

Department(s)/Institution(s): Center of Colorectal Disease, St Vincent's University Hospital, School of Medicine and Medical Research, University College Dublin.

Introduction: Alicaforsen is a phosphorothioate-modified antisense oligonucleotide designed to reduce expression of human intracellular adhesion module 1 through inhibition of messenger RNA levels.

Aims/Background: To determine the long-term remission rates following treatment with alicaforsen retention enemas for distal ulcerative colitis.

Method: Single center retrospective observational study. Patients having received alicaforsen were identified from the IBD database. All patients received nightly enemas of alicaforsen (240 mg) for a treatment period of 6 weeks. Mayo Clinical and Endoscopic Scores were used for evaluation of clinical improvement, relapse and

durability of response. Date of last follow-up was defined as date of last out-patient visit up to 30th July 2014.

Results: 7 patients (5 males; mean age 51.3 years; mean follow-up of 1.6 years) had received alicaforsen enemas during the study period. All patients had proctitis or protosigmoiditis and had received oral aminosalicylates, rectal aminosalicylates and/or rectal steroids. 2 (29%) patients and one (14%) patient were previously treated with azathioprine and infliximab respectively. 6 (86%) patients had a complete Mayo Score of 5 or above prior to starting treatment. 4 (57%) patients went into clinical remission following treatment (Mayo Score ?2). 3 (43%) patients did not respond to treatment (Mayo Score of ?8). Of those who responded, only one was retreated on long term follow-up. No patient discontinued alicaforsen during treatment period and no treatment related side effects were described.

Conclusion: Alicaforsen enemas is a useful alternative to patients with severe distal sided ulcerative colitis in whom immunomodulators or immunosuppressants have either failed or are contraindicated. Alicaforsen is well tolerated and induces clinical and endoscopic remission in more than half of patients. The durability of response suggests a disease modifying effect.

ABSTRACT 24 (14W116) POSTER PRESENTATION

Title of Paper: Host-microbe interactions in the Mucus Gel Layer– the role of mucolytic bacteria and mucin binding in ulcerative colitis.

Author(s): Earley H1,2., Lennon G1,2., Balfe A1,2., Lavelle A1,2., Coffey JC 3., Winter DC2., O'Connell PR1,2.

Department(s)/Institution(s): 1. School of Medicine and Medical Science, University College Dublin. 2. Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin. 3. GEMS, University of Limerick.

Introduction: Interactions between microbes and mucins may modulate physiology in the colonic mucus gel layer (MGL). Within the setting of ulcerative colitis (UC) mucolytic bacteria have been implicated in loss of integrity of the MGL. However, emerging evidence suggests that not all microbes with mucolytic potential are deleterious to the host. The species Akkermansia muciniphila, is one such mucolytic bacteria which is thought to have protective properties for the integrity of the MGL.

Aims/Background: This study aimed to: (1) Determine the relative abundance of A.muciniphila within the MGL of the colitic colon and to (2) Examine its affinity for binding to human mucin in health and UC.

Method: RT-PCR specific for A.muciniphila was used to determine its abundance in a cohort of 20 healthy controls, 14 patients with quiescent UC, and 20 with active UC. The mucin binding preferences of A.muciniphila (reference strain and 2 clinical isolates) were investigated through mucin array analysis.

Results: A. muciniphila was significantly more abundant in health compared to quiescent and active UC and showed a predisposition for binding to UC mucin when compared to that of health.

Conclusion: These data suggest that A.muciniphila is a member of the healthy microbiota. However, its increased affinity for UC mucin may afford this species an opportunity to bind to and metabolise the mucin resulting in a reduction in the thickness of the MGL, which is a feature of UC pathology.

ABSTRACT 25 (14W117) POSTER PRESENTATION

Title of Paper: Single centre experience in managing haemochromatosis according to AASLD

Author(s): A Shahin,Z Ahmad, R Farrell, C Smyth

Department(s)/Institution(s): Department of Gastroenterology, Connolly Hospital

Introduction: Hereditary Haemochromatosis is a common inherited disorder of iron metabolism that affects about 1:400 person of Northern European descend that is characterized by increasing iron absorption in the gastrointestinal tract with subsequent deposit in tissue causing serious complications like cirrhosis, cardiomyopathy and endocrinopathies, which can be prevented by venesection a cheap, easy and effective management

Aims/Background: To review our management of patients with Haemochromatosis against the American Association of Study of Liver disease 2011 guidelines, which includes that all first degree relatives of diagnosed patient should be screened by ferritin, transferrin saturation and genotyping. Venesection should be commenced as soon as the diagnosis is established, and should be conducted weekly till serum ferritin less than 50 with maintenance venesection every 3-4 months

Method: The charts of 14 patients who were diagnosed from April 2011 till March 2014, and a proforma were completed accordingly

Results: Of the patients involved, 73% of the patients were compliance with the initial phase of treatment and the target ferritin level was achieved in 32 % of patients, 18% had levels between 51-100. In 82% of the diagnosed patients, the treatment was initiated within 1-3 weeks of diagnosis, while 74 % of the patients have their first degree relatives screened; only 32 % were carrying the HFE gene mutations

Conclusion: Patients should have a structural approached follow up with more patients and family members educations will be beneficiary in improving the management of these patients according to the international standards and subsequently reducing preventable complications

ABSTRACT 26 (14W118) POSTER PRESENTATION

Title of Paper: Outcomes from the Irish national Hepatitis C prospective treatment registry

Author(s): Gray E, O'Leary A, Walsh C, Bergin C, Norris S

Department(s)/Institution(s): St. James' Hospital, Dublin 8 & Trinity College, Dublin

Introduction: The Irish Hepatitis C Outcomes and Research Network (ICORN) Treatment registry is designed to prospectively collect and collate real world clinical and economic outcomes for patients treated with triple therapy for Genotype 1 HCV.

Aims/Background: The aim of the study is to determine SVR rates, eligibility for response-guided therapy (RGT), discontinuation rates, tolerability and total costs of treatment for the Irish cohort

Method: The registry is hosted on a web-based platform developed by ICORN in collaboration with the Dublin Centre for Clinical Research. Its purpose is to collect demographic, clinical, virological, adverse event and economic data during treatment and follow-up.

Results: A total of n=279 patients are registered across 7 hospitals to date. The cohort is predominantly male (72.4%) with a median

age of 45 (range 18-72) and the majority are Irish born (71.3%). 70.4%% are treatment naive and 28.8% are cirrhotic. Genotype 1, 1a and 1b account for 27.1%, 44.7% and 28.2%. Telaprevir is the dominant DAA of choice (67.6%). At baseline, 60%% of patients satisfy the criteria for RGT. Of those patients who completed treatment, 96% achieved a SVR 24 weeks post treatment completion. Discontinuation of therapy due to treatment futility rules, adverse events and intolerance occurred in n=45 (16%) patients. An estimated €7.5 million has been spent on the DAAs to date.

Conclusion: Observational data generated from the registry facilitates an in-depth assessment of the effectiveness and tolerability of these high cost therapeutic regimens in the real world setting, and provides the basis for a comparison between efficacy and effectiveness.

ABSTRACT 27 (14W119) POSTER PRESENTATION

Title of Paper: Haematological Safety Profile of Telaprevir and Boceprevir in Chronic Hepatitis C: Real World Experience from the ICORN National Treatment Registry

Author(s): Egan C, Gray E, O'Leary A, Bergin C, Norris S, on behalf of ICORN

Department(s)/Institution(s): Department of Gastroenterology and Hepatology, St James' Hospital

Introduction: The Irish Hepatitis C Outcomes and Research Network (ICORN) treatment registry is designed to prospectively collect and collate real world clinical and economic outcomes for patients treated with triple therapy for Genotype 1 HCV.

Aims/Background: The aim of this review is to evaluate and report the preliminary haematological response, for a cohort of patients, to boceprevir and telapreivr triple therapy regimens in the 'real world' setting.

Method: DAA triple therapy has been initiated in 10 sites across the country since June 2010. The purpose of the registry is to collect demographic, clinical, virological, adverse event and economic data during treatment and follow-up. Using the registry dataset, the haematological profile of n=110 patients was evaluated.

Results: Sixty-five patients (59.1%) in this cohort completed a course of triple therapy, while forty-five (40.9%) discontinued prematurely. Telaprevir was the predominant PI of choice (66.4%). For telaprevir patients, 9.5%, 53.9% and 21.4% experienced grade 3/4 anaemia, neutropenia and thrombocytopenia, respectively. Grade 3/4 anaemia, neutropenia and thrombocytopenia occurred in 5.6%, 72.3% and 19.5% of the boceprevir cohort, respectively. Ribavirin dose reduction and EPO was most commonly used for the management of anaemia. Neutropenia was frequently managed by gCSF administration while IFN dose reduction was the most frequent intervention for the management of thrombocytopenia. IVIG was required on two occasions. Six patients (13.3%) discontinued treatment due to adverse haemoatological events.

Conclusion: As a consequence of timely intervention, treatment discontinuation as a result of haematological adverse events was limited to less than 14% .

ABSTRACT 28 (14W120) POSTER PRESENTATION

Title of Paper: An audit of Ampullary carcinoma reporting over a 10 year period

Author(s): Danielle Costigan, Kieran Sheahan, Justin Geoghegan, Niall Swan

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

Introduction: Ampullary carcinomas account for 6-8% of tumours in the pancreatic head region (1)(2) and approximately 30% of pancreatico-duodenectomy (Whipple) specimens. Although they tend to have a more favourable overall prognosis than carcinomas of the pancreatic head or distal bile ducts, ampullary carcinomas can arise from any of three epithelia and exhibit a wide range of clinical outcomes which can pose diagnostic and treatment challenges.

Aims/Background: The aim of our audit was to compare pathology reporting of ampullary cancers in Whipple and ampullectomy specimens in St. Vincent's University Hospital to the College of American Pathologists (CAP) 2012 reporting protocol.

Method: We examined 67 reports of invasive ampullary carcinomas found in Whipple and ampullectomy specimens over a ten year period. Ten key components of each report were examined for completeness including tumour size, grade, stage, lymphovascular invasion, resection margin status and nodal status.

Results: Overall 93% of Whipple reports were deemed complete by CAP standards, however only 40% of ampullectomy specimen reports met the same criteria. Of the 61 Whipple resections containing invasive carcinoma, 60 cases had all margins uninvolved by tumour (R0). In contrast, 80% of ampullectomy specimens had positive margins.

Conclusion: Standardised reporting of Ampullary carcinomas is an important tool in providing concise and relevant diagnostic and prognostic information. Our analysis also highlighted a number of 'clinically important' data elements, whose inclusion in reports is currently recommended but not required.

ABSTRACT 29 (14W121) POSTER PRESENTATION

Title of Paper: Trans-Balloon Visualization During Dilatation (TBVDD); Its safer to See.

Author(s): HA Khokhar, M Bughio, GA Bass, TN Walsh.

Department(s)/Institution(s): Upper GI Surgery, James Connolly Hospital, Blanchardstown, Dublin 15

Introduction: Hydrostatic balloon dilatation of upper gastrointestinal (GI) strictures is associated with a risk of perforation that varies with the underlying pathology and with the technique employed.

Aims/Background: We hypothesised that a technique of trans-balloon visualisation of the stricture during dilatation (TBVDD) would allow direct 'real-time' observation of the effect of dilatation on stricture, facilitating early recognition of mucosal abruption and reducing the perforation rate.

Method: TBVDD is achieved by forcibly retracting the balloon against the lens during dilatation while spraying water to establish a continuous interface between the lens and the water filled balloon. We analysed 100 consecutive patients undergoing TBVDD of

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esophageal strictures between 1st May 2011 and 1st Oct 2013.

Results: One hundred patients underwent 186 dilatations, with 34 having multiple procedures (mean 1.86 procedures/patient). All had strictures (mean diameter 8.49 mm, range 5-11mm) and most underwent dilatation up to a maximum of 20 mm (mean 14.7 mm). Fifty-six percent were male and the mean age was 62.5 years (17-89). Only one patient (0.5% of procedures,) had a full-thickness perforation requiring intervention while one further patient had a deep mucosal tear not requiring intervention.

Conclusion: TBVDD is a safe technique with a short learning-curve that allows potentially-difficult dilatations to be performed safely with a perforation rate of less than 1 %.

ABSTRACT 30 (14W122) POSTER PRESENTATION

Title of Paper: CT-TAP for occult malignancy in unexplained weight loss: low yield and high costs

Author(s): Wiebe M, Dyer A, McCabe M, Walsh JP, Wilson G

Department(s)/Institution(s): School of Medicine, Trinity College Dublin; Dept of Diagnostic Imaging, St James's Hospital, Dublin 8

Introduction: Computed tomography of the thorax, abdomen and pelvis (CT-TAP) accounted for 20% of CT scans performed in Ireland in 2009, but 40% of the CT population dose [1]. Few guidelines exist for the non-staging use of CT-TAP, particularly in the context of unexplained weight loss [2].

Aims/Background: Our objective is to audit the use of CT-TAP as an investigation for occult malignancy in the context of weight loss, quantify its yield, and determine how this may be improved with alternative initial assessments.

Method: All CT-TAPs in our institution from September 2013 to February 2014 inclusive were audited. Those performed for occult malignancy or unexplained weight loss were included, while those performed on patients with a personal history of malignancy, paraneoplastic syndrome or recent unprovoked pulmonary embolus were excluded. Work-up prior to CT-TAP was reviewed, including laboratory investigations, quantification of weight loss, nutritional assessment, and outcome of prior investigations, including endoscopy, plain films and ultrasound.

Results: Of 2034 CT-TAPs performed within the audit interval, 51 fulfilled inclusion criteria. 5.8% were positive for occult malignancy (n=4, 95% CI [2.2-16.5%]). Incidental findings requiring further investigation or follow-up were discovered in 82.3% (n=42, 95% CI [70.8-91.4%]). Within the six months prior to CT-TAP, OGD had been performed in 52%, colonoscopy in 47%, and ultrasound in 17.6%. Chest radiograph had been performed within one month in 70.5%.

Conclusion: The yield of CT-TAP for occult malignancy is low, and frequently prompts further investigations for incidental findings. Moreover, this investigation is generally performed in an older patient cohort, and full patient evaluation including clinical nutritional assessment is indicated [2].

References

1. Population Dose from CT Scanning: 2009, Health Service Executive, Dublin, January 2011
2. Investigation and management of unintentional weight loss in older adults, McMinn J et al, BMJ 2011;342:d1732

ABSTRACT 31 (14W123) POSTER PRESENTATION

Title of Paper: Oesophago-Gastric Carcinoma: Time For Triple Assessment For Suspicious Lesions?

Author(s): NV Kharytaniuk, C Brandon, GA Bass, R Brennan, A Salih, E Leen, TN Walsh

Department(s)/Institution(s): Academic Department of Surgery, Connolly Hospital, Blanchardstown, Dublin 15

Introduction: A diagnosis of oesophago-gastric carcinoma can be difficult to reach due to submucosal spread, ulcer slough and stromal proliferation increasing the possibility of a missed diagnosis, with disastrous consequences for the patient.

Aims/Background: We aimed to identify a series of patients presenting with symptoms suggestive of upper gastro-intestinal (GI) malignancy, to determine the number of upper GI endoscopies required to confirm a diagnosis, and the percentage of positive biopsies from each diagnostic endoscopy session.

Method: Patients presenting with such symptoms between 2008 and 2012 were included in this prospective study. Ethics Committee approval was granted.

Results: Data were collected on 132 consecutive patients. The diagnosis was achieved after one OGD/biopsy session in the majority of patients, 16 (12%) required two sessions for diagnosis, 6 (4.5%) required three sessions, 2 (1.5%) required four or more sessions; 2 (1.5%) were diagnosed on the histology of the resected specimen. One patient was falsely reassured of not having malignancy and returned one year later with gastric liver metastases. One patient with a gastric tumour but negative biopsies died prior to repeat OGD. Three patients presented with advanced malignancy having previously been reassured elsewhere they did not have carcinoma.

Conclusion: A single OGD diagnostic session cannot reliably exclude malignancy. We propose a triple assessment protocol for patients with suspicious lesions or symptoms suggestive of malignancy, as currently practiced for breast cancer. Clinical, radiological and pathological assessment must be satisfied rather than a pathological reassurance alone and endoscopy repeated in the event of negative histology.

ABSTRACT 32 (14W124) POSTER PRESENTATION

Title of Paper: Improvements in radial strain detected by speckle tracking echocardiography in patients with Hereditary Haemochromatosis following venesection.

Author(s): Byrne D, Walsh JP, Cadogan D, Ellis L, Norris S, McKiernan S, King G, Murphy RT.

Department(s)/Institution(s): Departments of Gastroenterology, Cardiology and Centre for Advanced Medical Imaging (CAMI), St James Hospital, Dublin 8.

Introduction: In the context of iron overload in Beta Thalassemia Major, radial strain has previously been shown to be a better prognostic marker than conventional measurements.

Aims/Background: To investigate whether patients with hereditary haemochromatosis without signs of heart failure exhibit subclinical alterations of systolic left ventricular (LV) dysfunction.

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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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Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 826 606.

Ireland

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

References:

1. Worthington J et al. Curr Med Res Opin 2008;24(2):481–488
2. Ell C et al. Aliment Pharmacol Ther 2006;24:1631–42
3. Ell C et al. Am J Gastroenterol 2008;103:1–11

Date of preparation: May 2014

NORGINE

Method: We performed a comprehensive echocardiographic evaluation of systolic and diastolic cardiac function using Tissue Doppler Imaging (TDI) and deformation imaging (strain) at initial diagnosis and one year after commencing a treatment programme of venesection. 56 patients have been assessed at baseline prior to commencement of venesection and 15 patients have had a follow-up echocardiogram after 1 year of venesection.

Results: In the 15 patients who have undergone repeat echocardiography, radial strain showed a significant improvement following venesection from 32.8 (SD ±14.2) to 52.3 (SD ±21.3) (p = 0.006). Average ferritin showed a significant decrease from a mean value of 957 µg/L (SD ±779) pre-venesection to 188 µg/L (SD ±73.7) post-venesection (p = 0.0007). There was no significant change in longitudinal strain or LVEF.

Conclusion: Patients with hereditary haemochromatosis have subclinical alterations of systolic and diastolic LV function. Among all parameters, radial strain was shown to significantly improve following a 1 year course of venesection. This suggests that radial strain which is synonymous with myocardial twist could be used to demonstrate improvements in cardiac function in patients with iron overload following venesection.

ABSTRACT 33 (14W126) POSTER PRESENTATION

Title of Paper: Gastroesophageal varices: An audit of adherence to AASLD management guidelines in an Irish setting.

Author(s): Aisling Murphy, Maeve Lucey, Orla Crosbie

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

Introduction: Bleeding from Gastroesophageal varices (GOV) is one of the major complications of cirrhosis and despite advancements in management mortality rates remain high.

Aims/Background: To evaluate adherence to AASLD (American Association for the Study of Liver Diseases) guidelines for the treatment and management of GOV.

Method: A retrospective audit of patients who received endoscopic variceal ligation (EVL) of their varices over a 18 month period at CUH. Adherence to primary prevention, acute bleeding and secondary prevention protocols were evaluated.

Results: EVL was performed 52 times in 26 patients; the majority had alcoholic liver disease. 8 EVL were for primary prophylaxis of variceal haemorrhage. All were for medium/large varices. 80% had high-risk features at the time of endoscopy (defined as Child Pugh B/C or variceal red marks), 40% were on nonselective B-blockers (NSBB). There were 18 acute variceal bleeds treated with EVL in 12 patients. Prior to endoscopy, 83% received prophylactic antibiotic and 72% terlipressin. 44% had OGD completed within 12 hours and 77% within 24 hours. The median time from presentation of bleeding to OGD was 14 hours. 42% of patients had rebleeds. The median time to rebleed was 16 days, 83% occurred during the same admission. There were 25 EVL for secondary prevention in 13 patients. 84% of patients were on a NSBB while undergoing treatment. The median time for repeat OGD after EVL was 12 weeks. 53% of patients who had secondary endoscopic prevention did not have any follow up OGD, although noncompliance was an issue.

Conclusion: Terlipressin, antibiotic and endoscopy therapy rate compare favourably to UK national data in acute variceal haemorrhage. However significant delays occur particularly at weekends. There was inadequate adherence to guidelines for follow up endoscopy after primary prophylactic EVL and secondary prevention.

ABSTRACT 34 (14W127) POSTER PRESENTATION

Title of Paper: Allergies, asthma and the risk of pancreatic cancer: a population-based case-control study in Ireland

Author(s): Miguel Santibañez(1), Michael O'Rorke(2), Eamonn O'Leary(3), Marie Cantwell(2), Marianna de Camargo Cancela(3), Liam Murray(2), Linda Sharp(3), on behalf of the PanCAM study group

Department(s)/Institution(s): 1 Universidad de Cantabria, Spain; 2 Queen's University Belfast, Northern Ireland; 3 National Cancer Registry, Ireland

Introduction: Although pancreatic cancer is the fifth most common cause of cancer death worldwide, its aetiology is poorly understood. Several studies have suggested relationships between self-reported allergies and the disease, but associations with other indicators of an overactive immune system (such as asthma) are unclear.

Aims/Background: We investigated associations between specific allergies, asthma and risk of pancreatic cancer.

Method: We conducted a population-based case–control study in the island of Ireland. 152 histologically confirmed incident exocrine pancreatic cancers were included. 288 controls, frequency-matched to cases on age, sex and region, were recruited through general practices. History of allergies and asthma was ascertained through structured face-to-face interviews. Odds ratios (OR) and 95% confidence intervals (CI) were estimated by logistic regression, adjusted for sex, age, region, education, smoking, diabetes and body mass index.

Results: Ever having asthma was associated with a borderline statistically significant halving of pancreatic cancer risk (multivariate OR=0.48, 95% CI 0.22–1.03); the association was almost identical when restricted to asthma confirmed by a doctor. It was more pronounced for long-term asthma (>15 years since first attack: OR=0.21, 95%CI 0.05-0.93; p(trend)=0.042). Nasal allergies, including hay fever, were associated with significantly reduced risk (OR=0.56, 95%CI 0.32-0.99). There were no associations with eczema, skin allergies or itchy rash.

Conclusion: These results confirm previously reported associations between hay fever and pancreatic cancer and also suggest a protective effect of asthma. The biological basis for these findings requires elucidation.

ABSTRACT 35 (14W128) POSTER PRESENTATION

Title of Paper: Diabetes, pancreatitis and smoking and pancreatic cancer risk: results from a population-based case-control study in Ireland.

Author(s): Miguel Santibañez(1), Michael O'Rorke(2), Eamonn O'Leary(3), Marie Cantwell(2), Marianna de Camargo Cancela(3), Liam Murray(2), Linda Sharp(3), on behalf of the PanCAM study group

Department(s)/Institution(s): 1 Universidad de Cantabria, Spain; 2 Queen's University Belfast, Northern Ireland; 3 National Cancer Registry, Ireland

Introduction: The aetiology of pancreatic cancer is not well understood. This is partly because of difficulties inherent in conducting robust, population-based, aetiological studies of the condition: late diagnosis, low levels of histological confirmation and treatment utilisation, and poor prognosis mean that studies often suffer from bias.

Aims/Background: We investigated associations between pancreatic cancer risk and the most firmly established risk factors – cigarette smoking, diabetes and chronic pancreatitis - in the population-based all-Ireland PanCAM study.

Method: 152 histologically confirmed incident exocrine pancreatic cancers were included. 288 controls, frequency-matched to cases on age, sex and region, were recruited through general practices. Participants underwent structured face-to-face interviews. Odds ratios (OR) and 95% confidence intervals (CI) were estimated by logistic regression, adjusted for sex, age, region, and other confounders.

Results: Strong statistically significant dose-response relationships (p trend <0.001) were found for tobacco smoking classified by: smoking status pre-diagnosis (never, former, current); number of cigarettes/day; years of cigarette smoking; and pack-years of exposure. Compared to never smokers, odds ratios for other groups were: former smokers with ?14 pack-years=1.15 (95%CI 0.62-2.14); former smokers with >14 pack-years=2.19 (95%CI 1.25-3.84); current smokers with ?29 pack-years=2.05 (95%CI 0.93-4.50); and current smokers with >29 pack-years=3.55 (95%CI 1.81-6.98). History of diabetes (OR=2.70, 95% CI 1.34–5.44) and chronic pancreatitis (OR=14.64, 95% CI 1.69–126.96) were also significantly associated with a higher risk.

Conclusion: The confirmation of associations between smoking, chronic pancreatitis and diabetes suggests that the population-based PanCAM case-control study does not suffer from significant selection or information biases.

ABSTRACT 36 (14W129) POSTER PRESENTATION

Title of Paper: Hepatitis C in the Era of Direct-Acting Antivirals: Real-World Costs of Untreated Chronic Hepatitis C

Author(s): Dr. Jennifer Kieran 1,2, Dr. Aisling O'Leary 2,8, Professor Suzanne Norris 3,7, Professor Cathal Walsh 4, Dr. Raphael Merriman 5, Dr. D Houlihan 5, Professor P. Aiden McCormick 5, Professor Susan McKiern

Department(s)/Institution(s): 1.Department of Pharmacology and Therapeutics, Trinity College Dublin, Ireland 2. National Centre for Pharmacoeconomics, St. James Hospital, Dublin, Ireland 3. Department of Hepatology, St. James Hospital, Dublin, Ireland

Introduction: Recent advances in Hepatitis C therapeutics offer the possibility of cure but will be expensive. The cost of treatment may be partially off-set by the avoidance of advanced liver disease.

Aims/Background: We performed a micro-costing study of the healthcare utilisation of patients with Hepatitis C.

Method: The staff utilisation costs associated with a Hepatitis C ambulatory visit were measured and combined with the costs of investigations to establish a mean cost per review. An annualised estimate of cost was produced by multiplying this by the number of reviews accessed, stratified by degree of liver impairment. Inpatient costs were established by identifying the number of inpatient episodes and multiplying by Irish diagnostic related group costs. Non-parametric bootstrapping was performed to derive mean and 95%CI values.

Results: 250 patients were identified. The cost of an outpatient medical review was €136 (€3.60 SD). The cost of a Hepatitis C nursing review was €128 (€7.30 SD). The annual mean costs of care were as follows (95%CI): Mild €398 (€336, €482), Moderate €417(€335, €503), Compensated cirrhosis €1790 (€990, €3164), Decompensated cirrhosis €10,596 (€6131, €16,097), Transplantation Year 1 €137,176 (€136,024, €138,306), Transplantation after Year 1 €5337 (€4942, €5799), Hepatocellular carcinoma €28,486 (€21,291, 36,181), Sustained virological response €44 (€27, €62).

Conclusion: The direct medical cost associated with Hepatitis C care in Ireland is substantial and increases exponentially with progression of liver disease. The follow-up costs of patients with a sustained virological response in this cohort were low in comparison to patients with chronic infection.

ABSTRACT 37 (14W130) POSTER PRESENTATION

Title of Paper: Health-State Utilities for Patients with Chronic Hepatitis C Infection

Author(s): Dr. Jennifer Ann Kieran 1,2, Dr. Roisin Adams 2, Dr. Jun-Liong Chin 3, Dr. Hamid Mushtaq3, Professor P. Aiden McCormick 3, Professor Susan McKiernan 4,7, Professor Cathal Walsh 5, Professor Colm Bergin 6,7,

Department(s)/Institution(s): 1. Department of Pharmacology and Therapeutics, Trinity College Dublin, Ireland 2. National Centre for Pharmacoeconomics, St. James Hospital, Dublin, Ireland 3.Liver Unit, St. Vincent's University Hospital, Dublin, Ireland

Introduction: There are many novel chronic hepatitis C (HCV) therapies in development. Publications documenting health-state utility in HCV are few and there are none describing utilities elicited using the novel EQ-5D 5-level questionnaire.

Aims/Background: We aimed to establish health-state utilities across the full spectrum of HCV disease.

Method: A cross-sectional study of 270 HCV patients attending two tertiary care hepatology units was performed. Qestionnaires gathering clinical, demographic and health-related quality of life (HRQOL) information were completed. The EQ-5D 5-Level was used to derive HRQOL. Health-states were assigned on clinical, histological and radiological criteria. Descriptive statistics were performed on clinical and demographic variables. Non-parametric tests were used to assess for differences in median utilities between the health-state and demographic subgroups. Multivariate linear regression analysis was performed on variables found to be significant on univariate analysis. Statistical significance was taken as p-value <0.05.

Results: Mean utility value was 0.7 (0.24 SD). Treatment-experienced patients reported higher utility values than treatment-naïve patients (0.74 versus 0.67 p=0.04). Patients with a sustained virological response (SVR) reported higher mean utility than patients with current viral infection (0.81 versus 0.68, p<0.001). Patients post-liver transplantation had higher utility scores than patients with decompensated cirrhosis (0.57 versus 0.46). On multivariate analysis, SVR, mild fibrosis and paid employment predicted improvement in HRQOL.

Conclusion: Patients achieving a SVR report utilities equivalent to those reported by the general population. Utility values representing the full spectrum of HCV derived using the EQ-5D 5-Level questionnaire will better inform researchers, policy decision-makers

and payers evaluating emerging therapeutics.

ABSTRACT 38 (14W131) POSTER PRESENTATION

Title of Paper: The prevalence of ultrasound diagnosed fatty liver disease among adults in Mayo General Hospital and its association with liver biochemistry and diabetes mellitus.

Author(s): Nawawi KN, Saha T, O'Donnell L, Egan BJ

Department(s)/Institution(s): Gastroenterology & Hepatology Department, Mayo General Hospital

Introduction: Fatty liver is associated mainly with alcohol usage and metabolic syndrome. With increasing prevalence of metabolic syndrome, non-alcoholic fatty liver disease (NAFLD) has become increasingly important cause of liver cirrhosis and its complications. Mayo has one of oldest populations and one of the highest prevalence of diabetes in Ireland.

Aims/Background: To determine the prevalence of ultrasound diagnosed fatty liver disease in adult patients underwent abdominal ultrasound in Mayo General Hospital and to investigate any association with liver biochemistry and diabetes mellitus.

Method: 500 consecutive abdominal ultrasound scan results were analysed. 451 patients (mean age 56.4 ± 18.6 years, 40.40% male) were included in the study after applying the exclusion criteria (repeated scans, patients less than 16 years old and scans without comment on the liver). Patients with ultrasound diagnosed fatty liver were identified, and subdivided into alcoholic (stated in the ultrasound referral as excess alcohol usage) and NAFLD. Their association with liver biochemistry was examined by using ANOVA, followed by unpaired t-test. The prevalence of diabetes mellitus also was determined among fatty liver disease patients.

Results: The prevalence of ultrasound diagnosed fatty liver was 11.5% (n=52). 92.3% (n=48) were NAFLD (alcoholic fatty liver disease; 7.7%, n=4). 25% (n=12) of the NAFLD patients have diabetes mellitus (none of alcoholic fatty liver disease has diabetes mellitus). Fatty liver is significantly more frequent in male compared to female (15.40% vs. 8.90%; P= 0.035). Analysis of the liver biochemistry parameters revealed that fatty liver patients had non-significant higher serum ALT levels (65.9 ± 92.5 vs. 44.9 ± 77.2; P=0.074) and serum GGT levels (249.5 ± 450.6 vs. 133.4 ± 227.9; P=0.073).

Conclusion: Almost one patient a day is identified with fatty liver in Mayo General Hospital. One quarter of patients in Mayo with ultrasound diagnosed NAFLD had diabetes mellitus. Patients with fatty liver disease had a tendency to have higher serum ALT and GGT levels. These findings highlight an increasingly common finding in the Irish population and a significant work load for hepatology services.

ABSTRACT 39 (14W132) POSTER PRESENTATION

Title of Paper: Mechanical Lithotripsy for difficult common bile duct stones

Author(s): Zaid Heetun, Sujeevan Maheswaran, Mohmand Khan, Jenny Moloney, Margaret Green, Garry Courtney, Abdur Rahman Aftab
Department(s)/Institution(s): Department of Gastroenterology and Hepatology, St Luke's General Hospital, Kilkenny

Introduction: Large common bile duct (CBD) stones are challenging and result in high rates of failed duct clearance.

Aims/Background: To evaluate our rates of duct clearance with the use of mechanical lithotripsy (ML) for large CBD stones.

Method: A single center retrospective observational study. All patients having an ERCP with ML from 1st January 2011 to the 30th June 2014 were identified from the ERCP database. To compare duration of procedure and amount of sedation used, age and disease matched controls were recruited from the database. All controls needed to have complete duct clearance at the end of the procedure.

Results: 40 ERCP procedures with ML were carried out on 36 patients (P group, 13 males (36%); mean age 67.6 years) during our study period. 40 controls (C group, 17 males (42%), mean age 67.6 years) were identified. Significantly more patients in the P group had undergone a previous ERCP and have had a previous stent compared to the C group (80% and 70% compared to 7.5% and 5% respectively; $p<0.05$). CBD diameter and dose of midazolam and pethidine used were not significantly different between the two groups ($p>0.05$). The duration of the procedure, the number of stones and size of stones were significantly higher in the P group compared to the C group ($p<0.05$). The duct clearance rate in the P group was 45% (C group: 100%). There were 3 (7.5%) complications in the P group (1 bleeding, 1 retained basket and 1 cholangitis) compared to 2 (5%) in the C group (2 bleeding) ($p>0.05$). In the P group patients with unsuccessful ML had a higher number of stones and a longer procedure compared to patients with complete duct clearance. No other parameters including CBD diameter were found to be statistically different between those two subgroups. 2 patients (6%) underwent CBD exploration and had epithelized stones at laparotomy. No predictors for failed duct clearance were identified on logistic regression analysis.

Conclusion: ML is a good option in the armamentarium of the endoscopist against large CBD stones and is associated with CBD clearance in half of patients and low complication rates.

ABSTRACT 40 (14W134) POSTER PRESENTATION

Title of Paper: An Inital Experience of Golimumab in Inflammatory Bowel Disease

Author(s): C.Rowan,M.Boyle, P.MacMathuna,J.Leyden, H.E. Mulcahy, G.A. Doherty,G.Cullen

Department(s)/Institution(s): Centre for Colorectal Disease,St.Vincent's University Hospital, Department of Gastroenterology, Mater Misericordiae University Hospital, School of Medicine and Medical Science,University College Dublin

Introduction: Golimumab is a fully humanised anti-TNF antibody that has been previously shown to be effective in the induction and maintenance of clinical remission in moderate-severe ulcerative colitis(UC). It has recently been licensed for this indication in Ireland.

Aims/Background: To describe our initial experience of golimumab in the treatment of IBD in two academic medical centres.

Method: Subjects with a diagnosis of IBD treated with golimumab were identified from prospectively maintained IBD databases at both study sites. Case notes including pathology, radiology and laboratory reports were analysed and data extracted retrospectively.

Results: Thirteen patients (7male)with IBD were treated with golimumab between December 2013 and September 2014. Twelve had UC and one Crohn's disease. The median age of these patients

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Prescribing Information

Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe and Humira 40mg/0.8ml solution for injection for paediatric use

Refer to Summary of Product Characteristics for full information.

Presentation: Each 0.8ml single dose pre-filled pen, pre-filled syringe or vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA): In combination with methotrexate (MTX) is indicated for the treatment of moderate to severe active RA in adult patients with inadequate response to disease modifying anti-rheumatic drugs (DMARDs) including MTX. Also indicated for the treatment of severe, active and progressive RA in adults not previously treated with MTX. Can be given as monotherapy in case of intolerance to or when continued treatment with MTX is inappropriate. Humira has been shown to reduce the rate of progression of joint damage on X-ray and to improve physical function, in combination with MTX. Polyarticular juvenile idiopathic arthritis (pJIA): In combination with MTX for the treatment of active pJIA in patients from the age of 2 years with inadequate response to one or more DMARDs, or as monotherapy in case of intolerance to or when continued treatment with MTX is inappropriate. Enthesitis-related arthritis (ERA): Treatment of active enthesitis-related arthritis in patients from 6 years of age with inadequate response to, or intolerance of, conventional therapy. Psoriatic arthritis (PsA): Treatment of active and progressive PsA in adults with inadequate response to DMARDs. Humira has been shown to reduce the rate of progression of peripheral joint damage on X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function. Ankylosing spondylitis (AS): Treatment of adults with severe active AS with inadequate response to conventional therapy. Axial spondyloarthritis non-radiographic (nr-axSpA): Treatment of adults with severe axial spondylosis for nr-axSpA without radiographic evidence of AS but with objective signs of inflammation by elevated CRP and/or MRI, who have had an inadequate response to, or are intolerant to nonsteroidal anti-inflammatory drugs (NSAIDs). Crohn's disease (CD): Treatment of moderately to severely active CD, in adult patients not responding 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. Paediatric Crohn's disease: Treatment of severely 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. Psoriasis (Ps): Treatment of moderate to severe chronic plaque psoriasis in adult patients not responding to or contraindicated for, or are intolerant to other systemic therapy including cyclosporine, MTX or PUVA. Ulcerative colitis (UC): Treatment of moderate to severe active UC in adult patients with an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or who are intolerant to or contraindicated for such therapies. **Dosage and administration:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition. Patients should be given the special alert card. After proper injection training patients may self-inject, subject to physician approval and appropriate medical follow up. During treatment other concomitant therapies should be optimised. PA, PsA, AS or nr-axSpA: 40mg administered every other week as a single dose via subcutaneous injection. RA MTX should be continued. In monotherapy, some patients who experience a decrease in their response to Humira may benefit from an increase to 40mg every week. There may be a need for dose interruption, e.g. before surgery or if a serious infection occurs. Re-introduction of Humira after discontinuation for 70 days or longer resulted in the same magnitude of clinical response and similar safety profile as before dose interruption. pJIA: Age 2 to 12 years: 24mg/m² body surface area to a maximum single dose of 20mg, for patients aged 2 -<4 years up to a maximum single dose of 40mg, for patients aged 4-12) administered every other week. The volume for injection is based on the patients' height and weight (see SmPC for height and weight dosing chart). For patients from 13 years: 40mg administered every other week regardless of body surface area. ERA: Age 6 years and older: 24 mg/m² body surface area up to a maximum single dose of 40mg administered every other week. The volume for injection is based on the patients' height and weight (see SmPC). For RA, pJIA, PsA, AS and nr-axSpA, available data suggest that the clinical response is usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within the time period CD: Adults: Induction dose of 80mg at Week 0 followed by 40mg at Week 2. For a more rapid response, 160mg at Week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days), 80mg at Week 2, can be used. Note that the risk for adverse events is higher during induction. After induction, the dose is 40mg every other week. If a patient has stopped Humira and signs and symptoms of disease recur, Humira may be re-administered. There is little experience from re-administration after more than 8 weeks since the previous dose. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Patients experiencing a decrease in their response may benefit from an increase in dosing frequency to 40mg every week. Patients who have not responded by Week 4 may benefit from continued maintenance therapy through Week 12 and should be carefully reconsidered in a patient not responding within this time period. Paediatric CD patients <40kg: Induction dose of 40mg at Week 0 followed by 20mg at Week 2. In case of need for a more rapid response to therapy, the regimen 80mg at Week 0 (dose can be administered as two injections in one day), 40mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 20mg every other week. Some patients who experience insufficient response may benefit from an increase in dosing frequency to 40mg every week. Paediatric CD patients >40kg: For induction dose double the dosing regimen for those patients <40kg. Continued therapy should be carefully reconsidered in a patient not responding by week 12. For Adult: Induction dose of 80mg at week 0, followed by 40mg subcutaneously given every other week from week 1. Continued therapy beyond 16 weeks should be carefully reconsidered in a patient not responding within this time period. UC: Adults: Induction dose of 160mg at week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days) and 80mg at week 2. After induction treatment, the dose is 40mg every other week. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Patients experiencing a decrease in their response may benefit from an increase in dosing frequency to 40mg every week. Available data suggest that clinical response is usually achieved within 2-8 weeks of treatment. Therapy is not recommended in patients failing to respond within this time period. **Contraindications:** Active TB or other severe infections such as sepsis, and opportunistic infections; moderate to severe heart failure (NYHA class III/IV); and hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings: In order to improve traceability of biological medicinal products, the tradename and the batch number of the administered product should be clearly recorded.** Infections: Patient taking TNF-antagonists are more susceptible to serious infections especially if they have impaired lung function. Patients must be monitored for infections, including tuberculosis before, during and for 4 months after treatment. Treatment should not be initiated in patients with active infections until they are controlled. The risks and benefits of treatment should be considered prior to initiating therapy in patients who have been exposed to tuberculosis or endemic mycoses. New infections during treatment should be evaluated and monitored closely. Treatment should be discontinued for new serious infection or sepsis and treated appropriately. Exercise caution when treating patients with a history of recurring infections or who are predisposed to infections. Serious infections: Serious infections, including those with

was 54 years (IQR 14.5). The median disease duration was 7yrs. 50% of the UC patients had pancolitis. Three patients were current smokers , 2 ex-smokers and the remaining were non-smokers at the time of golimumab induction. 30.7% (n=4)were anti-TNF naive and 30.4% (n=4) were previously on IFX(2 cases of primary non response;1 loss of response;1 adverse event) ; a further 4 were previously on adalimumab.2 patients had been on both infliximab and adalimumab. Median length of follow up from initiation of golimumab is 4 months.Ten patients (77%) treated with golimumab had an inital clinical response. Three patients discontinued golimumab due to primary non response:all were switched to IFX. One of these patients did not respond to IFX and had surgery,while the other 2 patients have responded clinically. None of our cohort stopped GLM due to infection/injection site reactions etc.

Conclusion: These early data from our two centres give inital real-life experience of the use of golimumab. The drug was well tolerated and associated with a clinical reponse rate similar to other anti-TNF agents. Ongoing collection of these data in addition to patient reported outcomes will add to our knowledge base.

ABSTRACT 41 (14W135) POSTER PRESENTATION

Title of Paper: Vitamin D Levels in IBD Patients- Are they as important as we think?

Author(s): Boyle MP1,2, Geraghty L2, Haire G2., Rowan C1., Doherty G1., Cullen, G1, MacMathuna PM2, Leyden JE2

Department(s)/Institution(s): 1.Centre for Colorectal Disease, St Vincents University Hospital and School of Medicine and Medical Science, University College Dublin 2. Mater Misericordiae University Hospital

Introduction: Vitamin D deficiency is common in IBD.

Aims/Background: Vitamin D Deficiency may feature in IBD pathogenesis secondary to anti-inflammatory and immune-modulating effects. We aim to analyse the performance of vitamin D measurement in IBD patients and to ascertain if vitamin D deficiency is an issue in our population

Method: Retrospective data collection from 164 IBD patients from 2 IBD centres between January 2009 and September 2014. Prospective analysis of vitamin D levels of 20 IBD patients and 20 healthy controls

Results: See Attached Table Vitamin D Levels in IBD Patients- Are they as important as we think?

	Institute 1 (n=82)	**Institute 2 (n=82)**
Age	41.2	46.5
Sex	45% female, 55% male	48% female, 52% male
Ethnicity	93% Irish, 7% Non-Irish	95% Irish, 5% Non-Irish
Disease phenotype	48% UC, 52% CD	49% UC, 49% CD, 1% IDC
Ileal Involvement	43%	31%
Previous Surgery	30%	44%
Dexa Scan in last 3 years	14%	2.40%
Vitamin D level(last 5 Years)	10% (n=8)	6% (n=6)
Mean Vitamin D level	57 mmol/l	54.24 mmol/l
Overall Level of Vitamin D Deficiency (<50mmol/l)	38%	

Prospective cohort			
	IBD Group (60% in remission, 30% ileal involvement)	**Control Group**	
Age	39.15	48.2	
Sex	35% female,65% male	55% female, 45% male	
BMI	23.8	27	
Mean Vitamin D Level	82.5 mmol/l	64 mmol/l	P=0.07
Suboptimal Vitamin D levels (<50mmol/l)	10%	25%	
Multivitamin	45%	15%	
Smoker	30%	35%	
Sun Exposure (Hours per week)	48.2	16.38	
Physical Activity	8.6	5.1	
Nutritional Status	80% (well nourished)	100% (well nourished)	

Conclusion: This study demonstrates that we are not actively measuring D. However, when we prospectively looked at vitamin D levels in 20 IBD patients and 20 healthy controls, the levels were higher in the IBD Group. Obviously, this may reflect increased sun exposure and more robust nutritional supplementation in a sicker population. Even though we are not actively checking vitamin D levels, based on this small preliminary pilot study in our IBD patients this may not be as big an issue as the literature would suggest. A large national study is needed to better assess the role for screening in Ireland where our Northerly latitude means that we are at risk of having one of the highest rates of vitamin D deficiency in the industrialised world.

ABSTRACT 42 (14W136) POSTER PRESENTATION

Title of Paper: Outcome of TIPS for ascites and variceal bleeding in the Mater since 2010 – a short term solution

Author(s): F Jones, Z Galvin, S Stewart

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

Introduction: Transjugular intrahepatic portosystemic shunt (TIPS) has an expanding role in the management of variceal haemorrhage and refractory ascites in cirrhosis. We sought to determine the indications and short/medium term outcomes of TIPS in our hospital since 2010.

Aims/Background: Twelve procedures were attempted between June 2010 and January 2014, all by interventional radiology. The mean age was 49 (29-60), 7 male, 5 female. Average pre-procedure MELD was 11.4 (8-14). 11/12 patients had alcohol-related liver disease, of which four had concomitant Hepatitis C (HCV). 1/12 had HCV only. 6 patients had TIPS for refractory ascites, 5 for bleeding and one for both. There were two procedural failures, one due to technical difficulties and the other due to early thrombosis. Both were excluded from further analysis.

Method: The study was conducted retrospectively using the patient charts and electronic records

Results: For the successful procedures, we compared variables for the 6 months post-TIPS to the 6 months pre-TIPS. For the whole group the mean number of Emergency Department admissions fell in this period (6.4±(SD 2.51-10.29) to 2.4±(SD 0.69 - 4.11); p=0.011). In the ascites patients the number of large volume paracenteses (LVPs) fell dramatically (9.8±(SD 5.22-14.37) to 0.4± (SD -0.15-0.95); p=0.004). In the variceal bleeding group presentations with gastrointestinal bleeding also reduced significantly (2.6± (SD 1.08 - 4.12) to 0.2± (SD -0.25 - 0.65); p=0.021). With regard to complications, 6/10 had evidence of encephalopathy at some point in the six months following TIPS. 2/10 required TIPS angioplasty for stenosis/thrombosis. One patient had a creatinine rise >20% in the 48 hours post-TIPS. Of the ten patients who successfully underwent TIPSS, three subsequently died. The 6-month mortality was 0% (0/10), 12-month 29% (2/7) and 24-month 43% (3/7). No patients proceeded to liver transplantation.

Conclusion: We conclude that TIPS is a safe and very effective procedure, which has a dramatic effect on hospital presentation, LVP frequency and variceal bleeding in well-selected patients. It has a very low short-term mortality but a high incidence of post-procedure encephalopathy. Mortality rises in the medium term, perhaps reflecting the selection of patients, with most having alcohol as their liver disease aetiology and not being suitable for liver transplantation.

ABSTRACT 43 (14W137) POSTER PRESENTATION

Title of Paper: Prospective Evaluation Of Utility Of NBI For Optical Diagnosis Of Colorectal Adenomas During Bowel Cancer Screening Colonoscopy

Author(s): Fatema Alalawi, Joanna Rea, Kieran Sheahan, Hugh Mulcahy, Glen Doherty, Garret Cullen

Department(s)/Institution(s): Centre for Colorectal Disease, St Vincent's University Hospital and School of Medicine and Medical Science, University College Dublin

Introduction: A number of endoscopic techniques have been developed to allow endoscopists differentiate between adenomas and non-adenomatous polyps. The aim of this study was to determine whether narrow band imaging (NBI) increased the accuracy of adenoma diagnosis using visual inspection of polyp morphology compared to white light.

Method: Individuals attending for screening colonoscopy as part of the National Bowel Cancer Screen Programme were prospectively recruited. Subjects were randomly assigned to a procedure room with or without an NBI processor. Procedures were performed by one of two endoscopists who predicted the size and histology of each polyp detected and removed. NBI was used to assist histology prediction when available. A simple score of 'confidence' in the optical diagnosis was recorded. Results were correlated with histopathology.

Results: 119 polyps were removed from 43 patients (32 male). NBI was used in the optical diagnosis of 79 polyps. Accurate adenoma detection was higher with NBI than white light (p= 0.03), with 63 polyps accurately predicted as adenomas. Endoscopist confidence in adenoma prediction was the factor most significantly associated with accurate histology prediction (p<0.001) and the only factor which remained significant on multivariate analysis (p<0.001). Subject gender, polyp location and the endoscopist did not affect adenoma diagnosis. Endoscopist prediction of polyp size was accurate in 93% of polyps.

Conclusion: NBI is superior to white light endoscopy in differentiating between adenomatous and non-adenomatous polyps of the colon during bowel cancer screening. However, operator confidence in adenoma prediction is probably more important, highlighting the necessity of careful inspection of polyp morphology.

ABSTRACT 44 (14W140) POSTER PRESENTATION

Title of Paper: Outcomes of a HCV treatment programme in PWID over 10 years support a disease eradication strategy for all patients in the DAA era

Author(s): El-Sherif O (1), Bannan C (2), Keating S (3), Mc Kiernan S (1), Bergin C (2), Norris S (1)

Department(s)/Institution(s): 1. Department of Hepatology, St. James's Hospital; 2. Department of Infectious Diseases, St. James's Hospital; 3. Drug Treatment Centre Board

Introduction: People who inject drugs (PWID) have historically been perceived to have "difficult to treat" disease, with physicians citing concerns regarding compliance, assumed high re-infection rates and perceived inferior treatment outcomes.

Method: A retrospective analysis of outcomes to anti-HCV therapy (pegylated interferon and ribavirin) in PWID was undertaken at our institution from 2002 – 2012, and compared to non-PWID patients receiving identical therapy. Analysis of SVR, discontinuation rates, and re-infection rates were recorded. Of 1,000 patients included in the study, the PWID subgroup comprised 693 patients who had a remote or recent history of injecting drug use with 307 patients in the non-PWID subgroup having other defined risk factors for HCV. Baseline characteristics are listed in table 1.

Results: SVR rate in the PWID cohort was 64.2% compared to 60.9% in the non-PWID group, and no statistically significant difference in SVR was observed across genotypes (Table1). Furthermore, there was no difference in the number of patients failing to complete treatment (8.4% in PWID group vs 6.8% in non-PWID). Follow up data on 135 patients in the PWID group who achieved SVR between 2002-2007 for a median of 48 months (range 6-112 months) indicated that 3.7% of patients (n=5) became viraemic. All 5 patients had a relapse in injecting drug use.

Table 1 Baseline patient characteristics of former and recent PWID and non - PWIDs treated for chronic HCV infection

	PWID (n=693)	non-PWID (n=307)
Age (years) [mean ± SD]	36.2 ± 7.7	43.0 ± 11.6
Sex (male) [n (%)]	547 (78.9)	196 (63.8)
Genotype [n (%)]		
1	290 (41.8)	142 (46.3)
2	29 (4.2)	15 (4.9)
3	364 (52.5)	131 (42.7)
4	8 (1.2)	15 (4.9)
5	1 (0.1)	2 (0.7)
6	1 (0.1)	2 (0.7)
Cirrhosis [n (%)]	83 (12)	43 (14)
HIV Co-infection [n (%)]	114 (16.5)	43 (14)
Viral load [n (%)]		
$< 10^6$ IU/ml	251/556 (45.1)	122/253 (48.2)
$> 10^6$ IU/ml	305/556 (54.9)	131/253 (51.8)

Conclusion: This study demonstrates that PWID have similar treatment adherence and SVR rates when compared to non-drug users. Over five-year follow-up, the re-infection rate was low. These data support a public health strategy of HCV treatment and eradication in PWID cohort in the DAA era.

ABSTRACT 45 (14W142) POSTER PRESENTATION

Title of Paper: An Interesting Case of Gastric Outlet Obstruction

Author(s): Dr Andrew Kerr, Dr Brooke Layard

Department(s)/Institution(s): Ulster Hospital Dundonald, Department of Gastroenterology

Introduction: Bouveret's syndrome is a rare complication of gallstone ileus and was first described in 1770 by Beassier with two cases reported by Leon Bouveret in 1896. It is caused by a gallstone entering the small bowel through a cholecystoduodenal fistula, becoming impacted in the duodenum or stomach causing gastric outlet obstruction.

Aims/Background: We are presenting a case report of a 77 year old male, with limited past medical history, who presented to our centre with a five day history of vomiting. X-ray imaging on admission revealed a faint calcified density in the right upper quadrant. Initially, he was managed as gastroenteritis, however vomiting persisted and a hypokalaemic, hypochloraemic alkalosis developed in keeping with gastric outlet obstruction. Repeat abdominal x-ray revealed massive gastric distension and an urgent CT abdominal scan confirmed a 7cm by 5cm gallstone located in his proximal duodenum obstructing the gastric outlet with pneumobilia identified. The patient required a laparotomy and gastroduodenotomy to extract the calculus with an uneventful postoperative course. This case demonstrates and discusses the presentation of Bouveret's syndrome, workup and management options. We provide a review of management techniques reported in case reports including endoscopic, surgical and other techniques such as extracorporeal shock wave lithotripsy.

ABSTRACT 46 (14W143) POSTER PRESENTATION

Title of Paper: Hepatocellular carcinoma: Management and clinical outcomes in a single-center study

Author(s): S. Naimimohasses, C. Quinn, S. Norris, S. McKiernan

Department(s)/Institution(s): Department of Hepatology, St. James' Hospital, Dublin

Introduction: Hepatocellular carcinoma is the 5th most common cause of cancer worldwide and its incidence is increasing. Despite evolving treatment options over the last decade, management is challenging and mortality rates remain high.

Aims/Background: To study the baseline characteristics of patients diagnosed with HCC, the treatment options employed and survival rates.

Method: We performed a retrospective study of HCC patients attending St. James Hospital, Dublin from 2008-2014.

Results: There were 78 incident cases. 82.1% (60) were male. Median age at diagnosis was 60 (range: 29-87). Diagnoses were based on radiological criteria. Alpha-fetoprotein levels were elevated in 75.6% (59) and correlated with disease severity. 84.6% (66) were cirrhotic. Alcohol and HCV infection accounted for 64.1% (50) of cases. 47.0% (31) were diagnosed during HCC surveillance, with no significant difference in BCLC score (p=0.99). 52.6% (41) were BCLC-A; of those 53.7% (22) received TACE. In 36.4% (4) of cases this was used as adjunctive therapy to transplantation. 22.0% (9) were listed for transplantation and 24.4% (10) underwent resection. The 1-year recurrence rate post resection was 20.0%. Complications were experienced in 30.0% (10) of patients treated with TACE; cholecystitis was the commonest occurring in 33.0% (4). 66.7% (8) of BCLC-C and 33.3% (1) of BCLC-D patients received treatment with Sorafenib. Side effects requiring dose reduction or cessation occurred in 50.0% (12). Overall mortality was 48.7%.

Table 1: BCLC score, treatment options and survival rates

BCLC score	Percentage of Patients	TACE therapy	RFA therapy	Resection
A	52.60%	53.70%	7.30%	24.40%
B	28.20%	77.30%	9.10%	9.10%
C	15.40%	8.30%	25.00%	0.00%
D	3.80%	0.00%	0.00%	0.00%

BCLC score	Transplant	Sorafenib	Mean survival (months)	1 yr survival
A	22.00%	9.80%	20.5	77.00%
B	9.10%	50.00%	14	50.00%
C	0.00%	66.70%	6.5	41.60%
D	0.00%	33.30%	1.3	0.00%

Conclusion: A small proportion of BCLC-A patients were suitable for transplantation. Management of HCC remains challenging particularly for BCLC grade B-D patients with low 1-year survival rates.

ABSTRACT 47 (14W145) POSTER PRESENTATION

Title of Paper: Lymphocytic meningitis in a 33 year old patient with Ulcerative colitis treated with Anti TNF. Is it TB meningitis?

Author(s): A Shahin, R Farrell,

Department(s)/Institution(s): Department of Gastroenterology / Connolly Hospital

Introduction: Infliximab is a chimeric anti-TNF antibody which is used in treatment of inflammatory conditions like IBD and rheumatoid arthritis. Adverse events include sepsis, opportunistic infections, autoimmune disorders and serum sickness like reaction

Aims/Background: A 33 year old male who was diagnosed with left sided ulcerative colitis, was initially started on Pentasa and topical treatment. Later azathioprine was commenced for poorly controlled disease; the work up for anti TNF revealed a positive mantoux subsequently was started on isoniazid and referred to the respiratory clinic; TB quantiferon was negative so isoniazid was stopped. Humira was started without control of the disease then infliximab was started, 2 infusions were given. Patient was admitted with general weakness and headache, CT brain was normal, patient developed seizure and GCS dropped, brain MRI was normal followed by LP and patient was intubated. CSF analysis revealed a WBC of 567 of which 93 % were lymphocytes with increased protein and normal glucose. An extensive search for bacteria, virus and mycosis was negative. In spite of broad spectrum antibiotic coverage including antibacterial, acyclovir and anti-fungal, there was no response and so anti-TB medications were started which resulted in improvement

Conclusion: Anti-TNF therapy associated with suppression of the T cell mediated immunity, which in turn will predispose to certain opportunistic infections, including viral, fungal and mycobacterial. So patients are worked up for latent infection of similar microorganisms before starting these medications, but the question that going to remain opened "Should this patient been continued on isoniazid".

ABSTRACT 48 (14W148) POSTER PRESENTATION

Title of Paper: Day case large-volume paracentesis is safe in selected patients; a comparison of day case and in-patient paracentesis at a regional liver unit.

Author(s): A McNeice, CH Adgey, NI McDougall, WJ Cash

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

Introduction: Large volume paracentesis (LVP) is a well-recognised treatment for diuretic intractable or resistant ascites. Even when combined with albumin administration, post-paracentesis circulatory dysfunction (PPCD) is a frequently occurring silent complication of LVP. Paracentesis can be performed in both inpatient and outpatient settings.

Aims/Background: To compare morbidity and mortality outcomes for patients who underwent LVP as a day case to those who had LVP as an inpatient.

Method: All patients who underwent elective paracentesis either as a day case (PTU) or inpatient between 1st January and 30th April 2014 were retrospectively identified. Aetiology of underlying liver disease, indication for paracentesis, volume of ascitic fluid removed, change in renal function, readmission rates and death was recorded.

Results: 16 LVP performed on 7 PTU patients were compared with 36 LVP in 19 inpatients. Mean age was 69.9 in PTU patients and 57.3 in inpatients with mean UKELD scores being 50.4 and 56.6 respectively. Aetiology of disease was comparable between groups. Median ascitic volume removed was 9 litres in PTU patients and 8 in inpatients. One inpatient was readmitted 12 days post-LVP with SBP and HRS, dying 3 days later. Each population had one readmission within 7 days, with the median length of admission for the inpatients being 4 days.

Conclusion: LVP is a commonly performed procedure in both inpatients and outpatients, with this study finding little difference in outcomes between the populations. The data therefore suggests that day case LVP is safe and should be considered as an alternative to admission in selected patients.

ABSTRACT 49 (14W150) POSTER PRESENTATION

Title of Paper: Retrospective Analysis of Enterocutaneous Fistula Management in IBD

Author(s): Boyle MP, O'Connell R, Hyland J, Winter D, Martin S, Cullen G, Mulcahy HE, Doherty GA

Department(s)/Institution(s): St Vincents University Hospital

Introduction: One third of patients with Crohn's disease develop at least one fistula episode during the course of their disease. 6% of these fistulas are enterocutaneous fistulas (ECF).

Aims/Background: To describe the characteristics, management and outcomes of disease-related ECFs in Crohn's disease in a well-defined cohort

Method: Patients with a history of enterocutaneous fistulae were identified from a prospectively maintained database of 3,200 patients with IBD. Pathology, radiology and laboratory reports were analysed and data extracted retrospectively.

Results: 41 CD patients were identified who were treated for ECF (22% post-op; 78% spontaneous) over a 36 year period. Median duration of disease was 19 years. Two thirds involved the small bowel. 17% had distal obstruction. 27% (n=11: 9 spontaneous, 2 post-op) had evidence of infection: 55% associated abscess; 46% positive blood cultures; 91% positive wound swabs. Most had active luminal disease. 76% received nutritional support (62% TPN, 38% enteral). 29% (n=12) were treated with biologics with 50% (n=6) treated pre-operatively. 25% (n=3) achieved fistula control. The mean time from surgery to biologic in those treated post-operatively was 3.5 years. Overall, 14% of our cohort was managed medically while 86% proceeded to surgery. There were no cases of fistula recurrence in surgically treated patients. The overall fistula healing rate at 6 months was 73%.

Conclusion: In this cohort, the majority of ECFs occurred in patients with long-standing, small bowel CD. Biologic therapy has a role to play is selected cases, but he majority of patients required surgical resection with excellent outcomes when combined with appropriate nutritional support.

ABSTRACT 50 (14W152) POSTER PRESENTATION

Title of Paper: A pilot study assessing the viability of the Pillcam Colon 2 capsule as a "one-stop" pan-endoscopic test for patients with Crohn's disease

Summer Meeting 2014

Deirdre McNamara Tallaght Hospital chairing a session at Summer Meeting

David Adams on PSC Autoimune Disease

Summer Meeting 2014

Alan Moss on IBD

Padraic MacMathuna, Humphrey O'Connor and Ross Carter speaks on Acute Pancreatitis

Author(s): B Hall, G Holleran, D McNamara

Department(s)/Institution(s): Department of Gastroenterology, Adelaide and Meath Hospital, Tallaght, Dublin 24

Introduction: Colon capsule endoscopy (CCE) was developed to provide a noninvasive, painless technique for colonic exploration without sedation and gas insufflation. CCE takes images of the small bowel at a similar rate to current generation small bowel capsules. CCE should be capable of providing images of both small and large bowel in a single minimally invasive investigation. To date, no studies have assessed the potential of CCE to accurately examine both small and large bowel images and detect changes consistent with CD.

Aims/Background: To prospectively assess whether CCE is a viable method of detecting both small and large bowel Crohn's disease.

Method: Following ethical approval, patients with established CD requiring colonoscopy were prospectively recruited. Major exclusion criteria included known small bowel stricture and chronic NSAID use. All participants underwent patency examination prior to SBCE. The degree of severity of small bowel disease was graded using the CECDAI score and the degree of severity of large bowel disease was graded using the SES-CD score. CCE and colonoscopy were scheduled within 2 weeks of SBCE. CCE findings were compared with SBCE for small bowel disease and with colonoscopy findings for large bowel disease. Correlations were assessed between variables using Spearman's correlation co-efficient (p value of <0.05 was considered significant).

Results: In total, 10 patients were recruited; median age 31 years (range 19-47), 7 (70%) female, 5 (50%) smokers. All patients had ileo-colonic disease location, 4 (40%) had inflammatory and 6 (60%) had stricturing disease phenotype. In total, 6 (60%) study participants had a previous surgical resection. At SBCE, 2 (20%) participants had a normal small bowel examination (CECDAI = 0), 5 (50%) had mild/moderate disease activity (3.5<CECDAI>5.8) with the remaining 3 (30%) being diagnosed with severe small bowel CD (CECDAI>5.8). In comparison, CCE demonstrated 2 (20%) normal, 6 (60%) mild/moderate with the remaining 2 (20%) severe disease. There was good overall correlation between SBCE and CCE images (R=0.896, p<0.0004). In terms of colonoscopic assessment, 8 (80%) had inactive disease (SES-CD=0-3) with 2 (20%) having mild disease activity (SES-CD=4-10). The majority of participants (9, 90%) were also graded as having inactive disease on CCE with only one participant meeting the criteria for mild disease activity. There appeared to be good overall correlation between the two modalities (R=0.6667, p<0.035).

Conclusion: In studies, patients have consistently preferred capsule technology to any other modality. Capsule technology could potentially alleviate the need for multiple radiation exposures and regular traditional endoscopies. The future direction of capsule technology is likely to pursue this pan-endosopic approach and this pilot study would suggest that current generation colon capsules have the capability to be such a device.

ABSTRACT 51 (14W153) POSTER PRESENTATION

Title of Paper: The relevance of ileitis as diagnosed by capsule endoscopy: A comparison with double balloon enteroscopy

Author(s): B Hall, G Holleran, D Brennan, D McNamara

Department(s)/Institution(s): Department of Gastroenterology, Adelaide and Meath Hospital, Tallaght, Dublin 24

Introduction: Capsule endoscopy (SBCE) is non-invasive and allows a complete view of the small bowel in the majority of cases. A drawback to SBCE remains the inability to obtain biopsies and the relevance of small bowel inflammation as detected by SBCE has been questioned. Current guidelines would suggest enteroscopy (DBE) with histological assessment should be performed when ileitis is detected on SBCE.

Aims/Background: To determine the clinical accuracy of SBCE in diagnosing small bowel CD as compared to DBE.

Method: Patients with evidence of ileitis on SBCE between June 2010 and July 2013 were identified from our database and included in the study. Importantly, record was made of whether the capsule reader considered the ileitis to be consistent with CD in each case. All patients with documented evidence of ileitis were cross-referenced using the hospitals endoscopy database (Unisoft Medical, Middlesex, England) to identify patients who had undergone DBE at our institution. A retrospective chart review was undertaken of all eligible study candidates to ascertain final diagnosis. Only patients with follow up in the Adelaide and Meath hospital were included. Exclusion criteria included any documentation of NSAID use in the 3 months prior to SBCE and any patient with less than 6 months follow up post procedure.

Results: A total of 820 SBCE procedures were performed during the three-year time-period. Approximately 140 (17%) had documentation of ileitis on SBCE. Of these, data was available on 22 (16%) patients had undergone DBE; mean age 45 years (range 18-73), 12 (55%) male with a mean follow up of 7 months (range 6-18). Table 1 demonstrates the findings of both SBCE and DBE. There was a statistically significant, albeit weak, correlation between SBCE and DBE findings (R=0.516, p<0.013). In terms of final diagnosis, 8 (36%) patients were subsequently diagnosed with definitive small bowel CD. Final diagnosis was based on numerous factors including the SBCE, DBE and histological findings coupled with radiological investigations and clinical symptoms. Of the remaining 14 patients, 8 (36%) were diagnosed with functional bowel disease and 6 (27%) with NSAID enteritis. All patients who were eventually diagnosed with CD had abnormalities consistent with small bowel CD on SBCE. SBCE had a moderate degree of correlation with final diagnosis (R=0.638, p<0.001). The positive and negative predictive value for SBCE was 70% and 92%, respectively based on final diagnosis.

Table 1. Capsule endoscopy (SBCE) and double balloon enteroscopy findings (n=22)

	Small bowel CD	Non-specific ileitis	Normal
SBCE findings	10	12	0
DBE findings	5	0	17

Conclusion: SBCE is effective at detecting ileitis. It has a high positive and negative predictive value although there will always be a tendancy towards a poorer positive predictive value until capsules are developed which are capable of interacting with their environment. A high index of suspicion is required for alternated diagnoses and DBE should be performed if there are doubts about the likely diagnosis.

ABSTRACT 52 (14W157) POSTER PRESENTATION

Title of Paper: Faecal Transplant in the Management of Crohn's Colitis with persistent Clostridium Difficile Infection-A Case Report

Author(s): Ali Mohamed, Niamh Hogan, Manus Moloney

Department(s)/Institution(s): Dept of Gastroenterology UHL Nenagh

Introduction: Faecal transplantation (FT)is established as an effective treatment for relapsing Clostridium Difficile infection. The role of FT in the management of inflammatory bowel disease is unknown. We report the first FT carried out at our instititution in a 75 year old male with longstanding Crohns Colitis with relapsing diarrhoea and persistent Clostridium Difficile Toxin (CDT) detectable in stool.

Aims/Background: The patient had multiple medical co-morbidities including congestive cardiac failure with ejection fraction <20% and chronic kidney disease. He was intolerant of immune-modulator and anti TNF treatment for his Crohn's disease. He had 3 admissions to hospital over the previous 3 months due to relapsing diarrhoea which was CDT positive on each occasion. Colonoscopy showed moderately active procto-sigmoiditis but was limited to 30cm by a Crohn's stricture in the sigmoid colon. The patient's symptoms were improved by steroid and vancomycin therapy but on the third admission we elected to use FT to attempt to eradicate CDT as a factor in his symptoms and to see if FT could induce a steroid free remission in his colitis.

Method: Stool samples were obtained from 2 first degree relatives after discussion and informed consent. The donors were pre-screened for communicable diseases by blood and stool testing. The patient received full colon preparation and vancomycin was stopped 3 days before the procedure. 80grams of the combined stool specimen was liquidised with 500mls on normal saline and filtered to remove fibrous material. 250mls of the stool solution was injected through a colonoscope into the lower 30cm of colon at an otherwise routine colonoscopic procedure. The procedure was well tolerated and there were no adverse effects.

Results: After one week follow up the patient has formed stool. Repeat CDT testing is awaited. Oral steroid therapy is being weaned. Longer follow up will determine if Clostridium Difficile carriage has been eradicated and whether FT can help the patient achieve steroid free remission form Crohn's colitis

Conclusion: Faecal transplantation is a well tolerated, acceptable and safe procedure. The role of FT in Clostridium Difficile infection has been estabiliched. Whether FT has a role in management of inflammatory bowel disease has yet to be determined.

ABSTRACT 53 (14W158) POSTER PRESENTATION

Title of Paper: Assessment of benefits of process change within the Endoscopy Day ward and appropriateness of NCHD intervention.

Author(s): C. Murphy, P. Dowling, C. Cooney, G. Mohamed, M. Buckley, J. McCarthy

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

Introduction: In May 2010, processes within the day case endoscopy admission pathway were modified in a bid to enhance patient flow and to make the unit more resource efficient for the Gastroenterology service in terms of allocation of NCHD time. The main process changes that were made included patient consent at home and nurse/phlebotomist patient cannulation. There was also removal of the need for full doctor and nurse admission with the introduction of a modified nurse admission and discharge format (see table 1). This change served to minimize NCHD interaction with day patients unless certain criteria such as patient desire to clarify procedural information, change in clinical state or failure of phlebotomy were met. The aim was to reallocate NCHD time saved to aid in provision of other departmental services. However, post implementation this new process change has not been examined for resource allocation effectiveness.

Aims/Background: To examine modified endoscopy day ward processes for compliance with process changes in relation to NCHD intervention.

Method: A record of all NCHD interventions in the endoscopy day ward were obtained by the NCHDs allocated to cover the day ward over a one-week period. Interventions were graded as appropriate or inappropriate in accordance with the new process protocol. Statistical analysis was performed on the results obtained.

Results: Over the course of one week there were 69 day-case endoscopy patients and a total of 24 patient interventions. The total time spent by NCHDs performing these tasks was 316 minutes. Prior to the process change there was a 100% patient intervention rate. There has been a total reduction in NCHD intervention by 64.5% with the new process. 17% of interventions that were performed were deemed inappropriate which accounted for a total of 83 minutes of NCHD time.
Table 1

Previous process

Current process

Conclusion: There has been a significant reduction of 64.5% in NCHD interventions with day case endoscopy patients. The majority

places were still unnecessary and these included five full patient medical admissions and several patient cannulations. Recommendations from this study include re-education of key endoscopy day ward staff and NCHDs regarding the process change and creation of an NCHD intervention protocol for staff reference. Staff allocation in the day units needs to be reexamined to ensure that adequately trained staff are available for cannulation with an overall aim in reducing further NCHD time allocation to the day ward. After implementation of these suggestions there will be need for re-examination of the process to ensure continuing compliance.

ABSTRACT 54 (14W159) POSTER PRESENTATION

Title of Paper: Evaluation of the use linked messaging services as an effective communication tool amongst NCHDs in the Gastroenterology Service, Mercy University Hospital, Cork

Author(s): C. Murphy, G. Mohamed, M. Buckley, J. McCarthy
Department(s)/Institution(s): Gastroenterology, Mercy University Hospital, Cork

Introduction: Communication amongst healthcare team members influences the quality of working relationships, job satisfaction and profound impacts patient safety. (1) Ideally, teamworking involves

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joint responsibility for decision-making, since this makes people more open and committed than they are in hierarchical structures. (2) Communication within a busy Gastroenterology team is challenging given clinical commitments to endoscopy, clinics, consult services and inpatients. A linked messaging tool was introduced within the department on a 9 month trial basis to help increase efficacy of communication. Strict guidance was given regarding anonymising patient information. A message that is sent by a group member via smart phone is delivered to the entire gastroenterology NCHD group. The aim of this communication method is to ensure that the team are aware of events, questions or problems as they arise in real time, eliminating duplication of work and keeping all team members informed especially during times of absence from the wards ie clinics and endoscopy. It also acts as a tool whereby team members are made aware of ward-based Gastroenterology consults.

Aims/Background: To evaluate Gastroenterology NCHD's opinions regarding the implementation of a linked messaging tool as an effective means of team communication.

Method: In this descriptive study, feedback questionnaires were distributed to all 18 NCHDs who took part in the 9 month pilot. Analysis of the contents of the linked-messaging tool was performed regarding daily usage and time taken to answer each query over a 3 month period. Statistical analysis was performed to assess satisfaction with this communication method.

Results: An average of 33.5 messages per day were sent between group members with an average response time of 3.9 minutes per question posed. 100% of participants found it was an effective communication tool with 94% of NCHDs planning to use it in future rotations. 100% of participants found it cost effective versus telephone calls with all participants being satisfied that the tool fulfilled its aim of allowing accurate transfer of information in a timely fashion. Flaws in the system were analyzed with 26% of participants feeling that too many messages were being sent, 77.8% having issues with smart phone battery-life and 22% experiencing difficulty with cellular signal in some hospital areas.

Conclusion: Using a linked messaging tool is an effective, inexpensive method of communication for use in a busy Gastroenterology team to transfer information regarding inpatients and consults in a timely manor once consideration is given to annonmysing data. It cannot however be recommended as a sole mode of team communication given issues with mobile phone batteries and cellular signal failure.

References

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ABSTRACT 55 (14W160) POSTER PRESENTATION

Title of Paper: The Role of TFF1 in Promoting Colonization of the Gastric Mucosa by Helicobacter pylori

Author(s): Ciara Dunne1, Michelle Kilcoyne2, Catherine Robbe-Masselot3, Leanne Kane4, Simon Clare4, Felicity EB May5 & Marguerite Clyne1

Department(s)/Institution(s): UCD SMMS, UCD, Dublin 41; Glycoscience Group, NUI Galway2; Univ Lille Nord de France3; The Wellcome Trust Sanger Institute,Cambridgeshire4; University of Newcastle upon Tyne5.

Introduction: Helicobacter pylori binds to the gastric mucin MUC5AC and to the trefoil peptide protein TFF1. Trefoil peptides play a role in promotion of mucus integrity. Binding of H. pylori to TFF1 is mediated via the core-oligosaccharide portion of LPS.

Aims/Background: This study aimed to investigate the effect of H. pylori LPS binding to TFF1 on binding of TFF1 to gastric mucin and to assess the relevance of TFF1 in mediating H. pylori colonization of the stomach.

Method: Binding of H. pylori and TFF1 to purified human gastric and colonic mucins was examined using a novel mucin microarray platform. H. pylori binding to murine gastric tissue from wild type and TFF1 null mice was examined using fluorescently-labelled organisms.

Results: H. pylori and TFF1 both bound to human gastric mucins but not to colonic mucins. Pre-incubation of TFF1 with H. pylori LPS did not inhibit the interaction of TFF1 with mucin indicating that TFF1 can bind to both mucin and LPS at the same time.

Conclusion: Together results suggest that TFF1 does not mediate binding of H. pylori to mucin. The interaction of H. pylori with TFF1 is unlikely to alter the interaction of TFF1 with mucin and result in a reduction of mucosal integrity. However, the expression of TFF1 is important for the interaction of H. pylori with the gastric mucosa.

ABSTRACT 56 (14W161) POSTER PRESENTATION

Title of Paper: Mucin Promotes Chronic Infection by Helicobacter pylori

Author(s): Ciara Dunne1, Kumar Anjan1, Colm Reid2 & Marguerite Clyne1

Department(s)/Institution(s): UCD School of Medicine and Medical Science, University College Dublin, Dublin 41; UCD School of Veterinary Medicine, University College Dublin, Dublin 42

Introduction: Helicobacter pylori colonises the gastric mucosa of humans and displays a tropism for MUC5AC-producing cells. The pathogen has been shown to impair mucin production and turnover in a murine model of infection.

Aims/Background: The aims of this study are to investigate (1) the effect of expression of the gastric mucin MUC5AC on the interaction of the bacteria with epithelial cells and (2) the effect of infection on mucin using an in vitro model.

Method: Gastric adenocarcinoma cells expressing recombinant MUC5AC were infected with H. pylori. The number of bacteria adherent to cells was assessed and ELISA was used to measure IL-8 production. The effect of infection on mucin expression was examined by Western Immunoblotting.

Results: There was no difference in adherence of bacteria to MUC5AC expressing cells compared to cells transfected with an empty plasmid, however less IL-8 was generated by MUC5AC expressing cells upon infection. A strain dependent reduction in mucin expression occurred in cells infected with H. pylori but not with Campylobacter jejuni. Mucin degradation did not occur when bacteria were incubated with purified mucin in the absence of cells indicating that mucin reduction is dependent on cross talk between cells and bacteria.

Conclusion: In vivo the presence of mucin may dampen the inflammatory response induced by H. pylori infection and a reduction in mucin production induced upon infection would lead to reduced mucus turnover and flow thus promoting infection. Together these results suggest that the presence of mucin promotes persistent infection by H. pylori.

ABSTRACT 57 (14W163) POSTER PRESENTATION

Title of Paper: Efficiency in Endoscopy unit

Author(s): G.Mohamed , C.Murphy , D.O'Connor , M.Buckley

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

Introduction: The demand for endoscopic services is increasing rapidly, which necessitates optimal efficiency in the endoscopy unit.

Aims/Background: To assess the efficiency of an endoscopy unit ,concentrating in the delay pre and post procedures.

Method: Retrospectively we examined the delay in endoscopic procedures between 19 May and 30 May 2014.The procedure process was examined at 3 different stages . Stage 1 is where the 'patients arrives to pre-procedure ward' to 'ready for procedure'. Stage 2 is from 'where the patient is ready and waiting to be called' to 'when the endoscopy procedure commences'. Stage 3 is from 'when the ward is contacted to collect patient post procedure' to 'when the patient is discharged from the ward'.

Results: The pathways for 238 endoscopic procedures were assessed . In total 249 episodes of delay were documented. Stage 1 accounts for 19-28% of the delays. There is 1.1-1.6 hours of a delay per patient at this stage. Stage 2 accounts for 50-53% of the delays. There is a delay of 2 ½ - 2¾ hours per patient at this stage. Stage 3 accounts for 19-32% of the delays. There is a delay of between 1 ¾ and 2 hours per patient at this stage.

Hours lost	Endoscopy day ward No of hours	Endoscopy day ward average hours	Endoscopy day ward No of days lost
Stage 1	50.5	1.63	4.21
Stage 2	130.5	2.29	10.88
Stage 3	45	2.14	3.75
Total	226	2.07	18.83

Hours lost	Surgical day ward No of hours	Surgical day ward average hours	Surgical day ward no of days lost
Stage 1	29.75	1.1	2.48
Stage 2	183	2.65	15.25
Stage 3	60.58	1.37	5.03
Total	273.33	1.85	22.76

Conclusion: Delays were a major factor affecting optimal use of available day ward/endoscopy resources. Significant delay can occur pre and post procedures .Strategies to reduce peri-procedural delays could have a favourable impact on day ward capacity and the the volume of procedures performed in the endoscopy unit.

ABSTRACT 58 (14W165) POSTER PRESENTATION

Title of Paper: Hidradenitis Suppurativa and Crohn's Disease : A Case Series

Author(s): S.Kirthi, R Hellen, R O'Connor, M Connolly, D McNamara, AM Tobin

Department(s)/Institution(s): Dermatology Department , AMNCH Tallaght & Trinity Academic Gastroenterology Group(TAGG)

Introduction: Hidradenitis Suppurativa (HS) is a chronic inflammatory skin condition characterized by recurrent, painful abscesses, nodules and draining sinus tracts with bands of severe scar formation. Cutaneous Crohn's Disease (CD) may also present with similar skin lesions and CD and HS occur together at a rate that varies from 0.6% to 38% based on isolated case reports. A recent cytokine and leukocyte profiling by H.H van der Zee et al demonstrated raised TNF?, IL-? and IL-10 in tissue samples of HS patients suggesting a common underlying pathology for both conditions.

Aims/Background: We wished to examine the overlapping syndrome of Crohn's Disease and Hidradenitis Suppurativa in an Irish cohort.

Method: Cases with HS and CD were identified by HIPE Code at Tallaght Hospital from 1990-2014. A retrospective chart review was performed of all cases.

Results: In total, 4 patients with both HS and CD were identified. 50% were female. The median age of diagnosis for both conditions was 31 years. In all 4 cases, CD had preceded the diagnosis of HS, with a median interval of 34.5 months to HS diagnosis. 100% of patients smoked. Of note, 75% of patients had additional autoimmune conditions, psoriasis, pyoderma gangrenosum and ankylosing spondylitis. Despite a high BMI being associated with HS, only 1 patient (25%) in this cohort had a BMI of >30. Of note, no patients had a family history of HS or CD. All patients required treatment with a TNF-alpha inhibitor in addition to standard antimicrobial therapy. 100% of patients (4 of 4) had an improvement of Hurley's score on commencing anti-TNF therapy. This is the largest case series to date reported in the literature for an Irish cohort to our knowledge.

Conclusion: Our cohort suggests that combined HS and CD syndrome affects young smokers and is frequently associated with other autoimmune conditions. Most will require anti-TNF alpha therapy to control symptoms. For those who do not respond, new therapeutic agents are eagerly sought, and further investigation with regard to interleukin 1 blockade is definitely worth investigating to treat combined CD and HS.

ABSTRACT 59 (14W169) POSTER PRESENTATION

Title of Paper: Comparing Effectiveness of Standard Culture Broth and Dent Broth for Successful Helicobacter Pylori culture

Author(s): Denise Brennan[1], Sinead Smith[1], Joseph Omorogbe[1], Grainne Holleran[2], Barry Hall[2], Mary Hussey[1], Andy Lawson[3], Colm O'Morain?, Deirdre McNamara[1,2].

Department(s)/Institution(s): [1]Trinity Academic Gastroenterology Group (TAGG), Dept of Clinical Medicine, TCD; [2]Gastroenterology Dept,Tallaght Hospital; [3]GI Reference Unit, Public Health England; ?Charlemont Clinic

Introduction: Culture and antibiotic susceptibility testing should be carried out to guide clinicians in their choice of antibiotics to treat H. pylori infection due to increasing antibiotic resistance. H. pylori is fastidious and culture can be difficult. To maximise yield, gastric biopsy samples should be stored in a nutrient medium which allows optimum growth and restricts contamination. Dent broth has

recently been developed which contains additional antibiotics and anti-fungal agents to reduce contamination and a tailored nutrient which is selective for H. pylori growth. Whether Dent broth substantially enhances culture yield is unclear.

Aims/Background: To assess and compare the rates of successful culture of H. pylori following storage in standard culture broth versus newer Dent broth.

Method: Following ethical approval, two gastric antral biopsies were obtained and one each placed into standard and Dent broth. Within 24 hours, both samples were plated onto Columbia Blood Agar (CBA) using aseptic techniques and successful culture was defined as the presence of H. pylori colonies on CBA plates within 7 days. Contamination levels were compared visually between standard and Dent plates. Individual colonies were isolated and antimicrobial susceptibility testing was performed using Etest strips (Biomerieux), MIC was calculated at 3 days using international standards.

Results: In all, dual biopsy samples were obtained from 68 H. pylori positive patients, 37 (54%) were culture positive. In all, four samples were positive only from one broth, 2 each from dent and standard. The rate of culture following storage in standard and dent broth was similar, 35 of 37. Overall yield however for both was low at 51%. Of the failed cultures, 17 (25%) were due to excessive contamination, with no difference between either broth. For positive culture plates (n=37), 9 (24%) showed significant levels of contamination. Overall contamination was worse from the standard broth (n=6, 66%) versus 3(33%) from the dent broth. MIC testing was successfully performed on all positive cultures.

Conclusion: Our study confirms H. pylori culture remains technically difficult; overall yield was only 51%. There was significantly less contamination with Dent broth (33%) versus standard broth (66%). Although yield did not vary according to broth, contamination accounted for 25% of failed cultures and larger numbers may show a benefit for Dent broth.

ABSTRACT 60 (14W170) POSTER PRESENTATION

Title of Paper: Detection of Helicobacter pylori and antibiotic resistance using a molecular genetics-based approach in human faecal samples.

Author(s): Denise Brennan[1], Sinead Smith[1], Joseph Omorogbe[1], Grainne Holleran[2], Barry Hall[2], Mary Hussey[1], Colm O'Morain[3], Deirdre McNamara[1?2]

Department(s)/Institution(s): [1]Trinity Academic Gastroenterology Group (TAGG), Department of Clinical Medicine, Trinity College Dublin; [2]Gastroenterology Department, AMNCH Tallaght Hospital; [3]Charlemont Clinic

Introduction: Due to increasing rates of antibiotic resistance in H. pylori infection, it is recommended that local surveillance should be carried out to guide clinicians in their choice of antibiotics. A recently developed assay for the molecular detection of antibiotic resistance is an attractive alternative to standard culture and susceptibility testing, which can be troublesome. The assay rapidly detects point mutations in genes which confer resistance to clarithromycin; the rrl gene encoding the 23S ribosomal RNA (A2146C, A2146G, A2147G) and to levofloxacin; the gyrA gene encoding the A subunit of the DNA gyrase (at positions 87 and 91). Traditional culture techniques and newer genetic assays generally rely on tissue samples which limits their application. H. pylori however can also be detected in faecal samples. Analysis of H. pylori DNA harvested from faecal samples instead of gastric biopsies represents a novel and a potential non-invasive, affordable method of determining local antibiotic resistance rates.

Aims/Background: To investigate whether H. pylori infection and antibiotic resistance can be determined from non-invasive faecal samples. Concordance between the Premier Platinum HpSA Test and the urease breath test (UBT) was also examined.

Method: Following ethical approval, a stool sample was obtained from patients who were attending UBT appointments at AMNCH, Tallaght Hospital and had not been previously treated for H. pylori. The presence of H. pylori in faecal samples was assessed using the Premier Platinum HpSA ELISA test (Meridian Diagnostics) in accordance with manufacturer's guidelines. An absorbance reading of >0.140 (at 450 nm) was considered positive. Patients were considered to be H. pylori positive based on their UBT result. DNA was harvested from the faecal samples of positive patients using the PSP Spin Stool DNA Plus Kit (Invitek) and for antibiotic resistance genotypes, by the GenoType HelicoDR PCR assay (Hain Lifesciences).

Results: To date, 21 patients (38% male, mean age 42 years) have been recruited. Overall, 6 (29%) were positive. Concordance in H. pylori detection between UBT and HpSA tests was 81% (17/21). There were 4 (66%) false negative HpSA tests, PPV=100%, NPV=79%. Of note, H. pylori DNA was isolated from all 6 H. pylori positive patients. A clarithromycin resistant genotype was observed in all 6 patients (100%), while a levofloxacin resistant genotype was observed in 2 (33%) patients. The time taken to obtain resistance data was short, at 1.5 days.

Conclusion: Non-invasive H. pylori antibiotic resistance genotyping is feasible using faecal samples and may represent a rapid, non-invasive and affordable alternative to culture and susceptibility testing. The NPV (79%) of HpSA suggests selection of patients for genotyping should be based on UBT results.

ABSTRACT 61 (14W171) POSTER PRESENTATION

Title of Paper: Quantifying nanoparticle & bacterial motility profiles in human colonic mucus

Author(s): McDermott FD, Fitzpatrick L, Rogers A, Dawson K, Winter DC, Baird A

Department(s)/Institution(s): University College Dublin & St Vincent's University Hospital

Introduction: There are 10 times more bacteria in the human colon than there are cells in the body. They inhabit the outer part of a 2-tier mucus system in the colon in a complex ecosystem, disruption of which leads to disease. Bacterial production of spermine (and other polyamines) may help define their mucus microenvironment but the mechanisms are unknown.

Aims/Background: To apply a new quantitative technique with which to model the interaction of the microbiome with colonic mucus.

Method: Human mucus samples were harvested from the healthy margin of colon resected surgically. Samples were centrifuged to remove particulate debris and vortexed with cell mask orange and wheat germ agglutinin to stain the mucus layer. E.coli transfected with green fluorescent protein or 1 um nanoparticles were added to mucus and imaged with 3-dimensional confocal laser microscopy. Mucus samples were either treated with PBS (control) or the polyamine spermine (1 uM). In separate experiments using ex-vivo

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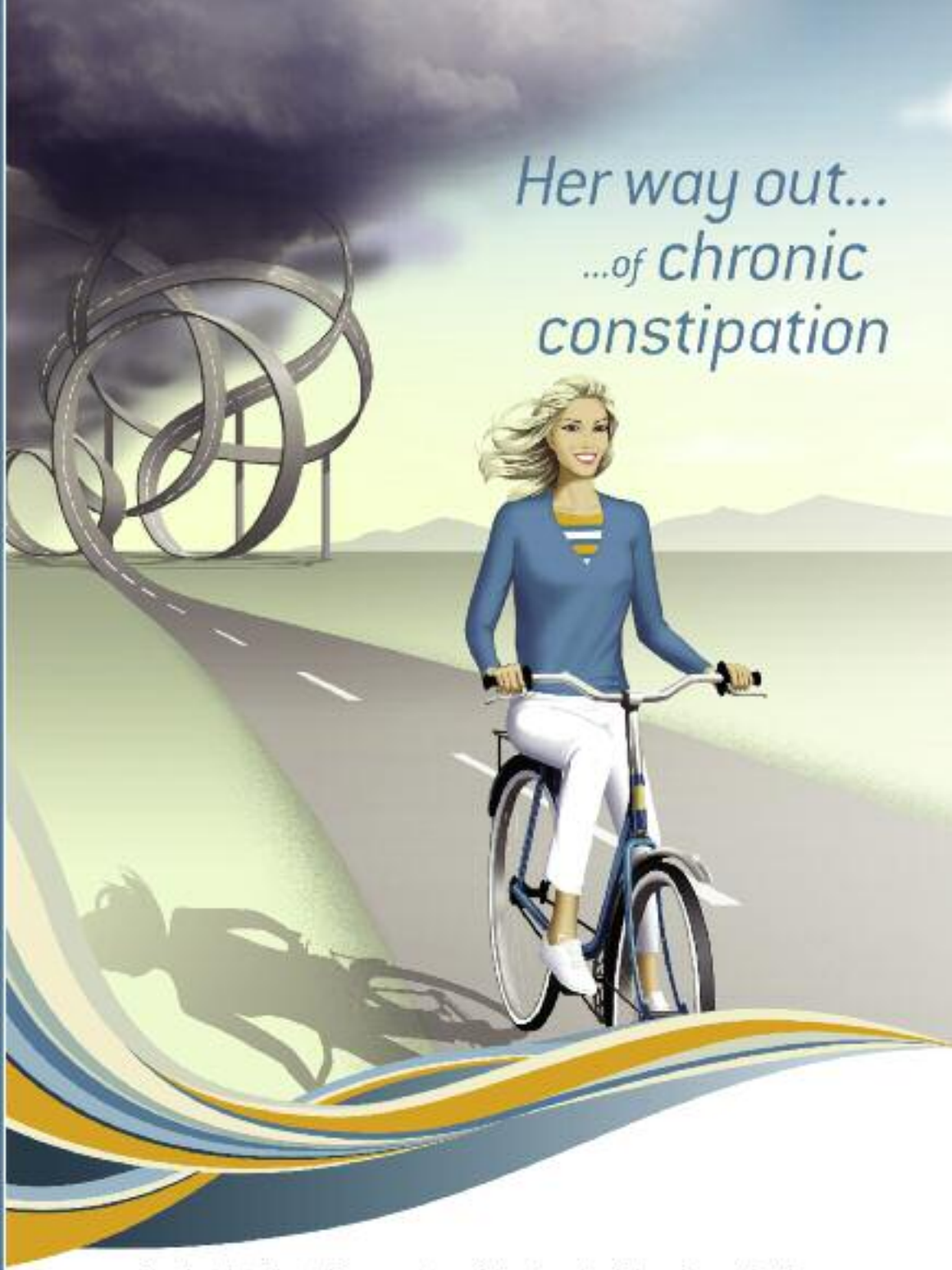

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mucosal sheets mounted in perfused chambers mucus production was measured.

Results: Experimentally spermine morphologically alters the structure of mucus by inducing a dimensional change in the mucus layer separable from goblet cell production (dry weight mucus yield in spermine treated mucosa 0.49mg/cm2 vs 0.53mg/cm2 p=0.416). Spermine increased the mean square displacement (MSD) of nanoparticles and GFP E.coli (52.49 to 299.9 um2/s and 9.42 to 324.8 um2/s respectively; both p<0.0001). Particles exhibit auto-regressive motion moving in all 3 dimensions but within the constraints of the mucin mesh.

Conclusion: Nanoparticle/ bacterial displacement provides quantification data to qualify probe movement within a gel. Spermine treatment increases motility. Future research with commensal and pathogenic bacteria will improve our understanding of the microbiome in health and disease.

ABSTRACT 62 (14W172) POSTER PRESENTATION

Title of Paper: Improving Quality of Colonoscopy: How Can We Push Up the Bar?

Author(s): Bowles DN, Daly C, Stack WA, Jackson LM

Department(s)/Institution(s): Department of Gastroenterology, Bon Secours Hospital Cork & University College Cork

Introduction: The success of colonoscopy in reducing colon cancer is significantly impacted by the ability of the endoscopist to identify and remove all histologically significant polyps. Recent National Quality Assurance Programme in GI Endoscopy has advised various quality indicators with the objective of attaining consistent high standards of endoscopy. The use of minimum withdrawal time as quality standard remains controversial and to date has not been included in these Irish guidelines.

Aims/Background: This study aims to determine whether the additional introduction of a mandatory, minimal withdrawal time for colonoscopy, when other quality indicators have been achieved, can improve overall polyp and adenoma detection rates.

Method: From August 2013, gastroenterologists (n=2) in our unit agreed to introduce a new intervention- the mandatory recording of minimum withdrawal time for colonoscopy. Over the following 9 months, the reports from all endoscopies, where polyps were detected, were collated and histology of all polyps reviewed. A comparison was made with colonoscopies performed for the same period prior to the introduction of the intervention.

Results: A total of 1208 colonoscopies were performed by 2 gastroenterologists over a 9 month period after the introduction of a mandatory withdrawal time. Pre-intervention caecal intubation rates were 92% (n=1084) for both endoscopists with an overall polyp detection rate of 20.9% (227/1084). Introduction of a minimum withdrawal time increased overall polyp detection rate to 25.75% (311/1208). Total number of polyps detected increased from 388 to 510 polyps per 1000 scopes. Colonoscopies in which adenomas were the most significant lesion increased from 16.3% to 17.4%. The increase in polyps detected in most cases reflected an increased detection of right sided sessile serrated or hyperplastic polyps. Detection of cancers and advanced lesions were not increased by intervention.

Conclusion: This study highlights that, even when quality indicators are being consistently achieved, by mandating withdrawal time, we may all have scope to push up the bar further with resultant improvement in polyp detection rates. In our unit, enforcing a minimal withdrawal time resulted in a significantly increased polyp detection rate. Although there was an increase in adenoma detection rate, the most significant change was an increased detection of right sided sessile serrated polyps. The importance of this increased detection rests on the aetiological significance of right sided lesions in cancer pathogenesis which remains to be definitively proven.

ABSTRACT 63 (14W173) POSTER PRESENTATION

Title of Paper: The feasibility of using faecal material for the molecular profiling of bacteria present in low abundance

Author(s): Brendan Dolan, Stephen Shovlin, Billy Bourke, Brendan Drumm, Marion Rowland and Marguerite Clyne

Department(s)/Institution(s): UCD School of Medicine and Medical Science

Introduction: Molecular profiling of bacteria from faeces provides a powerful non-invasive tool to both detect and discriminate strains of pathogenic bacteria from members of the normal intestinal microflora.

Aims/Background: This study aimed to assess the feasibility of utilising faecal material for the profiling bacteria present in low abundance in stool samples.

Method: Faecal material was collected from individuals known to be infected with Helicobacter pylori. We compared different methods of DNA isolation and also assessed the effect of enriching for H. pylori organisms prior to DNA isolation. The isolation of H. pylori DNA was confirmed by PCR analysis.

Results: Detection of H. pylori DNA using commercially available techniques specifically designed for isolation of faecal DNA was not successful. The use of H. pylori antibodies to capture organisms prior to DNA isolation followed by methods originally designed for the isolation of DNA from soil samples greatly improved detection of H. pylori DNA. PCR amplification was most efficient for small (<200bp) DNA products, suggesting that for low abundance bacteria, faecal material may not be suitable for genotyping methods such as MLST where larger size products need to be amplified.

Conclusion: Enrichment methods maximise the isolation of DNA from low abundance bacteria. Due to difficulties in the amplification of PCR products >200bp, real-time PCR based biprobe assays may provide a means to accurately profile low abundance bacteria in the gastrointestinal tract.

ABSTRACT 64 (14W175) POSTER PRESENTATION

Title of Paper: The hepcidin/ferritin ratio is significantly lower in C282Y homozygotes and correlates inversely with transferrin saturation, non-transferrin bound iron and ALT.

Author(s): Eleanor Ryan [a], John D. Ryan [a], Jennifer Russell [a], Barbara Coughlan [b], Harold Tjalsma [c], Dorine W. Swinkels [c], Stephen Stewart [a], John P.Crowe [a].

Department(s)/Institution(s): [a] Liver Centre, Mater Misericordiae University Hospital, Dublin, Ireland. [b] School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland. [c] Department of Laboratory Medicine, Laboratory of Genetic, Endocrine and Metabolic Diseases. Radboud University Medical Centre, Nijmegen, The Netherlands.

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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

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Gerry McEntee MMUH speaking on Pancreatitis

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Introduction: C282Y homozygosity is characterised by a deficiency in hepcidin, a high transferrin saturation (and subsequent formation of non-transferrin bound iron (NTBI), increased serum ferritin levels and eventual parenchymal iron overload.

Aims/Background: The purpose of this study was to examine the serum hepcidin:ferritin ratio in a cohort comprising male C282Y homozygotes, compound heterozygotes (heterozygote for C282Y and H63D) and controls and to examine the relationship of this ratio with transferrin saturation, NTBI and ALT.

Method: Fasting blood samples were collected from individuals referred to the Liver Centre by GPs for further evaluation. Serum hepcidin levels were measured using a combination of weak cation exchange chromatography and time of flight spectrometry while NTBI levels were measured using a one step fluorescence-based assay. Transferrin saturation, ferritin and ALT were measured using routine laboratory methods. Data was analysed using SPSS version 18.

Results: The hepcidin:ferritin ratio was significantly lower in C282Y homozygotes compared to compound heterozygotes and controls despite similar ferritin levels across the groups. Transferrin saturation levels were significantly higher in C282Y homozygotes compared to compound heterozygotes and controls and C282Y homozygotes had significantly higher NBTI levels compared to controls. ALT levels and age were not significantly different between groups. See Table. Within the C282Y homozygous cohort, the hepcidin:ferritin ratio strongly correlated with transferrin saturation (r=-0.639, p=0.001) and NTBI (r=-0.647, p=0.001) while ALT showed a moderate correlation with NTBI (r=0.431, p=0.035) and with the hepcidin:ferritin ratio (-0.405, p=0.049).

	C282Y (1) n=29	Compound Heterozygote (2) n=22	Controls (3)* n=26	Anova/*post hoc* Tukey HSD (1)vs(2); (1)vs(3)
Hepcidin nM	3.2 (2.2-3.7)	5.1 (3.1-7.2)	6.0 (4.6-10.6)	**<0.001; <0.001**
NTBI µM	5.9 (4.7-7.1)	4.63 (4.1-5.69)	3.9 (3.1-4.8)	0.115; **<0.001**
Ferritin µg/L	594 (364-1028)	405 (320-696)	470 (379-730)	0.273; 0.774
Trans Sat %	72.4 (19.2)	47 (10)	38.5 (14.1)	**<0.001; <0.001**
ALT IU/L	37 (25-51)	41 (28-56)	40 (25-59)	0.434; 0.265
Age (yrs)	48.3 (10.3)	47.1 (12.1)	54 (16)	0.825; 0.158
Hepcidin:ferritin ratio	4.96(3.7-6.3)	11.5 (7.1-18.5)	11.5 (7.1-18.5)	**<0.001; <0.001**

*6 H63D homozygotes, 6 C282Y heterozygotes, 7 H63D heterozygotes and 7 normal genotypes

Conclusion: Low hepcidin:ferritin ratios are associated with high transferrin saturation and NTBI levels. The serum hepcidin/ferritin ratio may be useful as an index of examining inadequate hepcidin responses to increased iron loading.

ABSTRACT 65 (14W176) POSTER PRESENTATION

Title of Paper: Hyperferritinaemia is less indicative of iron overload in overweight and obese C282Y homozygotes: implications for venesection?

Author(s): Eleanor Ryan [a], John D. Ryan [a], Jennifer Russell [a], Barbara Coughlan [b], Harold Tjalsma [c], Dorine W. Swinkels [c, a], John P.Crowe [a], Stephen Stewart

Department(s)/Institution(s): [a] Liver Centre, Mater Misericordiae University Hospital, Dublin, Ireland. [b] School of Nursing, Midwifery and Health Systems, University College Dublin, Ireland. [c] Department of Laboratory Medicine, Laboratory of Genetic, Endocrine and Metabolic Diseases. Radboud University Medical Centre, Nijmegen, The Netherlands.

Introduction: C282Y homozygosity is associated with innately low hepcidin levels, increased transferrin saturation and parenchymal iron overload. However, penetrance of the C282Y mutation is incomplete, implying other genetic or environmental factors play a role.

Aims/Background: The purpose of this study was to examine hepcidin levels in a cohort of iron loaded male C282Y homozygotes with respect to BMI and to assess whether BMI has a role in modulating the C282Y homozygous phenotype.

Method: Fasting blood samples were collected from individuals referred to the Liver Centre by GPs for further evaluation. Serum hepcidin levels were measured using a combination of weak cation exchange chromatography and time of flight spectrometry. Transferrin saturation and ferritin were measured using routine laboratory methods. Data was analysed using SPSS version 18.

Results: Hepcidin levels in normal weight iron loaded C282Y homozygous males were significantly lower (1.2nM) compared to those who were overweight (3.6nM) or obese (3.2nM). See Table. Normal weight, iron loaded C282Y homozygotes had significantly higher serum iron and transferrin saturation levels despite having similar ferritin levels.

	Normal weight C282Y n=4 (1)	Overweight C282Y n=9 (2)	Obese C282Y n=4 (3)	Anova/post hoc Tukey (1)vs(2); (1)vs(3)
Hepcidin nM	1.2 (0.54-2.90)	3.6 (2.9-4.1)	3.2 (2.5-3.8)	0.003; 0.025
NTBI mM	6.7 (4.3-7.1)	7.1 (6.1-7.1)	4.8 (3.9-5.1)	NS; NS
Ferritin mg/L	645 (415-1417)	740 (559-1360)	619 (485-837)	NS; NS
Iron mM	39 (2.1)	35.4 (5.9)	28.1 (6.7)	0.500; 0.033
Trans Sat%	90.5 (10.1)	75 (16.7)	57 (21)	NS; 0.028
Age	48 (11.3)	50 (9.7)	51 (18)	NS; NS
BMI	22 (1.7)	27.3 (1.5)	31.5 (0.75)	0.000; 0.000
Hepcidin:ferritin ratio	2.2 (0.7-4.2)	5.1 (3.7-5.7)	4.6 (4.4-6.0)	0.059;0.056

Conclusion: Hyperferritinaemia in overweight C282Y homozygotes could be due to iron overload and/or obesity. This may have implications regarding the usefulness of ferritin as a marker of when venesection should be initiated. Hepcidin and the hepcidin:ferritin ratio could be evaluated as alternative markers of iron overload.

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Date of preparation: February 2013 IE/13500

ABSTRACT 66 (14W177) POSTER PRESENTATION

Title of Paper: Helicobacter pylori infection is extremely rare in older children and adults

Author(s): Marion Rowland,1 Billy Bourke,1 Gerard Bury,1,2 Thomas O'Dowd, 3 Humphrey J. O'Connor,4 Leslie Daly5 Lucy Connolly1 James Ryan,3 Stephen Shovlin,1 Brendan Dolan,1 Marguerite Clyne,1 Brendan Drumm1

Department(s)/Institution(s): 1School of Medicine and Medical Science University College Dublin, 2Coombe Health Care Centre Cork Street Dublin 8, 3Public Health and Primary Care, Trinity College Centre for Health Sciences Tallaght

Introduction: In the first prospective study internationally on the acquisition of Helicobacter pylori (H. pylori) infection, we followed 290 index children (24-48 months of age at enrollment) with annual breath tests between 1997 and 2002 to determine the age-specific incidence of H. pylori.[1] Family members were tested in Year 1 and Year 5. 48 (16.5%) index children became infected with H. pylori, with 47 becoming infected before the age of 5 years. Having an infected mother or an infected older sibling were risk factors for infection.

Aims/Background: Determine if H. pylori infection occurs after the age of five years.

Method: Participants were traced with the support of their family doctor. 13C urea breath tests were preformed on index children, their parents and siblings.

Results: 250/290 (86.2%) index children participated in the study. The mean age in 2014 was 17.1 years SD 0.8, mean duration of follow-up 11.09 years SD 1.13, and 115 (46%) were female. 37/48 (77.1%) children infected with H. pylori in 2002 participated. 30/37 (81.1%) remained infected, while 7 had been treated for H. pylori. 213/242 (88.0%) non-infected index children in 2002 participated and only 8 (3.7%) had acquired H. pylori infection during a mean follow-up of 11.09 years SD 1.13. Only 1/226 mothers' acquired H. pylori. In 2002 64/222 (28.8%) siblings were infected. In 2014 only 2 (1.26%) of 158 non-infected siblings in 2002 had become infected.

Conclusion: H. pylori infection is acquired at a very young age and new infection is extremely rare in older children and adults.

References

Rowland M, Daly L, Vaughan M, Higgins A, Bourke B, Drumm B. Age-specific incidence of Helicobacter pylori. Gastroenterology 2006;130:65-72.

ABSTRACT 67 (14W178) POSTER PRESENTATION

Title of Paper: Cigarette Smoke Extract alters the inflammatory tissue microenvironment, independent of NF?B and HIF-1? activity, in human and murine models of colitis

Author(s): Aoife Cannon, Rachel Horan, Nasir Mahmud, Naeem Ullah, Finbar McCarthy, Joanne Lysaght, Padraic Fallon, Patrick Walsh and Jacintha O'Sullivan

Department(s)/Institution(s): Dept. of Surgery Trinity College Dublin & Dept. of Clinical Medicine, Trinity College Dublin.

Introduction: Ulcerative Colitis (UC) is a form of inflammatory bowel disease, characterised by chronic or relapsing inflammation in the gastrointestinal tract. The severity of UC is higher in non-smokers than smokers; however, the biological mechanisms controlling this effect are unknown.

Aims/Background: This study is examining the effect of Cigarette Smoke Extract (CSE) using ex vivo and in vivo models of UC to determine if inflammatory mediators and transcription factors are altered by CSE.

Method: Colonic biopsies were obtained from consenting UC patients attending the endoscopy suite at St. James's Hospital. These ex vivo biopsies were cultured in the presence or absence of CSE. Multiplex ELISAs assessed the levels of inflammatory mediators. In mice, colitis was induced with 3% DSS. CSE was injected intraperitoneally. Disease activity index (DAI) scores and weight were recorded daily. Gene expression of inflammatory mediators was measured in murine colonic tissue. Expression of NF?B and HIF-1? was measured by ELISA in human and mouse colonic tissue.

Results: Secreted levels of CXCL1, IL-1?, TNF-?, IL-2, IL-6, IL-10, CCL2, CCL20, and from treated UC biopsies were decreased (all, $p < 0.05$). Mice treated with CSE had lower DAI scores ($p<0.001$). Gene expression of MMP9 and CCL2 were down-regulated in CSE treated mice ($p < 0.001$ and $p < 0.05$ respectively). This effect was specific to recto-sigmoid tissue. Expression of NF?B and HIF-1? was not significantly different between the treated and untreated groups in humans or mice.

Conclusion: CSE elicits similar anti-inflammatory effects in mouse and human models of UC. These changes are independent of NFkB and HIF-1 expression.

ABSTRACT 68 (14W179) POSTER PRESENTATION

Title of Paper: The Incidence of Liver Disease in Cystic Fibrosis

Author(s): J. Dummond,1 B. Bourke,1,2 C. Gallagher,3 P. Mc Nally,2 AM Broderick,2 P. Greally,4 D. Slattery,5 LE. Daly,6 NG Mc Elvaney,7 R. Ó Laoide,3 M. Rowland1 on behalf of the Irish Cystic Fibrosis Liver Dis

Department(s)/Institution(s): 1School of Medicine and Medical Science University College Dublin, 2 Our Lady's Children's Hospital Crumlin, Dublin, 3 St Vincent's University Hospital Elm Park, Dublin, 4 The National Childrens's Hospital

Introduction: As life expectancy in cystic fibrosis (CF) increases, complications such as cystic fibrosis liver disease (CFLD) assume increasing importance. CFLD is a complex condition with no well-defined diagnostic criteria. While the prevalence of CFLD has been determined in a number of different populations using a number of different criteria for the diagnosis of CFLD there is no data on the incidence of CFLD.

Aims/Background: The aim of this study was determine the incidence of liver disease in CF in Ireland, using the criteria proposed by the North American Cystic Fibrosis Foundation (NACFF): clinically significant liver disease (CFLD), non-specific CFLD (NSCFLD) and no liver disease (NoLD).

Method: All children under18 years of age were invited to participate in a long-term national cohort study of CFLD and had detailed clinical and radiological evaluations in 2007 and 2012 to carefully evaluate the presence of any liver disease.

Results: 521 children participated, mean age 9.03years SD 4.9. In 2007 the prevalence of CFLD was 6.7% (n= 35), NSCFLD 22.8% (n =119) and NoLD 367 (70.4%). Over 4.1 years SD 1.05 of follow-up 22 participants developed CFLD (from NoLD or NSCFLD) incidence

rate 1/100 patient years of follow-up (95% C.I. 0.60-1.54). The incidence of NSCFLD (from NoLD) was 7/100 patient years (95% C.I 5.42-8.99).

Conclusion: Based on these data, it is expected that there will be four new cases of clinically significant liver disease in Ireland each year. Having used the NACFF criteria this will allow comparison with other countries and monitor any change in incidence of CFLD in Ireland.

ABSTRACT 69 (14W183) POSTER PRESENTATION

Title of Paper: To measure induction, maintenance and reversal of targeted pancreatic hypothermia using a trans-gastric heat transfer catheter: a proof of concept study

Author(s): Caroline Gaynor1, Kiel McCool1, Stephen Bligh2, Deirdre McNamara2,3 , Christoph Blau4, Barry Hall2,3, Grainne Holleran2,3, Mark d'Alton5, Nasir Mahmud2,6 Barry McMahon2

Department(s)/Institution(s): 1Bioinnovate, NUI Galway; 2TAGG, Department of Clinical Medicine, Trinity College, University of Dublin; 3Department of Gastroenterology, Adelaide & Meath Hospital, Tallaght, Dublin 24; 4Bioresources

Introduction: A review of the role of hypothermia in other systems reveals that it slows several of the signalling pathways operant in acute pancreatitis leading to the potential for hypothermia to provide a multimodal approach to the treatment of acute pancreatitis. In vitro and published data suggest that multiple cell death and inflammatory phenomena in the pancreas may slow or cease when cooled to between 23°C and 34°C. A novel balloon catheter (NUIG, Galway) was developed to provide a method for targeted trans-gastric cooling of the pancreas

Aims/Background: To assess whether continuous circulation of cold liquid (saline or water) through a heat exchange balloon catheter (HypoFX, NUIG, Galway) positioned in contact with the stomach wall can reduce pig pancreatic temperature by at least 3oC from baseline over a period of up to 5 hours without causing concomitant systemic hypothermia.

Method: Four female large white landrace cross pigs (average weight 43.58kg) were anesthetized and intubated. A midline laparotomy was performed and temperature probes affixed to the surface of the pancreas and exterior stomach wall of each pig. The incision was closed and pig rectal temperature allowed to stabilise between 37–39°C. The transgastric heat exchange balloon catheter was advanced into the stomach orogastrically under endoscopic guidance. The balloon catheter was connected to an external cooling machine set at 2°C and a 3-4 hour cooling protocol was initiated. Histopathologic analysis was conducted post procedure.

Results: Overall single point pancreatic temperature reductions of between 0.2°C to 13.4°C were recorded. A consistent drop in temperature across the pancreas as a whole was not observed. Systemic hypothermia was prevented through the use of external warming. Histopathological analysis identified diffuse mild loss of the most apical portions of the gastric mucosa and a diffuse severe edema of the gastric submucosa. No damage to the pancreas was observed.

Conclusion: Transgastric cooling of the pancreas using the novel balloon catheter facilitated focal pancreatic hypothermia but a general temperature reduction of ? 3°C across the pancreas as a whole was not recorded. Systemic temperature could be managed within 2°C of baseline through use of external heating mechanisms

ABSTRACT 70 (14W185) POSTER PRESENTATION

Title of Paper: Using EndoFLIP™ to Understanding Pyloric Sphincter Function.

Author(s): Arroyo J#, Park P-O#, Bergstrom M#, Bligh S*, McMahon BP*

Department(s)/Institution(s): #South Alvsborg Hospital, Boras, Sweden *Trinity Academic Gastroenterology Group, Trinity College & Tallaght Hospital, Dublin, Ireland

Aims/Background: The aim of the study was to investigate whether distending the pyloric sphincter with the functional lumen imaging probe (FLIP) would provide a better understanding of the pyloric sphincter physiology. The effect of Neostigmine® on the sphincter function was also studied.

Method: Two healthy female pigs (540-50 kg) were acquired for the study which had full ethical approval. The pigs were anaesthetised and gastroscoped. The EndoFLIP™ Catheter EF-353 (Crospon, Galway, Ireland) was inserted through the scope and placed in the pylorus. The optimal position was when the probes 16 measurements were straddling the pyloric sphincter so that the central measurements represent the narrowest region in the middle. Stepwise volume controlled distensions to balloon fill volumes of 20ml, 30ml, 40ml and 50ml were carried out. The volumes were maintained for 1 min and the complete step protocol was repeated. 1.5mg of neostigmine was then administered intravenously and no measurements were taken for 5 minutes to allow for the effect of the drug to occur. The stepwise volume controlled distensions were then repeated.

Results: The EndoFLIP catheter could successfully be inserted into the pylorus and infused with a liquid volume. Patterns of motility observed at all bag volume levels indicated a constant rhythmic opening of the narrowest region in the pyloric sphincter while simultaneous a drop in pressure in the bag was observed, indicating that the movement was specifically of an opening and closing nature and not similar to peristaltic wave movement observed in other parts of the GI tract. Plots of narrowest CSA (Cross Sectional Area) and bag pressure during the 1 minute volume hold period indicated that as volume increased the opening patterns grew larger and the pressure increased, consistent with a valvular region that is relatively compliant. A plot of distensibility at the step volumes before and after neostigmine administration indicates that the pylorus becomes more distensible after the administration.

Conclusion: Endoflip has the potential to represent an entirely new method of measuring pyloric sphincter activity. It confirms the pyloric action as a valve and may have the ability to determine the role of the pylorus in diseases related to gastric emptying.

ABSTRACT 71 (14W186) POSTER PRESENTATION

Title of Paper: Title: Inpatient endoscopy: Referral appropriateness, bowel preparation quality and diagnostic yield.

Author(s): Grace Chan, Jun Liong Chin, Lasse March, Osama Hamid, Aman Afridi , Mary Hackett Brennan, Mary O'Sullivan, Genevieve Corrigan, Garry Courtney, Abdur-Rahman Aftab.

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

Introduction: There is an increasing burden on endoscopy units in Ireland to reduce waiting lists and to provide an efficient service. Therefore, it is essential that all inpatient endoscopy referral indications are appropriate and that quality of inpatient bowel

preparation is optimal to ensure satisfactory diagnostic yield.

Aims/Background: To evaluate the appropriateness of inpatient endoscopy requests and the source of referral. Also to determine the quality of bowel preparation and the diagnostic yield.

Method: All inpatient endoscopy requests were included retrospectively from 1st September 2013 to 31st August 2014. Appropriateness of referral indication was compared against the American Society of Gastroenterology guidelines as well as criteria pre-determined by gastroenterology consultants and registrars in the department. Data was also collated by assessing Endoraad, electronic histology reports and patients' charts.

Results: There were 355 inpatient endoscopy requests during the period. Of these, 52.1% (185/355) were for oesophagogastroduodenoscopies (OGD), 38.6% (137/355) were for colonoscopies/sigmoidoscopies and 9.3% (33/355) were for percutaneous endoscopic gastrostomy tube insertion. 93.2% (331/355) of the requests were thought to be appropriate. The most common indications for endoscopy requests were anaemia for gastroscopy (30.8%) and colonoscopy (41.7%). The Geriatrics team had the highest amount of request (48.5%; 172/355). The quality of bowel preparation was excellent in 32.8%, satisfactory in 47.3%, poor but completed colonoscopy in 18.3%, and failed colonoscopy due to poor preparation in 1.5%. Endoscopy yielded positive findings in 56.3% of the OGDs and 48.5% of the colonoscopies/sigmoidoscopies. The mean waiting time for endoscopy was 2.46 days, with 45.1% waiting less than 24hours and 3.1% waiting more than 7 working days. The majority of patients waiting more than 5 working days were referrals for PEG insertion in patients who received alternative feeding means while awaiting procedure.

Conclusion: Almost all of the inpatient endoscopy requests were thought to be appropriate, confirming that hospital doctors have good awareness for referral indications. The endoscopy service provided in our hospital is very efficient with approximately half of patients undergoing their procedures within a day of referral. However, bowel preparation was unsatisfactory in a fifth of patients and optimisation of this would be required to improve diagnostic yield.

ABSTRACT 72 (14W187) POSTER PRESENTATION

Title of Paper: CT Imaging In Acute Pancreatitis (Ap): Timing And Necessity Of The Exam

Author(s): Aman Yadav, Jawad Rasool, Stephen Cheyny, John Keohane, Subhasish Sengupta

Department(s)/Institution(s): Gastroenterology Department, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Introduction: As per established guidelines, the diagnosis of acute pancreatitis (AP) should be made from clinical symptoms and laboratory testing, and CT/MRI imaging should be reserved for patients in whom diagnosis is uncertain and who fail to improve due to complications arising from AP.

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

timing and necessity of CT imaging in AP.

Method: In this retrospective study, we identified all patients with AP between 1st January 2012 and 31st December 2013. From chart review patient age, gender, presenting complaint, Amylase levels on admission, imaging done (US Abdomen +/- CT), Time of admission and time of CT filmed were recorded. Patients with history of abdominal pain with a serum amylase level > 3 times the upper level of normal (ULN) were included in this study.

Results: In this retrospective study, we identified all patients with AP between 1st January 2012 and 31st December 2013. From chart review patient age, gender, presenting complaint, Amylase levels on admission, imaging done (US Abdomen +/- CT), Time of admission and time of CT filmed were recorded. Patients with history of abdominal pain with a serum amylase level > 3 times the upper level of normal (ULN) were included in this study.

Conclusion: CT imaging should be reserved for patients in whom diagnosis is unclear and to access severity in patients who fail to improve clinically within 48- 72 hours. Reducing unnecessary CT for diagnosing AP may improve quality and reduce waste.

ABSTRACT 73 (14W189) POSTER PRESENTATION

Title of Paper: Delayed Post- Polypectomy Bleeding after Large EMR in spite of prophylactic hemoclip application

Author(s): Sarah Rafferty, Aman Yadav, Subhasish Sengupta

Department(s)/Institution(s): Gastroenterology Department, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Introduction: Delayed bleeding after polypectomy is well known complication and can happen in up to 29% of patients. We report a case of post polypectomy delayed bleeding after EMR of a >5 cm polyp

Aims/Background: 55 year old healthy lady with no background illness, underwent a colonoscopy for recent onset irregular bowel movements with a strong family history of colorectal cancer in 3 first degree relatives

Results: At colonoscopy a large >5 cm superficially elevated polyp was noted in the ascending colon. Successful piecemeal EMR of the entire polyp was performed. No immediate bleeding or complications occurred. Since the resulting defect from the EMR was large, 8 prophylactic haemoclips were applied to prevent post polypectomy bleeding. On the sixth night after her polypectomy the patient had melaena with clots of blood per rectum. Next day morning (7th day) she had a repeat colonoscopy with phosphate enema bowel preparation. Although no active bleeding was noted from previous polypectomy site, clots and old blood was noted in the ascending colon. The polypectomy site was sprayed with polysaccharide hemostasis system (EndoClot) for hemostasis. Patient was discharged on same day and never reported any further bleeding PR.

Conclusion: Patient should be made aware of delayed bleeding after polypectomy. Prophylactic application of hemoclips do not necessarily reduce incidence of delayed post polypectomy bleeding. EndoClot application is effective in achieving hemostasis after polypectomy bleeding.

ABSTRACT 74 (14W190) POSTER PRESENTATION

Title of Paper: Ustekinumab in Crohn's Disease: Experience from a Single Tertiary Centre

Author(s): C Kiat, E Stanley, Y Bailey, N Breslin, D McNamara, B Ryan

Department(s)/Institution(s): Department of Gastroenterology, AMNCH, Tallaght

Introduction: Ustekinumab is a monoclonal antibody to the common p40 subunit of interleukin-12 and interleukin-23. It is licensed for use in psoriasis and literature exists showing efficacy in Crohn's disease (CD) although this remains as unlicensed indication. To date, the optimal treatment dosing and schedule has not been characterized for patients with CD. However, there is preliminary evidence that significantly higher doses are required for CD compared to psoriasis.

Aims/Background: We aim to report on the response rate and dosing schedule in our cohort of patients who have been treated with ustekinumab at the Inflammatory Bowel Disease (IBD) centre in AMNCH.

Method: This was a retrospective study of all patients with CD who have been treated with ustekinumab attending the IBD centre in AMNCH. Patients' demographics, disease phenotypes and duration, previous treatments, clinical symptoms and dosing schedule were all reviewed. Clinical response or remission to ustekinumab was based on patients' self-reported clinical status and where available, the Harvey-Bradshaw Index (HBI) score prior to commencement of ustekinumab and follow up. Inflammatory markers were also assessed. Two induction dose regimes were used in AMNCH : (1) 180mg at week '0' followed by 90mg at week 2, or (2) 90mg at time 0 and a further 90mg at week 2. The maintenance dose is 90mg every eight weeks with dose escalation as clinically indicated.

Results: 12 patients attending the IBD centre at AMNCH have been treated with ustekinumab to date (8 female and 4 male patents with a mean age of 37). The mean disease duration is 10.8 years. Eight patients had ileocolonic disease and the other 4 have Crohn's colitis. All patients had previous anti-TNF therapy (infliximab and/or adalimumab). Of the 12 patients, two discontinued the ustekinumab (one had an adverse reaction and one patient refused further dosage). 10 patients remain on ustekinumab, with a mean duration treatment of 14.4 months. Seven patients required dose escalation (shortened interval of 3 to 6 weeks between maintenance doses) to maintain clinical remission / response. Two patients reported clinical symptoms consistent with active disease at their most recent clinic visits.

Conclusion: 10 patients in our cohort are currently on ustekinumab with eight being in clinical remission (albeit seven requiring significantly shortened interval between maintenance doses compared to the licensed dosing schedule). Ustekinumab provides a viable option for patients with CD but may require higher dosage to achieve remission.

ABSTRACT 75 (14W191) POSTER PRESENTATION

Title of Paper: Audit of pancreatic cytology at St. Vincent's University Hospital

Author(s): Sampada Gupta, Jean Murphy, , Aurelie Fabre, David Gibbons, , Kevin Conlon, Donal Maguire, Justin Geoghegan, Emir Hoti, Dermot O' Toole, Niall Swan

Department(s)/Institution(s): Departments of Histopathology, Surgery and Gastroenterology, SVUH.

Introduction: EUS FNA is diagnostically challenging and we present the experience at our institution, which is the National surgical pancreatic cancer centre.

Aims/Background: To establish diagnostic accuracy of EUS-FNA pancreas at SVUH.

Method: All cases with pancreatic cytology were retrieved from the Laboratory information system(LIS) for the duration of 12months-July 2103-June 2014 and the data evaluated on excel data sheet.

Results: We evaluated a total of 134 cytology specimens from 124 patients-83 external cases (62%), 51 in-house cases (38%). A pathologist attended for rapid on site evaluation (ROSE) in 32(67%) of the in-house cases. 103 masses, 17 cystic lesions and 4 cases with suspected pancreatitis were evaluated, resulting in; C1(non diagnostic)=20(15%), C2(benign)=17(12.5%), C3(atypical)=6(4.5%), C4(suspicious)=15(11%), and C5(malignant)=76(57%). All cases were discussed at the multidisciplinary meeting and a total of 22 patients underwent surgery, with the following outcomes: 4 cases of chronic pancreatitis, (two C1 and two C2), 3 mucinous cystic neoplasms (two C1 and one C2), 3 IPMNs (one C2, C4 and C5 each), nine adenocarcinomas (four C4 and five C5), one sarcomatoid carcinoma (C5) and two neuroendocrine tumours (both C5).The sensitivity and specificity of FNA in pancreatic cytological material was 100% and these results meet the current standard (Herbert-Magee S et al.Cytopathology 2013;24:159-71). Results for cystic lesions are not as sensitive or specific and MDT discussion is essential for deciding patient management.

Conclusion: Our results show that pancreatic cytology is a sensitive and specific method for diagnosis of solid mass lesions but not for cystic lesions, which is at par with international experience.

ABSTRACT 76 (14W192) POSTER PRESENTATION

Title of Paper: Submucosal Injection of 4% Succinylated Gelatin is Effective for Resection of Large Sessile Colonic Polyps

Author(s): Aman Yadav, Sarah Rafferty, Subhasish Sengupta

Department(s)/Institution(s): Gastroenterology Department, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Introduction: Sub mucosal injection of 0.9% Normal Saline is commonly used for raising sessile colonic polyps for Endo Mucosal Resection (EMR). Due to lack of viscosity, Normal Saline fails to maintain the sub mucosal bubble for longer periods necessary for Endo mucosal resection of large sessile or superficially elevated colonic polyps. Succinylated Gelatin 4% (Gelofusine), is more viscous than saline and has been shown in porcine models as a better alternative to Saline for submucosal injection for EMR.

Aims/Background: We report our single centre, single operator experience of using Gelofusine 4% for submucosal injection of sessile and superficially elevated large colonic polyps of > 3 cm for EMR.

Method: A stock solution for sub mucosal injection was prepared before colonoscopy by injecting 2mls of Indigo Carmine in a 500 ml bag of 4% Gelofusine to give it a light blue colour. Depending on the size of the polyp submucosal injection of the above solution was injected in enough volume so as to create a substantial fluid cushion to aid EMR.

Results: A total of 6 sessile polyps with mean size of 3.6 +/- 0.68 cm were removed by piecemeal resection using Gelofusine for submucosal injection. Gelofusine was injected only at the beginning of the EMR. Mean time of removal of these polyps was 35.6 +/- 3.5 mins.

Conclusion: Submusosal injection of Gelofusine is effective in removing large sessile polyps by EMR technique.

ABSTRACT 77 (14W193) POSTER PRESENTATION

Title of Paper: Shorter maintenance Infliximab infusions in Inflammatory Bowel Disease are well tolerated.

Author(s): Vikrant Parihar, Muriel O'Callaghan, Mary Kennedy, 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: Infliximab is a chimeric monoclonal antibody to tumour necrosis factor alpha (TNFa) with efficacy in inducing and maintaining remission for moderate-to-severe inflammatory bowel disease (IBD). Infliximab is typically administered as an intravenous infusion over 2-3 hours which is both time-consuming and costly. Since January 2014 we have adopted shorter 30-60 minute maintenance infliximab infusions in order to increase the number of infusions performed in our gastroenterology infusion unit.

Aims/Background: To examine the safety and tolerability of 30-60 minute short maintenance infliximab infusions compared to 2 hour standard maintenance infliximab infusions.

Method: Between January and September 2014, a prospective cohort study of consecutive short maintenance infliximab infusions was undertaken in our department's infusion unit. Demographics, diagnosis, number of infusions, infusion rate, premedication, concurrent immunosuppressant therapy and adverse events were recorded.

Results: Between January 2008 and September 2014 a total of 48 IBD patients (38 Crohn's disease, 10 ulcerative colitis, mean age 36 years, 26 female, 22 male) received a total of 825 infliximab infusions. Between January 2014 and September 2014, we prospectively enrolled a total of 22 IBD patients (19 Crohn's disease, 3 ulcerative colitis, mean age 38 years, 14 female, 8 male) who had successfully completed three induction infusions and who subsequently received a total of 103 short 30-60 minute maintenance infliximab infusions. None of the patients receiving short maintenance infusions developed infusion reactions or significant adverse events.

Conclusion: Maintenance infliximab infusions can be safely administered over 30-60 minutes in patients who have previously tolerated three standard 2 hour induction infusions without adverse events. Shorter 30-60 minute maintenance infliximab infusions facilitate the scheduling of more infusions in a time of depleted healthcare resources and acute staff shortages in our infusion units. Shorter infusions may further improve adherence, scheduling and quality of life among IBD patients requiring infliximab infusions.

ABSTRACT 78 (14W194) POSTER PRESENTATION

Title of Paper: Pre-operative Imaging in Crohn's Disease: Comparison with Operative Findings and with Histology

Author(s): Lucy Mathews, Conor Lahiff, Anna Smyth, Hugh Mulcahy, Garret Cullen and Glen Doherty

Department(s)/Institution(s): Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin 4

Introduction: Cross-sectional imaging is increasingly used by clinicians to accurately phenotype patients with Crohn's disease (CD), and often to assess treatment response or determine the need for surgical management. Computed tomography (CT) or magnetic resonance enterography (MRE) are the primary modalities used.

Aims/Background: No data currently exists comparing CT and MRE for accurate prediction of surgical and histological findings.

Method: A large, prospectively maintained institutional database was interrogated for all patients with CD, who had undergone surgery over a seven-year period (2007-2014) and had a CT or MRE performed within 100 days prior to surgery. Baseline demographic and clinical data was collected, in addition to radiological features, which were correlated with surgical and histological findings.

Results: In the overall cohort (n=70), acute inflammation was recorded in 29 radiology reports (41%) and was subsequently found in 15 (21%) surgical specimens (p=0.001) and recorded in 34 (49%) histological reports (p=0.697). Fistulae were recorded in 17 (24%) radiology reports and found in 17 (24%) surgical (p=1.0) and 15 (21%) histological (p=0.687) specimens. Mural thickening was recorded in 55 (79%) radiology reports and found in 4 (6%) surgical (p<0.001) and 11 (16%) histology (p<0.001) specimens. Strictures were recorded in 28 (40%) radiology reports and found subsequently in 21 (30%) surgical (p=0.215) and 29 (41%) histology specimens (p=0.863). An abscess was recorded in 2 (3%) radiology reports and found in 9 (13%) surgical (p=0.028) and 15 (21%) histological specimens (p=0.001). On subgroup analysis, similar patterns of comparison were observed for both CT (n=28) and MRE (n=42), except for the presence of strictures recorded by MRE. In this case, MRE recorded strictures in 20 (48%) and in 22 (52%) of histological specimens (p=0.663), while being found in 11 (16%) surgical specimens (p=0.042).

Conclusion: Pre-operative radiological imaging correlates well with surgical findings and histological analysis for the presence of fistula, strictures and abscesses. Radiology does not accurately predict mural thickening in either surgical or histological specimens, while acute inflammation correlates well for radiology compared to histology, but not for surgery. MRE may be superior to a surgeon's eye for locating strictures in Crohn's disease.

ABSTRACT 79 (14W195) POSTER PRESENTATION

Title of Paper: BowelScreen® Detected Colorectal Cancers: A Single Screening Centre's Experience

Author(s): Vikrant Parihar, Ann Joyce, Catherine Garry, 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 asymptomatic average risk adults aged 60-69 yrs.

Aims/Background: Compare our experience with known international experience.

Method: All BowelScreen® patients were identified from our EndoRAAD endoscopy reporting system using their unique NCSS number (COR ID). Data extracted from EndoRAAD included colorectal cancer diagnosis and location. A diagnosis of colorectal cancer was confirmed by histology. Colorectal cancers were staged post-operatively using TNM classification. Patient and tumour characteristics including gender, age, tumour location and stage were collated. Right-sided tumours were considered proximal to the splenic flexure

Results: Between May 2013 and September 2014 360 FIT+ve individuals have been pre-assessed and 290 individuals (153 male, 137 female) have undergone screening colonoscopy at our centre. Twenty-four patients (8.2%) had colorectal cancers; 16 males and 8 females; average age 67.6 years, 20/24 were left-sided cancers, 8 of which were rectal cancers and 4/24 were right-sided cancers. 20/24 colorectal cancers have undergone curative treatment while 1 patient diagnosed with Stage 4 CRC underwent a palliative resection. Overall stage distribution was stage 0(n=1), 1(n=3), 2(n=11), 3(n=6), 4(n=1).

Conclusion: The initial experience of the BowelScreen® programme at our centre reflects international experience with FIT-based screening with an 8.2% colorectal cancer detection rate. 95 percent of our screen detected colorectal cancers were Stage1-3 which is associated with an increased rate of survival.

ABSTRACT 80 (14W196) POSTER PRESENTATION

Title of Paper: Development of a Mixed Triglyceride Breath Test for Pancreatic Exocrine Insufficiency in an Irish Hospital Setting

Author(s): L Barry, A Blake, G Mohamed & M Buckley

Department(s)/Institution(s): GI Function Lab, Mercy University Hospital & Department of Physiology UCC

Introduction: Pancreatic exocrine insufficiency (PEI) is thought to be an under recognised clinical problem. Several non-invasive tests are available to assess pancreatic function, most commonly faecal elastase is used in the hospital setting. This test has limitations however & is thought not to be useful in mild-to-moderate pancreatic exocrine insufficiency.

Aims/Background: To develop a mixed triglyceride breath test in an Irish hospital setting. To assess the risk of pancreatic exocrine insufficiency (PEI) as an unrecognised secondary effect of chronic Somatostatin analogue therapy. To use a non-invasive, inexpensive and effective test for measuring pancreatic exocrine insufficiency.

Method: 6 patients (4 male) on Somatostatin analogue treatment underwent a 13C Mixed Triglyceride Breath Test (13C-MTGBT). All patients received a standardized high-lipid (16g of fat) test meal, which consisted of 100g of toast with 17g of butter and the recommended dose of 200mg pure powder of the mixed triglyceride (1,3-diastearyl-2 octanoyl glycerol). The meal was ingested within 10 minutes with 200ml water. We collected breath samples before ingestion of the test meal and every 15minutes for a six hour period. We determined the 13C/12C isotope ratio in the subject's breath by using isotope-ratio-mass-spectrometry. Our results were expressed as delta values and expressed as % cumulative 13C – exhalation.

Results: It has been shown that cumulative 13C exhalation

recovery over 6 hours of >29% of dose administered is the best parameter for evaluation of 13C-MTGBT when compared to the gold standard secretin test. We found 2 patients (33%) with abnormal 13C-MTGBT with %cum 13C exhalation <29%. GI symptoms were common among the group with 66% of patients reporting diarrhoea, 50% steatorrhoea, 66% a frequent urgency to defecate, 50% reported bloating and 66% reported abdominal pain

Conclusion: This limited study demonstrated the first experience of 13C-MTGBT. Further studies need to be undertaken to assess the usefulness of this indirect method of detection of PEI. Also the long period of breath sampling involved is a limitation in a routine clinical setting, studies looking at the possibility of shortening the study without compromising the sensitivity would be worthwhile.

ABSTRACT 81 (14W197) POSTER PRESENTATION

Title of Paper: How Good are the Amsterdam II Criteria at identifying Lynch Syndrome?; Experience of an Irish Family Colorectal Cancer Screening Service

Author(s): M. Walshe, M. Boyle, I. Cretu, M. Farrell, D. Gallagher, P. MacMathúna.

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

Introduction: Amsterdam II criteria are used to identify HNPCC kindreds. However, Amsterdam II criteria and genetically confirmed Lynch Syndrome (LS) do not necessarily correlate.

Aims/background: To assess the strength of the correlation between Amsterdam II criteria and genetically confirmed LS.

Methods: In the context of a family colorectal cancer screening service, we interrogated a dedicated database to identify patients from kindreds fulfilling Amsterdam II criteria and/or in which a genetic diagnosis of LS had been made.

Results: We identified 270 patients (118 male, 152 female) from 89 kindreds. Amsterdam II criteria were satisfied in 72(80.9%) kindreds. A genetic diagnosis of LS was present in 30(33.7%) kindreds. Both Amsterdam II criteria and a genetic diagnosis of LS were evident in 16(18.0%) kindreds.
Genetic testing has been performed on 91(33.7%) patients. LS was confirmed in 57(21.1%) patients, belonging to 25 different kindreds. The remaining 34(12.6%) patients had negative predictive gene testing. The mutations responsible for LS were found in the MLH1, MSH2, and MSH6 genes in 19(7.0%), 28(10.4%), and 10(3.7%) patients respectively. A further 4 patients are awaiting gene testing, and 1 patient has been deemed gene negative on the basis of his father's negative gene test. Of the 57 patients with a genetic confirmation of Lynch syndrome, only 23(40.4%) were from kindreds fulfilling Amsterdam II criteria.

Conclusion: Kindreds with a genetic diagnosis of LS frequently do not fulfill Amsterdam II criteria. In addition to suboptimal sensitivity of Amsterdam II criteria, the inability of many patients to provide a full accurate family cancer history is a likely factor.

ABSTRACT 82 (14W198) POSTER PRESENTATION

Title of Paper: Altered expression of inflammatory caspases-4 and -5 during inflammatory bowel disease and colorectal cancer highlights a novel diagnostic tool with therapeutic potential.

Author(s): B. Flood[1], K. Oficjalska[1], D. Laukens[2], J. Fay[3], K.H.G. Mills[1], K. Sheahan[4], E.J. Ryan[4], G.A. Doherty[4], E.W.Kay[3] and E.M. Creagh[1].

Department(s)/Institution(s): [1]School of Biochemistry & Immunology, Trinity Biomedical Sciences Institute, Trinity College Dublin, Ireland; [2]Department of Gastroenterology, Ghent University, Belgium; [3]RCSI and Beaumont Hospital, Dublin 9; and [4]Centre for Colorectal Disease, St. Vincent's University Hospital and School of Medicine and Medical Sciences, University College Dublin, Ireland.

Introduction: Caspases are a group of proteolytic enzymes involved in the co-ordination of cellular processes, including cellular homeostasis, inflammation and apoptosis. Altered activity of caspases, particularly caspase-1, has been implicated in the development of intestinal diseases, such as inflammatory bowel disease (IBD) and colorectal cancer (CRC). However, the involvement of two related inflammatory caspase members, caspases-4 and -5, during intestinal homeostasis and disease has not yet been established.

Aims/Background: The aim of this study was to characterise the involvement of inflammatory caspases during inflammatory diseases, namely inflammatory bowel disease (IBD) and colorectal cancer (CRC).

Methods: Inflammatory caspase expression was examined in IBD patients from a Belgian cohort by qPCR (n=103); and in ulcerative colitis (UC) patients (n=36), CRC patients (n=25) and UC-associated CRC patients (n=8) from Irish cohorts by immunohistochemical (IHC) staining.

Results: qPCR identified increased expression of inflammatory caspases within inflamed tissue from IBD patients. Caspase-4 and -5 levels in stromal cells correlated with inflammation and disease activity in UC patients. In contrast, colorectal tumours robustly expressed caspases-4 and -5 in intestinal epithelial cells. Examination of adjacent-normal, inflamed and tumour tissue from patients with UC-associated CRC confirmed that stromal expression of caspases-4 and -5 is increased in inflamed tissue, while epithelial expression is restricted to neoplastic cells and tissue.

Conclusions: This study identifies caspases-4 and -5 as potential targets for limiting intestinal inflammation; and proposes epithelial-expressed caspases-4 and -5 as novel diagnostic indicators with therapeutic potential for CRC.

ABSTRACT 83 (14W199) POSTER PRESENTATION

Title of Paper: Faecal Calprotectin to screen out IBS: Is it being used correctly?

Author(s): Reed O, Doyle J, Murphy S

Department(s)/Institution(s): Department of Medicine, Daisy Hill Hospital, Southern Health & Social Care Trust

Introduction: The BSG and NICE recommend use of faecal calprotectin (FC) as an option in screening out irritable bowel syndrome (IBS) in adults with recent onset lower gastrointestinal symptoms[1].

Aims/Background: To evaluate the early use of FC to screen out IBS.
Methods: The Clinical Biochemistry Department in the Southern Trust maintains a database of all FC requests. We analysed these requests to determine if FC was being used correctly

Results: The database contained 47 patients - 24 of these patients were from primary care and 23 from secondary care.

Of the 23 secondary patients, 9 had FC performed to check for an IBD flare. Of the remaining 14, 10 had FC performed to screen for IBS. 5 had a negative FC - however, 3 patients proceeded to invasive investigations including: two OGDs, two flexible sigmoidoscopies and one colonoscopy - all investigations were normal.

Of the 5 patients with a positive FC invasive investigations included: one OGD, two colonoscopies and one flexible sigmoidoscopy. 2 were diagnosed IBS, 1 with IBD and 2 have on-going investigations.

Of the 24 primary care patients, data are currently available for 12 patients. Four patients had a negative FC and were diagnosed with IBS - however, two of these had further investigations including US abdomen, an OGD and a colonoscopy - all investigations were normal.

Conclusions: These early results suggest that a negative FC result is not being acted on appropriately as patients are still having further invasive investigations. Further research and education is required.

References:

1. National Institute Clinical Excellence. Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel. NICE Guidance, 2013 Oct

ABSTRACT 84 (14W200) POSTER PRESENTATION

Title of Paper: Measuring Cardiovascular Risk and Metabolic Parameters in Patients with Crohn's Disease

Author(s): S Kirthi, D McNamara, M Hussey, C Grant

Introduction: The association between Inflammatory Bowel Disease (IBD) and venous thromboembolic events has been supported by abundant scientific evidence and has been related to hypercoagulability. However, the evidence of the risk of arterial thromboembolic disease with IBD is debatable, with the role of elevated inflammatory mediators, such as CRP, IL-6, and TNF-□ leading to atherosclerosis being a plausible link between the two. Previous studies using the Framingham Risk Score have been performed; however this may not be an entirely accurate tool to use in a young population cohort.

Aims/Background: We wished to assess the Cardiovascular risk in patients with Crohn's Disease (CD) and the presence of Metabolic Syndrome (MetS) using established international criteria (QRISK2 and IDF criteria).

Methods: Patients with a known diagnosis of CD, older than 25 years and with no history of Cardiovascular Disease (CVD) or on statins were prospectively recruited from the Inflammatory Bowel Disease Clinic. A prospective QRISK2 assessment was undertaken which predicts the 10 year risk of CVD with a score of >20% indicating a high risk and <10% low risk. To calculate the QRISK2 score, a face to face interview was undertaken to obtain clinical information including smoking history, chronic kidney disease, atrial fibrillation, and rheumatoid arthritis status. Height, weight, blood pressure and waist circumference were also taken. Patient then returned to have fasting bloods checked including HDL and total cholesterol levels. In addition, the MetS in these patients was assessed using the International Diabetes Federation(IDF) criteria which requires the patient to have an increased waist circumference along with 2 of either ;Triglycerides 1.7 > mmol/L , HDL cholesterol<1.03 mmol/L in men and <1.29 mmol/L in women, or treatment for either low HDL or elevated triglycerides ,systolic blood pressure >130, diastolic blood pressure >85, or treatment for hypertension ,fasting plasma glucose>5.6 mmol/L or previously diagnosed type 2 diabetes.

Results: To date, 16 patients have been recruited for this study with a median age of 42 years, ranging from ages 32 to 69 years, of which 62.5% were females and 37.5% smoked. QRISK2 score was high in 1 patient and low in 15. Of interest, 5 patients (31.25%) met the diagnostic criteria of MetS. Of note, the patient with the high QRISK2 score also had metabolic syndrome. Age, smoking or gender were not associated with either MEtS or QRISK2 risk.

Conclusions: To date, this pilot study has shown that there is a small but significant proportion of relatively young patients with CD who have an established risk of CVD and 1/3rd of patients have MetS. The lack of association with traditional risk factors such as age, gender and smoking supports the role of chronic inflammation as a driving force in their risk of atherosclerosis. Further application of this simple assessment tool should be undertaken to identify at risk individuals suitable for prevention therapy.

Brenda Scannell, Clogadh McCormack, Deirdre Rafferty, Robert Felton, Nicola Garvey and Tess Cooke of Norgine

Nikki Walsh, Sinead Cadden, Natasha Caulfield of Tillotts and Prof Stephen Patchet

Full house at the ISG Summer meeting in Kilashee House Co Kildare

Dr Hamid Mushtav, Dr Zaheer, Dr Aftab, Dr Anwar and Dr Haider

Summer Meeting 2014

Shane O'Driscoll Oral Presentation on Liver Transplantation

Paul Carroll Oral Presentation on Oesophageal Cancer

Michael Henegan speaking on Liver Disease

Mary Shuhaibar Oral presentation on IBD

Mark Hudson speaking on Cirrhosis

Maria Boyle speaking on Pregnancy & IBD

Margaret Connaughton Oral presentation on Liver Disease

Grainne Holleran Oral presentation on Gene Expressions

Summer Meeting 2014

Finbarr McCarthy Oral presentation on 1L-1B nad SERPINA-3

Edel McDermott Oral presentation on Patient Education in IBD

Clifford Kiat Oral presentation on targetting metabolic parameters in type 1

Brooke Layard Oral presentation on use of Histoacryl glue injection

Barry Hall Oral presentation on Chrohns Disease

Ashraf Monged Oral presentation on Endoscopic Oesophageal Stricturotomy

Aongas Lavelle Oral presentation on Ulcerative Colitis

Dr Eileen Murphy and Diarmuid Gavin of Alimentary Health

Summer Meeting 2014

Dr Gavin Harewood of Beaumont Hospital

Jennifer Morrow of Coeliac Society of Ireland

Ann Liddell, Elaine Millington and Caroline Hall of Cook Medical

Anne Marie Carrigan and Fabiawnne Rapinett of Fleetwood Healthacare

David Rossiter, David O' Brien, Philip Cullinan and Fergal Kierans of Olympus Ireland

Declan O'Reilly and Dermot Murphy of GS Medical

Prof Garry Courtney, Mick Flannery of Janseen, Prof Humprey O'Connor President of ISG, Dr Naeem Ullah and Dr Malik Anwar

Summer Meeting 2014

Dr Johnny Cash and Dr Stephen Stewart

Eva Hill, Davina Smith and Jill McViter of Scope Healthcare

L-R Linda O' Keefe, Fiona Corville, Celia Davan and Geraldine Covney

Michael Dineen CEO ISG, Dr Stephen Stewart, Dr Mark Hudson, Prof Graham Foster and Dr Johnny Cash

Prof Humprey O'Connor President of ISG speaking with delegates

Summer Meeting 2014

Prof Nicholas Shaheen of the University of North Carolina with his family at the ISG Gala Dinner

Olivia O'Rahilly and Georgina Gadner

Prof Alan Moss at the ISG Summer Gala Dinner

Prof Cliona Farrelly of UCD

Dr Ammar Shahin of Connolly Hospital, Dr Ashraf Monged of MUH, and Dr Mohamed Alhini of Beaumont Hospital

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ASACOLON 400mg and 800mg GR Tablets: Pentilled 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, initial dose 30 to 50mg/kg/day in divided doses, maximum 75mg/kg/day, do not exceed 4.0g/day. Maintenance: titrate to individual, 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, proteinuria, liver impairment, previous myo- or pericarditis or a lung background, and in the elderly. Monitor use in patients with a history of mesalazine-induced cardiac hypersensitivity. Monitor closely in patients sensitive to sulfasalazine. 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 (78mg/152mg), not for use in lactose intolerant patients. Intact tablets in stool may be simply tablet casing. **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 leucopenia. 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. Concomitant use of sulfonylide agents, such as NSAIDs, azathioprine, or methotrexate, 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 if using 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, flatus, headache, dizziness, myocarditis, pericarditis, abdominal pain, diarrhoea, flatulence, nausea, vomiting, dyspepsia. Very rare: blood dyscrasias, bone marrow depression, eosinophilia, blood disorder, hypersensitivity reactions such as allergic exanthemas, drug fever, lupus erythematosus syndrome, pancolitis, peripheral neuropathy, allergic and fibrotic lung reactions, pneumonia, interstitial pneumonia, eosinophilic pneumonia, lung disorder, acute pancreatitis, changes in liver function, hepatitis, bilestasis, 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 syndrome 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, United Drug House, Magna Drive, Magna Business Park, Citywest Road, Dublin 24, Ireland. **DATE OF PREPARATION:** December 2013. CODE: 2013/16. 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 (4.8 g) 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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For adult patients with moderately to severely active ulcerative colitis (UC)*
For adult patients with moderately to severely active Crohn's Disease (CD)*
BEYOND MILD
YOU HAVE MODERATE TO SEVERE DISEASE*
*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, Liffey Valley Office Campus, Quarryvale, Co Dublin, Ireland | Legal Category POM | Marketing Authorisation Numbers:
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