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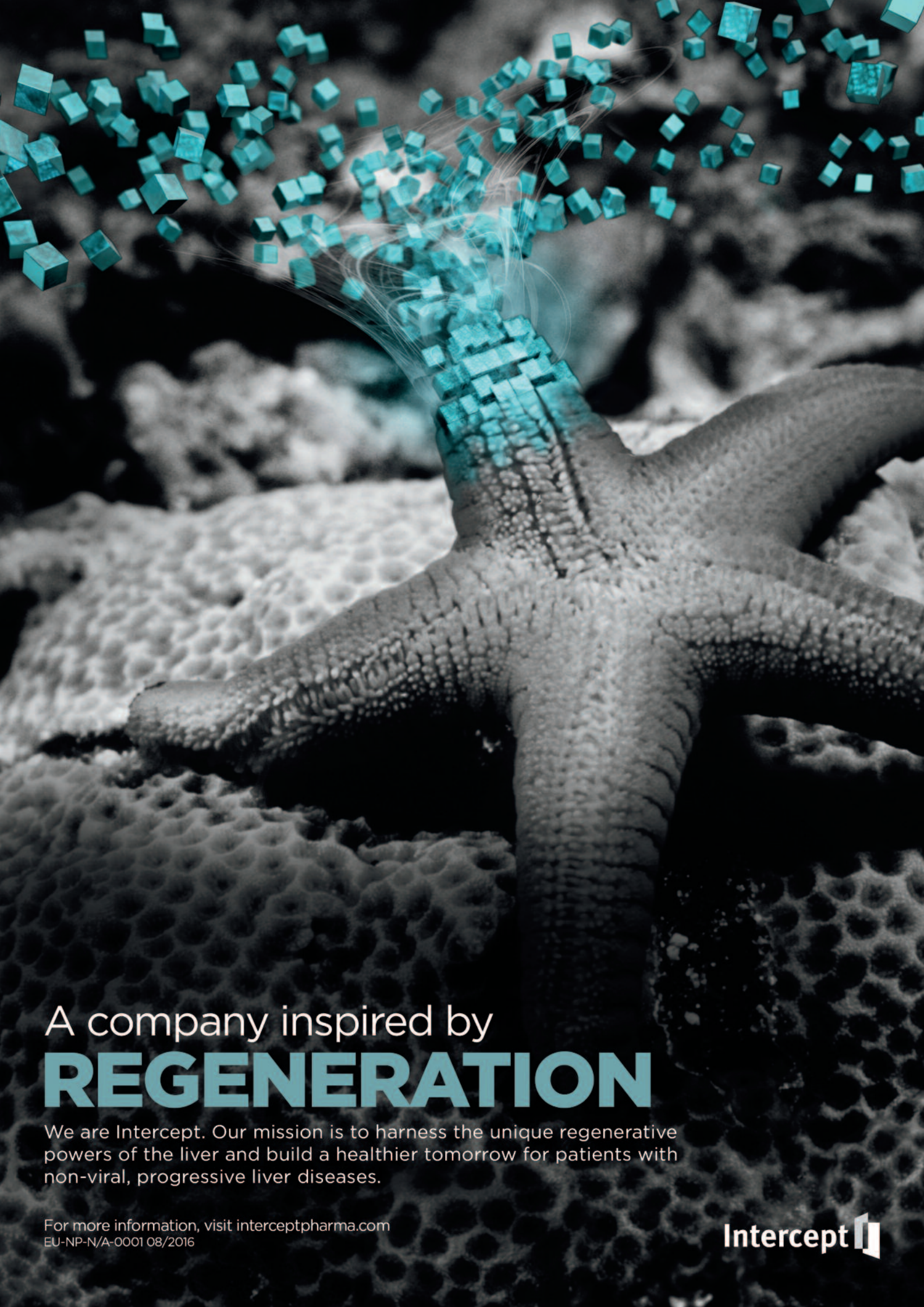
Irish Society of Gastroenterology

Winter Meeting

24 - 25 November 2016
Fitzpatrick's Castle Hotel,
Killiney, Co. Dublin.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EU-NP-N/A-0001 08/2016
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Welcome Message from the President Professor Padraic MacMathuna

Dear Colleagues and Friends,

It is my very great pleasure to welcome you back to Killiney Castle Hotel for our winter meeting. The Irish Society of Gastroenterology has a proud history and tradition. As the Society enters its 55th year its main strength lies in the cross-speciality involvement of Gastroenterologists, other clinicians and scientists in an all-Ireland capacity. The ISG not only supports the profession in delivering high quality care of patients but also lobbies centrally to influence government policy.

The teaching sessions cover more 'hot' topics within GI including Cancer genetics, CT Colonography, IBD, Serrated lesions, Rectal cancer and Nutrition. Our overseas visitors include Ian Tomlinson, James East and Roel Hompes from Oxford and Mark Silverberg from Toronto, all with distinguished international reputations. Their presentations allied to those of our own Helen Fenlon (Radiology), Des Winters (Surgery) and Derek Power (Oncology) should be stimulating, provocative and entertaining. My colleagues Jan Leyden, Martin Buckley, David Gallagher, David Kevans, Orla Crosbie, John Reynolds and Sengupta were really helpful in putting this programme together. It is also opportune that we address the state of Endoscopy in Ireland with Chris Steele and Steve Patchett, both of whom are national leads and have kindly agreed to bring us up to date.

The participation of nursing and paramedic gets stronger with the inclusion of the GI Physiology group to the existing Endoscopy, Hepatology and IBD Nurses. We wish them all well. I am very grateful to our Abstract Review Panel for their diligence in selecting the best abstract submissions for oral and poster presentation. The various chairs for all the sessions plus the judges for oral and poster presentations need to be congratulated for their input.

The new Website is proving a success with very positive feedback from membership. In keeping with the best of international GI websites, it is providing an invaluable resource for members to register for meetings, submit abstracts, link to relevent sites, update on national and international events as well as facilitating membership renewal on line. The board will continue to respond to feedback from members to make the site more interesting and user friendly. Our IT colleagues from Fruit Design, who were instrumental in the website design, are participating this year as part of the novel Video section being driven by Gupta. I want to give special mention to our outstanding trainees who work hard in clinical posts but manage to devote time to research and generate the abstracts presented to ISG. They are the clinicians and academics of the future.

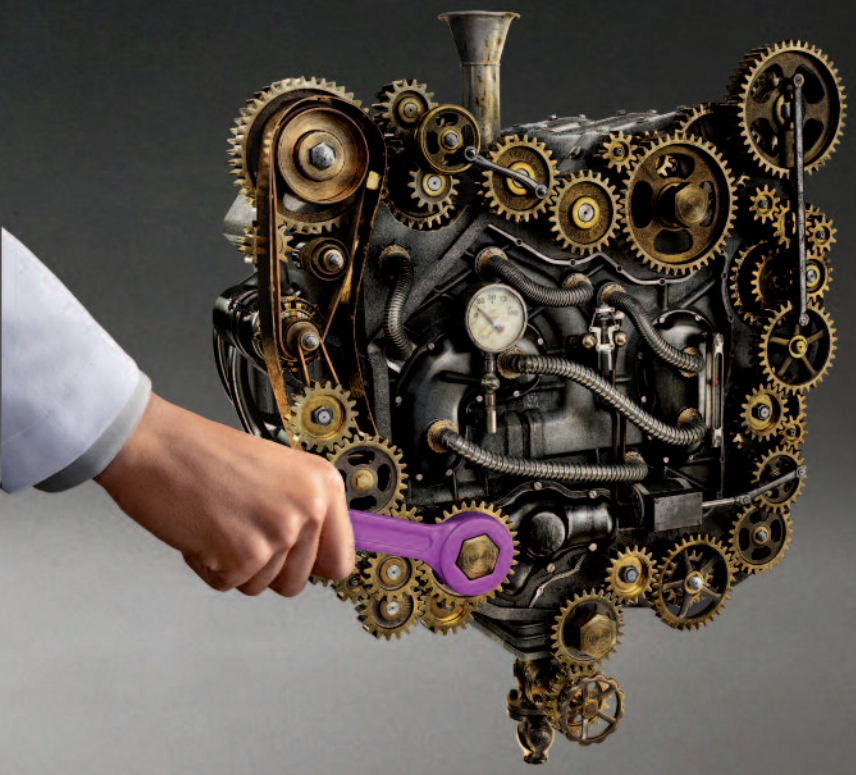
I would like to thank the officers and board for their support. A particular word of thanks again to Michal Dineen and Cora Gannon who continue to do most of the behind the scenes work to make this a vibrant, active and collegiate society. I trust that you will find the programme educational, interesting and stimulating. Once again a big thank you to our colleagues in Industry for their continued support. For now let us all enjoy the educational and social inter-action! I look forward to meeting with all of you here, renewing old acquaintances and making new ones.

Padraic MacMathuna
President ISG
Consultant Gastroenterologist

Introducing Entyvio: the first and only gut-selective biologic for patients with moderately to severely active ulcerative colitis (UC) or Crohn's disease (CD)

TREAT WITH PRECISION

The first and only gut-selective biologic[1]



- Achieved remission at Week 52 in:
  - 42% of UC patients vs 16% for placebo in patients responding at Week 6 (*P*<0.001)
  - 39% of CD patients vs 22% for placebo in patients responding at Week 6 (*P*<0.001)
- Targeted mechanism of action[1] different from anti-TNFα therapies
- One dose for all patients[1]: 300-mg IV infusion

References: 1. Entyvio Summary of Product Characteristics. Takeda Pharmaceuticals Ireland Ltd. www.medicines.ie

ITEM CODE: IRE/VED/14/0008c(1)
DATE OF PREPARATION: October 2015

Entyvio® ▼
vedolizumab

YOUR GUT-SELECTIVE BIOLOGIC

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

Presentation: 300 mg powder for concentrate for solution for infusion. **Indication:** Adult patients with moderately to severely active ulcerative colitis(UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist. **Dosage & Administration:** Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn's disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. **Ulcerative colitis:** Recommended dose regimen 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Reconsider treatment if no evidence of therapeutic benefit at week 10. If patients experience a decrease in response, they may benefit from increased dosage frequency to 300mg every 4 weeks. Corticosteroids may be reduced/discontinued in patients who respond to treatment with Entyvio. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. **Crohn's disease:** Recommended dose regimen is 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Patients who have not shown evidence of therapeutic benefit may benefit from a dose at week 10. Continue therapy every 8 weeks from week 14 in responding patients. Therapy should be discontinued if no evidence of therapeutic benefit is observed at week 14. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. **Paediatric populations:** No data available in children aged 0-17 years. Not recommended. **Elderly patients:** No dosage adjustment required. **Renal or hepatic impairment:** Entyvio has not been studied in these populations. No dose recommendation can be given. **Contraindications:** Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, cytomegalovirus, listeriosis and opportunistic infections such as Progressive Multifocal Leukoencephalopathy (PML). **Warnings and Precautions:** Patients should be observed continuously during infusions for signs/symptoms of hypersensitivity reactions. Patients should continue to be observed for two hours following infusion completion for the first two infusions and one hour for subsequent infusions. **Infusion-related reactions (IRR):** Hypersensitivity reactions have been reported, the majority were of mild to moderate severity. Discontinue treatment if anaphylaxis or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IRR, slow or interrupt infusion. Consideration for pre-treatment with antihistamine, hydrocortisone and/or paracetamol should be given prior to next infusion, for patients with history of mild/moderate IRR to Entyvio. **Infections:** Not recommended in patients with active, severe infections until infections are controlled. Consider withholding in patients who develop severe infection while on treatment with Entyvio. Before initiating treatment, patients must be screened for TB. If latent TB is diagnosed, anti-tuberculosis appropriate treatment must be initiated prior to Entyvio treatment.

Progressive Multifocal Leukocephalopathy (PML): No cases were observed in Entyvio clinical trials, but John Cunningham (JC) virus infection resulting in PML and death has occurred in patients treated with other integrin receptor antagonists and systemic immunosuppressive agents. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs/symptoms. **Malignancy:** Underlying increased risk of malignancy in UC and CD. Immunomodulatory products may increase risk. **Prior and concurrent use of biological products:** No clinical data available for Entyvio use in patients previously treated with natalizumab or rituximab. Patients previously exposed to natalizumab should wait at least 12 weeks prior to initiating Entyvio therapy. Entyvio not recommended for concomitant use with biologic immunosuppressants as no clinical data available. **Live and oral vaccines:** Patients may continue to receive non-live vaccines. Patients recommended to be up-to-date with all appropriate immunisations prior to initiating Entyvio. Live vaccines may be administered concurrently only if benefit clearly outweighs risk. **Interactions:** No interaction studies performed. Concomitant administration of corticosteroids, immunomodulators (azathioprine, 6-mercaptopurine, and methotrexate) and aminosalicylates did not have a clinically meaningful effect on Entyvio pharmacokinetics. **Fertility, pregnancy and lactation:** Women of child-bearing potential should use adequate contraception and continue for at least 18 weeks after last Entyvio treatment. Since maternal antibodies are excreted in breast milk, decision whether to discontinue breast-feeding or discontinue/abstain from Entyvio should be made according to relative benefit to child of breast-feeding or to mother of Entyvio. **Undesirable Effects:** *Very Common (≥ 1/10):* nasopharyngitis, headache, arthralgia. *Common (≥1/100, <1/10):* bronchitis, gastroenteritis, URTI, influenza, sinusitis, pharyngitis, paraesthesia, hypertension, oropharyngeal pain, nasal congestion, cough, anal abscess, anal fissure, nausea, dyspepsia, constipation, abdominal distension, flatulence, haemorrhoids, rash, pruritis, eczema, erythema, night sweats, acne, muscle spasm, back pain, muscular weakness, fatigue, pain in extremities, pyrexia. *Other serious undesirable effects (≥1/1000 to <1/100):* respiratory tract infection, infusion site reaction, infusion-related reaction. Refer to the SmPC for details on full side effect profile and interactions. **Legal Classification:** POM. **Marketing Authorisation Number:** EU/1/14/923/001; 300mg powder for concentrate for solution for infusion. Further information is available from Takeda UK Ltd. Building 3, Glory Park, Glory Park Avenue, Wooburn Green, Buckinghamshire, HP10 0DF. Tel: 01628 537900 Fax: 01628 526617. **PI Approval Code:** IRE/VED/15/0014
Date of revision: September 2015.

Adverse Events should be reported to the Pharmacovigilance Unit at the Health Products Regulatory Authority (medsafety@hpra.ie). Information about Adverse Event reporting can be found on the HPRA website (www.hpra.ie). Adverse Events should also be reported to Takeda UK Ltd on 1800 937 970.

ISG Winter Meeting
24th & 25th November 2016, Fitzpatrick's Castle Hotel Killiney Co. Dublin.
Programme

Thursday 24th November

10.30 **Satellite Meeting** (Spon by AbbVie)

12.00 **Registration**

12.45 **Lunch Poster Viewing & Meet the Indusry**

13.30 **Oral Free Papers 1 - 6**

14.30 **Colorectal Cancer:**
Early detection and screening

Ian Tomlinson
Prof of Molecular & Population Genetics
University of Oxford UK
"Personalised Colorectal Cancer Screening: translating progress in cancer genetics"

Helen Fenlon
Consultant Radiologist
UCD/Mater University Hospital
"The role of CT Colonography in screening"

15.30 **Coffee Break, Poster viewing & meet the Industry**

16.00 **Oral Free Papers 7 - 10**

16.40 **IBD:**

Mark Silverberg
Consultant Gastroenterologist
Mount Sinai Hospital Toronto, Canada
"Biologic Therapies in Inflammatory Bowel Disease – Optimal Current Use & Future Promise"

18.00 **ISG Board**

18.15 **Satelitte Meeting** (Spon by Janssen Cilag)

19.15 **Pre Dinner Drinks**

20.00 **Conference Dinner**

Friday 25th November

8.00 **Satellite Meeting** (Spon by Tillotts)

9.00 **Oral Free Papers 11 - 16**

10.00 **Endoscopy:**

James East
Consultant Gastroenterologist
John Radcliffe Hospital, Oxford
"Serrated lesions: significance, detection, resection and follow-up"

Chris Steele
Consultant Gastroenterologist
Letterkenny General Hospital
National Lead /
Stephen Patchett
Consultant Gastroenterologist
Bon Secours Hospital - Dublin
Joint RCPI/RCSI lead
"What is the national plan for GI endoscopy?"

11.15 **Coffee Break, Poster viewing, Meet the Industry**

11.45 **Surgery - Rectal Cancer:**

Roel Hompes
Consultant Colorectal and General Surgeon
Oxford, UK
"Rectal cancer - controversies in management"

Des Winters
Consultant Colorectal and General Surgeon
St Vincent's University Hospital
"Rectal Cancer: optimum treatment in 2016"

12.45 **Video Presentations** (S. Sengupta)

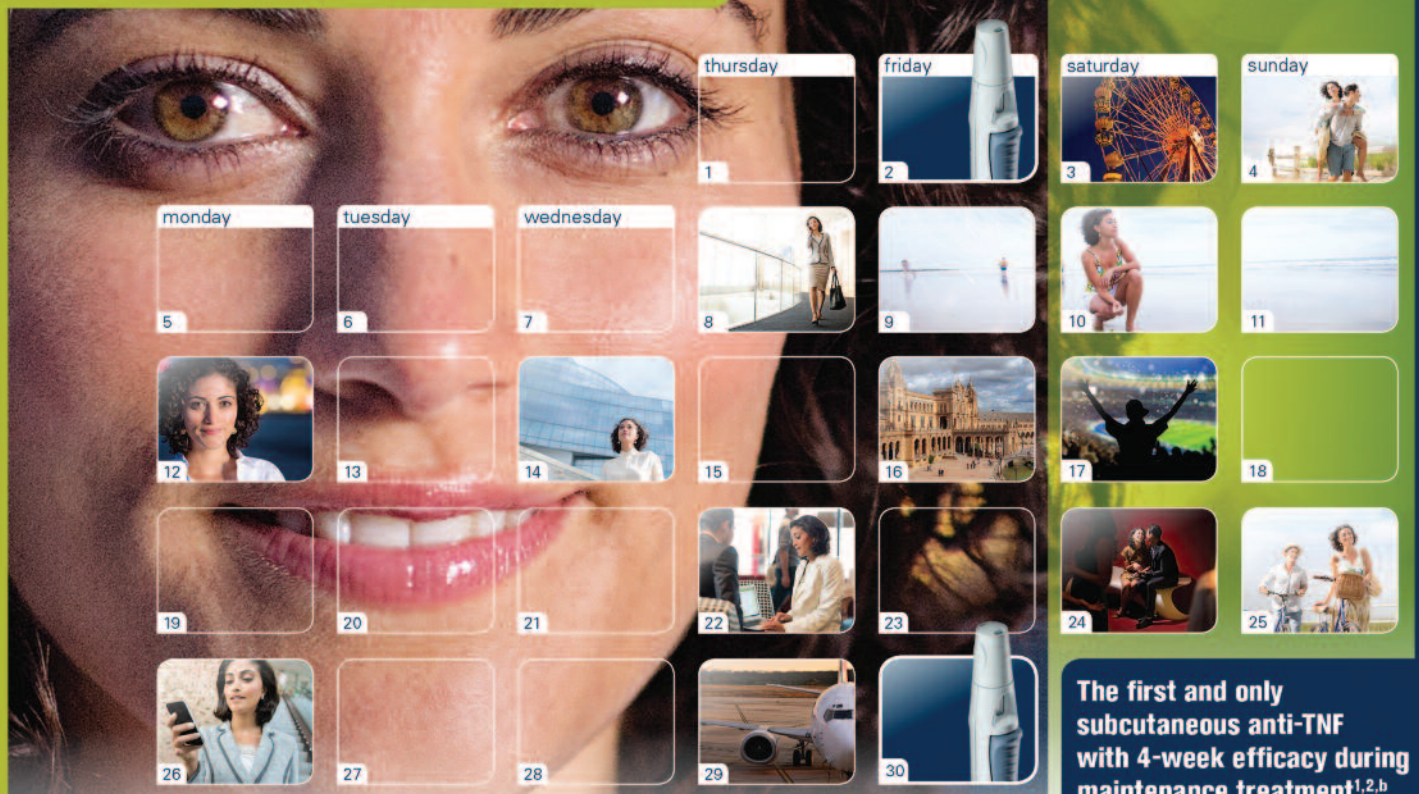
13.15 **Nutrition**

Derek Power
Medical Oncologist (CUH/UCC)
"The Impact of Body Composition on Cancer Outcome"

14.15 **Prize Giving and Close of Meeting**

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

EFFICACY THAT LASTS[1-2,a]



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

Please consult the Summary of Product Characteristics before prescribing.

[a]Based on results of PURSUIT Maintenance study.

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

Simponi® golimumab

SIMPONI 50 MG, 100 MG SOLUTION FOR INJECTION IN PRE-FILLED PEN
SIMPONI 50 MG SOLUTION FOR INJECTION IN PRE-FILLED SYRINGE(GOLIMUMAB)

Prescribing Information [Refer to full SPC text before prescribing Simponi (golimumab)]

Indications: *Rheumatoid Arthritis (RA):* Simponi, in combination with methotrexate (MTX), is indicated for: the treatment of moderate to severe, active rheumatoid arthritis in adults when the response to disease-modifying anti-rheumatic drug (DMARD) therapy including MTX has been inadequate; the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with MTX. Simponi, in combination with MTX, has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function; *Psoriatic Arthritis (PsA):* Simponi, alone or in combination with MTX, is indicated for the treatment of active and progressive PsA in adults when the response to DMARD therapy has been inadequate. Simponi has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function. *Ankylosing Spondylitis (AS):* Simponi is indicated for the treatment of severe, active AS in adults who have responded inadequately to conventional therapy. *Non-radiographic axial spondyloarthritis (nr-Axial SpA):* Simponi is indicated for the treatment of severe, active *nr-Axial SpA who have had an inadequate response to or are intolerant to NSAIDS. Ulcerative colitis (UC):* Simponi is indicated for treatment of moderately to severely active UC in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6 mercaptopurine (6 MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies. **Dosage and administration:** Simponi should be injected subcutaneously. Treatment should be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of RA, PsA, AS, nr-Axial SpA or UC. After proper training in subcutaneous injection technique, patients may self-inject, if their physician deems it appropriate. *RA:* Simponi 50 mg given once a month, on the same date each month, concomitantly with MTX. *PsA:* Simponi 50 mg given once a month, on the same date each month, alone or in combination with MTX. *AS and nr-Axial SpA:* Simponi 50 mg given once a month, on the same date each month. Clinical response is usually achieved within 12-14 weeks of treatment (3 or 4 doses). Continued therapy should be reconsidered in patients who show no evidence of therapeutic benefit within this time period. In patients weighing more than 100 kg who do not achieve an adequate clinical response after 3 or 4 doses, increasing the dose of golimumab to 100 mg once a month may be considered, taking into account the increased risk of certain serious adverse reactions with the 100 mg dose compared with the 50 mg dose. *UC: Patients weighing < 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks. *Patients weighing ≥ 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks. During maintenance treatment, corticosteroids may be tapered, following clinical practice guidelines. Clinical response is usually achieved within 12-14 weeks of treatment (after 4 doses). Missed dose: If a patient forgets to inject Simponi on the planned date, the forgotten dose should be injected as soon as the patient remembers. The patient should be instructed not to inject a double dose. *Older patients (> 65 years):* no dose adjustment required. *Paediatric patients (<18 years) and patients with renal and hepatic impairment:* Simponi is not recommended in these populations. **Contraindications:** Patients with a hypersensitivity to golimumab or any of the excipients; Patients with active tuberculosis (TB) or other severe infection such as sepsis and opportunistic infections; patients with moderate or severe heart failure (NYHA class III/IV). **Precautions and Warnings:** Infections: Patients must be monitored closely for infection before, during and for 5 months after cessation of treatment. Exercise caution when considering Simponi in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Simponi should not be given to patients with clinically important active infection. Patients should be advised of the potential risk factors. Bacterial infections (including sepsis and pneumonia), mycobacterial (including TB), invasive fungal and opportunistic infections, including fatalities, have been reported. The invasive fungal infection should be suspected if they develop a serious systemic illness. There was a greater incidence of serious infections, including opportunistic infections and TB, in patients receiving golimumab 100 mg compared with patients receiving golimumab 50 mg. Serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease, could predispose them to infection.There have been reports of active TB in patients receiving Simponi, including patients previously treated for latent TB. Patients should be evaluated for active or latent TB before Simponi treatment. All such tests should be recorded on the Patient Alert Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be monitored closely for signs and symptoms of active TB and advised to seek medical advice if signs and/or symptoms of TB appear. *Hepatitis B (HBV) reactivation:* Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi *Malignancies and lymphoproliferative disorders:* Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy, additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded. Rare cases, usually fatal, of hepatosplenic T-cell lymphoma (HSTCL) have been reported, the majority of cases occurred in adolescent and young males nearly all on concomitant treatment with azathioprine (AZA) or 6 mercaptopurine (6–MP). The potential risk with the combination of AZA or 6 MP and Simponi should be carefully considered. A risk for the development for HSTCL in patients treated with TNF-blockers cannot be excluded. Colon dysplasia/carcinoma - Screen for dysplasia in all patients with UC who are at increased risk or had a prior history for dysplasia or colon carcinoma. In newly diagnosed dysplasia patients the risks and benefits of continued Simponi use should be carefully assessed. Melanoma (all TNF-blocking agents including Simponi) and Merkel cell carcinoma (other TNF-blocking agents) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. *Heart Failure:* Simponi should be used with caution in patients with mild heart failure (NYHA class I/II). Patients should be closely monitored and Simponi must be discontinued in patients who develop new or worsening symptoms of heart failure. Some cases had a fatal outcome. *Neurological events:* Use of anti-TNF therapy, including Simponi, has been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and peripheral demyelinating disorders. Discontinuation of Simponi should be considered if these disorders develop. Carefully consider the benefits and risks before initiation of therapy in patients with a history of demyelinating disorders. *Surgery:* Patients requiring surgery whilst on Simponi therapy should be closely monitored for infections. *Autoimmune processes:* If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Simponi and is positive for antibodies against double-stranded DNA, treatment should be discontinued. *Haematological reactions:* There have been post-marketing reports of pancytopenia, leukopenia, neutropenia, aplastic anaemia, and thrombocytopaenia in patients receiving TNF-blockers. Cytopenias including pancytopaenia have been reported infrequently in clinical trials. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant haematologic abnormalities. *Vaccinations/therapeutic infectious agents:* It is recommended that live vaccines or any therapeutic infectious agents should not be given concurrently. *Allergic reactions:* If an anaphylactic reaction or other serious allergic reaction occurs, administration of Simponi should be discontinued immediately, and suitable treatment initiated. The needle cover of the pre-filled pen contains latex and may cause allergic reactions in those sensitive to latex. *Special populations:* Adverse events, serious adverse events and serious infections in patients aged ≥65 were comparable to those observed in younger patients. However, caution should be exercised when treating the elderly, particular attention should be paid to infections. There were no patients age 45 and over in the nr-Axial SpA study. *Excipients:* Simponi contains sorbitol (E420). Patients with rare hereditary problems of fructose intolerance should not take Simponi. **Interactions:** Combination of Simponi and other biological therapeutics used to treat the same conditions as Simponi, including anakinra and abatacept is not recommended. **Pregnancy and Lactation:** Administration of Simponi is not recommended during pregnancy or breast-feeding. Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Simponi treatment. **Side-effects: Refer to SmPC for complete information on side effects** *Very Common (> 1/10):* upper respiratory tract infection; *Common (> 1/100):* bacterial infections, lower respiratory tract infections, viral infections, bronchitis, sinusitis, superficial fungal infections, abscess, anaemia, allergic reactions, autoantibody positive, depression, insomnia, dizziness, headache, paraesthesia, hypertension, asthma and related symptoms, dyspepsia, gastrointestinal and abdominal pain, nausea, gastrointestinal inflammatory disorders, stomatitis, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, rash, alopecia, dermatitis, pyrexia, asthenia, injection site reaction, chest discomfort, bone fractures were reported. Serious, including fatal adverse events have been reported including septic shock, lymphoma, leukaemia, melanoma, Merkel cell carcinoma*, hepatosplenic T-cell lymphoma*, leukopenia, thrombocytopaenia, pancytopaenia, aplastic anaemia, serious systemic hypersensitivity reactions (including anaphylactic reaction), skin exfoliation, vasculitis (systemic), sarcoidosis, demyelinating disorders, congestive heart failure, arrhythmia, ischaemic coronary artery disease, thrombosis, interstitial lung disease and lupus-like syndrome. *Observed with other TNF-blocking agents, but not observed in clinical studies with golimumab **Package quantities:** 1 50 mg pre-filled pen containing 50 mg of golimumab in 0.5 ml solution for injection or 1 50 mg pre-filled syringe containing 50 mg of golimumab in 0.5 ml solution for injection or 1 100 mg pre-filled pen containing 100 mg of golimumab in 1 ml solution for injection. **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number:** 50 mg Pre-filled Pen EU/1/09/546/001; 50 mg Pre-filled Syringe EU/1/09/546/003; 100 mg Pre-filled Pen EU/1/09/546/005. **Marketing Authorisation Holder:** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands. **Date of Revision of Text:** December 2015. **Further information is available on request from:** MSD, Red Oak North, South County Business Park, Leopardstown, Dublin D18X5K7 or from www.medicines.ie. **Date of preparation:** May 2016.

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie
Adverse events should also be reported to MSD (Tel: 01-299 8700)

References: 1. EU Summary of Product Characteristics for SIMPONI 12 Jan 2016. 2. Sandborn WJ, Feagan BG, Marano C, et al. Subcutaneous Golimumab Maintains Clinical Response in Patients with Moderate-To-Severe Ulcerative Colitis, Gastroenterology. 2014;146:96-109.

GAST-1118398-0001

MSD Red Oak North, South County Business Park, Leopardstown, Dublin D18 X5K7, Ireland.

Irish Society of Endoscopy Nurses

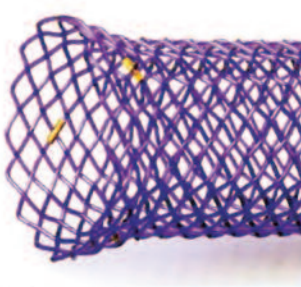
Fitzpartrick's Castle Hotel, Killiney, Dublin

Agenda

Time	Chair	Speaker	Topic
09:00-09:20	Leah Palado	Joy Gordan, Clinical Nurse Manager 2 Tallaght Hospital, Dublin.	Welcome to Dublin.
09:20-09.50	Margaret O Donnell	Eddie Myers RANP Colorectal Screening, Kerry General Hospital Kindly sponsored by Norgine	Adenoma detection – a key quality indicator.
09.50-10.30	Mary Hackett Brennan	Dr Chris Steele National Lead Quality Services. Consultant Gastroenterologist Letterkenny General Hospital.	The Gastrointestinal Endoscopy National Quality Improvement Programme
10:30-11:10	COFFEE	COFFEE	COFFEE
11:10-11:50	Mary Hackett Brennan	Mr. Faisil Awan Consultant Surgeon. St. Luke's Hospital, Kilkenny.	Diathermy and Argon Plasma Coagulation (APC)
11:50-12:20	Margaret O Donnell	Sinead Horgan Group Sepsis Lead South/Southwest Hospital Group.	National Sepsis Programme
12.20-13.00	Sheila King	Dr John Keohane Consultant Gastroenterologist Our Lady of Lourdes Hospital Drogheda.	PEG and PEJ
13:00-14:00	LUNCH	LUNCH	LUNCH
14.00-14.10	Mary Hackett Brenan	Mary Hackett Brennan & Sheila King Chairperson & Vice Chairperson	Future of the ISEN.
14:10-14:50	Louise Mc Carville	Sheila King Vice Chairperson ISEN.	Clinical Audits: Improving patient care and outcomes in Endoscopy.
14:50-15:40	Leah Palado	Dr Gerard Colleran Lecturer at Institute of Technology Tallaght, Dublin.	Microbiological control in Endoscope Reprocessing
15: 40 - 15:50		Margaret O Donnell ISEN Treasurer	Mary Shea Treasurers Report
15:50-16:00	Mary Shea	Deirdre Clune	Education Update /ESGENA Feedback

BD Stent

SX-ELLA Stent Esophageal Degradable BD



- Biodegradation
- Unique delivery system
- Excellent flexibility
- Radiopaque markers

FLEETWOOD HEALTHCARE

EXCELLENCE THROUGH INNOVATION

Biographical Sketches

Padraic MacMathuna
President ISG
Consultant Gastroenterologist
Mater Misericordiae University Hospital, Dublin

1981 UCD graduate with training in Ireland, London and Boston in Gastroenterology. Appointed Consultant Gastroenterologist to Mater University Hospital in 1995. Track record in clinical and laboratory research in areas from Colon Cancer biology, CT Colon Imaging, High Risk colorectal Cancer screening and endoscopic intervention. Appointed Associate Professor of Medicine in recognition of contribution to the postgraduate (Former Postgraduate Dean) and undergraduate academic activity of the Mater and UCD. Currently a member of the NCSS Advisory group on Colorectal Cancer Screening and a participant in the NCSS Expert Group on Herediary Cancer Risk

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

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

Barbara Ryan
Consultant Gastroenterologist,
Tallaght Hospital, Dublin

Barbara Ryan graduated from Trinity College Dublin in 1993. She completed her higher specialist training in Ireland during which time she completed a MSc in Molecular Medicine and also a MD in colorectal cancer biology. She did a fellowship in endoscopic ultrasound at the Klinikum Rechts der Isar, at the 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.

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

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

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 peerreviewed medical literature, many dealing with the importance of resource utilisation and economics in healthcare.

Johnny Cash
Consultant Hepatologist
Royal Victoria Hospital, Belfast

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

Humphrey O'Connor
Consultant Gastroenterologist
Clane General Hospital

A native of Cahersiveen, Co. Kerry, Prof. Humphrey O'Connor M.D., F.R.C.P.I., A.G.A.F., graduated with honours in 1977 from University College Dublin. The Gastroenterology "bug" was acquired during general medical training working for the late great Prof. Oliver Fitzgerald and the recently arrived Dr. Diarmuid O'Donoghue. Specialist training followed in the UK, firstly, in Leeds with Prof. Tony Axon and then Birmingham with Dr. Roy Cockel and Prof. Elwyn Elias. Prof. O'Connor was awarded the BSG Hopkins Endoscopy Prize in 1982. He returned to Ireland in 1989 as Consultant Physician at 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.

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

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

He has been Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast since 1997. During this time, he has developed gastroenterology services in the Ulster Hospital, especially in therapeutic endoscopy and ERCP. His other interests include inflammatory bowel disease (IBD). He has more than 70 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" and the third edition has just been published. He is the Guidelines Editor for Gut and on the international editorial board of Gastrointestinal Endoscopy.

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

Jürgen Mulsow
Consultant
General and Colorectal Surgery

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

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

Paul Lynch
Consultant Gastroenterologist
Antrim Area Hospital

Paul Lynch is a consultant gastroenterologist at Antrim, Causeway and Whiteabbey Hospitals with a particular interest in therapeutic endoscopy and ERCP. He is a graduate of Queen's University of Belfast and undertook his specialist training within the Northern Ireland Deanery which included undertaking a PhD into gastric neuropeptides at QUB. He completed his training with an advanced endoscopy fellowship in Westmead Hospital, Sydney, Australia. Dr Lynch presently sits on the ISG board and has served as the Secretary for the USG from 2009 to 2012 as well as being the organizing chair for the joint BSG and ISG (BIG) meeting held in Belfast in 2013. He has been involved in regional service development for Northern Ireland including services for standardizing the testing of calprotectin and H. pylori and has been the clinical lead for a regional endoscopy reporting program.

Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin

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

David Gibson
Specialist Registrar
St James' Hospital, Dublin

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

Speakers

Ian Tomlinson
Prof of Molecular & Population Genetics
University of Oxford UK

Ian Tomlinson graduated from Trinity College, Cambridge, UK. He has been Group Leader at the MRC Laboratory of Molecular Biology in Cambridge. He spent 11 years at the MRC Laboratory of Molecular Biology in Cambridge, where he initially worked on the completion of the sequencing and mapping of all human antibody genes, and latterly on engineering recombinant antibodies. He is a recognized expert in the field of antibodies and antibody engineering and co-founded the Human Proteome Organisation (HUPO). He serves as a Director at Human Genome Sciences Inc. He has been a Director of Stevenage Bioscience Catalyst Ltd since October 2011. He also serves as Executive Director of Domantis Inc., and Domantis Limited, as a Member of Advisory Board of Syncona Partners and as the Senior Vice President and Head of Biopharmaceuticals R&D and Worldwide Business Development (WWBD).

Helen Fenlon
Consultant Radiologist
UCD/Mater University Hospital

Prof Fenlon is a Consultant Radiologist at the Mater Misericordiae University Hospital, Breast Check and the Mater Private Hospital, and a Clinical Associate Professor at University College Dublin (UCD) School of Medicine and Medical Science.

She graduated with an honours degree from the Faculty of Medicine, UCD in 1989, undertook her pre-fellowship training in Radiology at Faculty of Radiologists of the Royal College of Surgeons in Ireland and the Mater Misericordiae University Hospital from 1992 to 1996 before undertaking a Fellowship in Body Imaging at Boston Medical Centre and Boston University from 1996 to1998. Professor Fenlon was a Staff Radiologist and Section Head of Oncology Imaging and Assistant Professor of Radiology at Boston Medical Centre and Boston University from1998 to 1999 and obtained American Board of Radiology Certification in 1999. She has been involved in many research projects that were grant funded by the RSNA, Irish Cancer Society, Health Research Board, and Science Foundation of Ireland and has over 100 scientific presentations / exhibits, 80 scientific publications, 100 invited lectures, 10 book chapters and one book to her name.

Mark Silverberg
Consultant Gastroenterologist,
Mount Sinai Hospital Toronto, Canada

Dr. Mark Silverberg graduated from the University of Toronto Faculty of Medicine in 1992 and completed his internal medicine and gastroenterology training there in 1997. He then obtained his PhD studying the genetics of inflammatory bowel disease (IBD) in 2002 at the Samuel Lunenfeld Research Institute of Mount Sinai Hospital. He is currently a Professor in the Department of Medicine at the University of Toronto, a clinician-scientist in the Lunenfeld-Tanenbaum Research Institute of Mount Sinai Hospital and a practicing gastroenterologist in the Inflammatory Bowel Disease Group.

Dr. Silverberg's medical practice is devoted to the care of patients with IBD and IBD makes up the majority of his clinical work. He is an active researcher and scientist searching for causes of IBD and also leads clinical trials and clinical research studies in IBD to help improve management and therapy of patients affected by IBD. He is also heavily engaged in training physicians and other allied health staff about the management of IBD.

Dr. Silverberg is an internationally recognized clinician and leader in the field of IBD and lectures around the world. He is an elected member of the International Organization for the study of Inflammatory Bowel Disease (IOIBD), runs a research centre of the NIH IBD Genetics Consortium and is an active participant in the International IBD Consortium. He is the co-chair of the Canadian GI Fellows Program in IBD and the Program Director of the Advanced IBD Fellowship at Mount Sinai. Fellows and students come from around the world to train in this program with the MSH IBD Group.

James East
Consultant Gastroenterologist
Radcliffe Hospital, Oxford

Dr. James East MD(Res) FRCP is a Consultant Gastroenterologist and Endoscopist, and Honorary Senior Clinical Lecturer, based at the Translational Gastroenterology Unit, John Radcliffe Hospital, Oxford. He is Clinical Lead for Endoscopy and Clinical Director of Bowel Cancer Screening Oxfordshire. He trained in Edinburgh, Cambridge and London, with a research fellowship at St. Mark's Hospital leading to an MD from Imperial College. He received the British Society of Gastroenterology's Hopkins Prize on the basis of this work. His research interests include quality in endoscopy, serrated polyps, endoscopy in IBD, and advanced endoscopic imaging and therapy.

Chris Steele
Dr Steele is a Consultant Gastroenterologist in Letterkenny General Hospital. He is also Associate Clinical Director of Endoscopy.

Stephen Patchett
Consultant Gastroenterologist
Bon Secours Hospital - Dublin

Professor Patchett is a Consultant Gastroenterologist working in Beaumont and The Bon Secours hospitals and is also an Associate Clinical Professor in the Royal College of Surgeons Dublin. Having graduated from UCD, he commenced his training in Dublin before moving to London to train in St Bartholomew's and The Royal London Hospitals.

He was appointed Senior Lecturer in Barts in 1996 and returned to take up in current position in Beaumont in November 1998. Professor Patchett's professional interests focus on diagnostic and therapeutic gastrointestinal endoscopy and therapeutics of inflammatory bowel disease. He is currently chair of the working group for the national QA programme in endoscopy and represents the College of Physicians on the QA Steering group and the Conjoint Endoscopy Curriculum development group.

Professor Patchett is also the clinical lead for endoscopy services in both Beaumont hospital and The Bon Secours.In addition he is Chair of the Medical Advisory Committee in the Bon Secours Hospital Dublin, and has served as chairman of the division of Medicine in Beaumont and as National Specialty Director in Gastroenterology.

Derek Power
Medical Oncologist (CUH/UCC)

On graduating in pharmacy from Trinity College in 1994, I worked in Beaumont Hospital for two years as a pharmacist and I also worked as a community pharmacist. I then decided to switch to medicine and applied to the Royal College of Surgeons of Ireland.

I continued to work part-time as a pharmacist during my medical degree and did my training in general medicine back in Beaumont. My oncology training took me to St James's Hospital, the Mater hospital and Beaumont. I then spent three years training with leading oncologists in the Memorial Sloan Kettering Cancer Centre in Manhattan, one of the largest cancer centres in the world.

I moved back from New York to take up the position of consultant oncologist working between the Mercy Hospital in Cork and Cork University Hospital (CUH).

Roel Hompes
Consultant Colorectal and General Surgeon
Oxford, UK

Mr Roel Hompes, General Surgery, Colorectal. Mr Roel Hompes graduated as MD at the Catholic University of Leuven, Belgium, Cum Laude, in 2002. He became a surgeon in 2008, and has undergone extensive training in the field of coloproctology and abdominal wall surgery. He received postgraduate training in coloproctology and pelvic floor surgery in two renowned UK expert centres, Oxford and Basingstoke.

Since 2013, Mr Hompes has been a consultant surgeon at the Department of Colorectal Surgery at the Oxford University Hospitals NHS Trust. He is especially skilled in minimally invasive surgery, including laparoscopic (keyhole) and transanal surgery (TEM/TAMIS).

Mr Hompes has published several peer-reviewed scientific papers and book chapters, with a main focus on pelvic floor pathology and minimal invasive techniques. He has given talks on pelvic floor disorders and minimal invasive colorectal surgery at various international surgical meetings, and has trained numerous other surgeons in the technique.

Other interests include recurrent rectal cancer, new surgical technologies and training.

Mr Hompes has current research interests in transanal minimally invasive surgery (TAMIS) and transanal total mesorectal excision of the rectum (TME). He is also involved in research into local excision for rectal cancer, abdominal wall reconstruction and recurrent rectal cancer. He has a keen interest in developing robotic surgery for colorectal procedures.

Des Winters
Prof Des Winters is a Consultant General Surgeon Colo-rectal in St. Vincent's University Hospital.

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Oral Presentations – Winter Meeting 2016

Ref	Author	Title of Paper	Day	Time
111	L Barry	Can symptoms predict findings of High Resolution Ano-refectal Manometry?	Thurs. 24th	13.30
113	L Daly	Malnutrition impacts on quality of life and survival in gastrointestinal cancers: a cross-sectional study of 509 ambulatory patients undergoing chemotherapy	Thurs. 24th	13.40
121	J Brown	Mechansims underpinning successful Faecal microbiota transplantation (FMT) for recurrent Clostridium difficile infection.	Thurs. 24th	13.50
141	Louise Elliott	Myeloid Cell interaction with the Tumour Microenvironment and tumour phenotype in Colorectal Cancer	Thurs. 24th	14.00
146	Mary Hussey	Feasibility of same day Colon capsule endoscopy (CCE) in patients with incomplete colonoscopy.	Thurs. 24th	14.10
108	D O'Donoghue	BowelScreen, The National Screening Programme for Colorectal Cancer: Round 1: Achievements and Challenges	Thurs. 24th	14.20
114	G. Elsafi	Cost Effectiveness of introduction of IBDoc faecal calprotectin post induction of biological agents	Thurs. 24th	16.00
158	J. O'Connell	A Multicentre Retrospective Study of Golimumab Therapy outcome in U.C.	Thurs. 24th	16.10
164	Catherine Rowan	An Steig- Stelara Treatment Effectiveness in Irish Gastroenterology; a multicentre retrospective analysis of treatment outcomes with Ustekinumab in Crohn's Disease.	Thurs. 24th	16.20
169	Z Heetun	CD4+ and CD8+ T cells in Crohn's disease show a dysfunctional and incongruent response to TCR ligation	Thurs. 24th	16.30
102	Anne-Marie Byrne	Identification of novel PGE2 Receptor Antagonists that modulate angiogenesis and inflammation in Oesophageal Adenocarcinoma	Fri. 25th	09.00
124	Cara Dunne	Indications and Outcomes of Intestinal and Multivisceral Transplant at Addenbrooke's Hopsital Cambridge	Fri. 25th	09.10
126	Denise Brennan	Tailored therapy versus standard triple therapy for first-line eradication of H. pylori infection	Fri. 25th	09.20
127	Grainne Holleran	Serum Angiopoietin-2 is an accurate capsule endoscopy screening tool for the detection of small bowel angiodysplasia	Fri. 25th	09.30
128	A O'Malley	Paediatric Eosinophilic Oesophagitis in Ireland – A 10 Year Review of Incidence, Presenting Symptoms, Phenotype and Management at Diagnosis.	Fri. 25th	09.40
139	Deirdre McNamara	The Irish Helicobacter pylori Working Group consensus for the diagnosis and treatment of Helicobacter pylori infection in adult patients in Ireland.	Fri. 25th	09.50

ABSTRACT 1 (111) ORAL PRESENTATION

Can symptoms predict findings of High Resolution Ano-rectal Manometry?

Author(s)
L Barry1, L Quinlivan1, G Elfasi2, M Farman2, J McCarthy2 & M Buckley1&2

Department(s)/Institutions
1. GI Function Clinical Measurement Laboratory, Mercy University Hospital, Cork
2. Department of Gastroenterology, Mercy University Hospital, Cork

Introduction
Constipation is a common problem thought to affect up to 27% of the general population. The health care costs of constipation are significant as evidenced by the hundreds of million euros spent yearly on laxatives alone. Despite the high prevalence of constipation the management of these patients can vary widely.

Aims/Background
HRAM not only allows for measurement of anorectal sphincter function but also allows for a better understanding of the dynamic processes of defecation. Poor toileting behaviour and inappropriate recruitment of pelvic floor muscle is a significant factor on the pathophysiology of constipation.

Method
We retrospectively reviewed HRAM tracings of 80 (64F) consecutive patients attending our GI Function Laboratory between October 2015 and Sept 2016. 23 of these patients (19F) presented primarily with features of constipation. We analysed the pattern of simulated defecation as per Rao classification of dyssynergic defecation.

Results
23 of 80 patients who attended our laboratory for HRAM were classified as presenting with symptoms of Constipation. 82.6% were female (mean age 48 +/-17yrs). The predominant symptom in these patients was incomplete evacuation (47.8%). The remaining 52.2% of patients had non-specific constipation without predominant pelvic floor/anorectal symptoms.
40% were categorised with HRAM patterns revealing Rao Type IV Defecatory Dyssynergia, 10% RaoType I, 20% Rao Type II & 20% Rao Type III. 10% of patients with symptoms of incomplete evacuation had a normal defecatory pattern on HRAM.
In those patients with constipation who did not complain primarily of incomplete evacuation (52.2%- disparate symptoms) 33% were classified as Rao Type IV, 25% Rao Type II, 16.6% Rao Type I & 16.6% Rao Type III. One patient had a normal defecatory pattern (4.4%) and one had a large rectal prolapse and Rao was not classified.

Conclusions
In all patients with constipation we found that defecatory dyssynergia is a common finding. Symptoms of incomplete evacuation alone do not solely predict obstructed defecation. In those with disparate symptoms of constipation such as abdominal pain, infrequent bowel movements & pain on defecation defecatory dyssynergia is very common and it is unclear if this is a primary or secondary phenomenon in these patients.

ABSTRACT 2 (113) ORAL PRESENTATION

Malnutrition impacts on quality of life and survival in gastrointestinal cancers: a cross-sectional study of 509 ambulatory patients undergoing chemotherapy

Author(s)
L Daly1, E Ní Bhuachalla1, S Cushen1, DG Power2, P McEneaney3, AM Ryan1.

Department(s)/Institutions
1Nutritional Science, University College Cork, Cork, 2Medical Oncology, Mercy and Cork University Hospital, Cork, Ireland.3Dept of Radiology, the Mercy University Hospital, Cork.

Introduction
Malnutrition is common in oncology and negatively impacts on clinical outcomes.

Aims/Background
The aim of this study was to assess the nutritional status of our cohort and the impact of malnutrition on quality of life (QOL) and survival.

Method
A cross sectional study of adult patients with gastrointestinal cancers undergoing chemotherapy between 2012-2016 was conducted. A survey was devised, incorporating clinical, nutritional, biochemical and QOL data (EORTC). Nutritional status was evaluated using cancer cachexia diagnostic criteria and CT assessment of body composition to define sarcopenia (low muscle mass) and myosteatosis (poor muscle quality). Univariate and multivariate analyses for overall survival were conducted using cox proportional hazards model; hazards ratios (HR) and corresponding 95% confidence intervals (CI) were obtained.

Results
509 patients with gastrointestinal cancers participated in the study, 336 (66%) were male with a median age of 65 years (IQR 57-71 years). Colorectal cancer accounted for (54%), followed by gastro-oesophageal cancer (29%) and hepatobilliary cancer (17%). 56% had a BMI>25kg/m2, while only 4.5% had visible malnutrition (BMI<18.5kg/m2). 41% of patients had lost >5% body weight in 6 months, 50% had cancer cachexia, 41% were sarcopenic, 46% had myosteatosis, 24% had both sarcopenia and myosteatosis. Regarding QOL, weight loss >5% and cancer cachexia were significantly associated with poorer global QOL scores, as well as worse physical, role, emotional and social function scores (all $p<0.05$) and higher symptoms, e.g. fatigue, nausea and vomiting, pain and appetite loss (all $p<0.05$). Patients with sarcopenia, myosteatosis or both had a lower overall survival of 19.3 months (95% CI: 15.6- 23.0) compared to patients without these features (36.4 months, 95% CI: 25.6- 47.1 months, $p=0.012$). On multivariate analysis, controlling for age (>65 vs. <65 years), gender, performance status (ECOG, 2-4 vs. 0-1), cancer stage (IV vs. I-III), patients with an abnormal body composition feature had an increased risk of mortality (HR 1.6, 95% CI: 1.15-2.30, $p=0.011$).

Conclusions
Malnutrition and abnormal body composition features are common in patients with gastrointestinal cancer, but are masked by excessive adiposity. Malnutrition adversely impact on patients QOL and survival. Treatments to increase muscle mass and influence outcome warrant further investigation.

ABSTRACT 3 (121) ORAL PRESENTATION

Mechansims underpinning successful Faecal microbiota transplantation (FMT) for recurrent Clostridium difficile infection.

Author(s)
Brown J,1,2 Sheehan D,1,4 Flemer B,1,2 Zulquernain S. A,1,4 Gahan C,1,2 Joyce S,1,3 Shanahan F 1,4, O'Toole PW1,2

Department(s)/Institutions
APC Microbiome Institute, University College Cork
School of Microbiology, University College Cork
Dept of Biochemistry, University College Cork
Dept. Of Medicine, University College Cork

Introduction
FMT is an effective treatment for recurrent Clostridium difficile infection (CDI). We used microbiota analysis to elucidate the abnormal microbiota of patients with CDI, the changes that occur with and factors that determine successful FMT and the mechanisms that underpin susceptibility to CDI.

Aims/Background
Perform successful FMT for recurrent CDI. Characterise donor microbiota and recipient microbiota changes pre/post FMT. Study changes in bile acids and fatty acids.

Method
FMT was administered via endoscope into the doudenum and colon. Faecal samples were collected from donors and patient pre and post FMT. The microbiota was profiled by rRNA gene sequencing.

Results
Nine FMTs were peformed between January 2015 and December 2015. 8/9 were CD negative following one FMT, 1/9 required a second FMT. FMT resulted in partial recovery of microbiota diversity and establishment of a donor-like microbiota. Alpha diversity was significantly lower ($p<0.01$) prior to FMT but recovered to levels observed in donors. Abundance of individual genera, including Proteus, Fusobacterium, Clostridium_XVIII, Escherichia/Shigella, Klebsiella and Streptococcus was significantly higher in patients with CDI compared to donors($p<0.0001$). Abundances of these bacteria approached donor-levels post-FMT indicating successful colonization and established communities from the donor. Decreased levels of taxa including Prevotella, Clostridium XIVb, Faecalibacterium and Roseburia were observed.

Secondary and tertiary bile acids significantly increased in recipients post-FMT compared to the pre-FMT samples. The overall profile of bile acids as well as individual bile acids significantly correlated with the abundance of several bacterial OTU's. Lachnospiraceae, Ruminococcus and Clostridium XIVa were negatively associated with primary bile acids and positively with secondary bile acids and GDCA. Taxa including Anaerostipes, Enterococcus and Sutterella were positively associated with primary bile acids levels and negatively to secondary bile acids and GDCA.

Conclusions
FMT is an effective,viable treatment for patients with rCDI. It results in an microbiota that resembles the donor with significant increase in microbiota diversity. FMT restores secondary bile acids. Secondary bile acid production is dependant on specific microbiota. Depletion of these bacteria via antibiotics and resultant loss of beneficial effects of secondary bile acids may be a factor in CDI. This study also supports a bile acid mechanism to underpin efficacy of FMT

ABSTRACT 4 (141) ORAL PRESENTATION

Myeloid Cell interaction with the Tumour Microenvironment and tumour phenotype in Colorectal Cancer

Author(s)
Louise Elliott, Kieran Sheahan, Glen Doherty, Elizabeth Ryan

Department(s)/Institutions
The Centre for Colorectal Disease, St Vincent's University Hospital University College Dublin

Introduction
Tumour promoting inflammation is now recognised to play an important role in tumour progression. Central to this is the innate immune response.

Aims/Background
Here we characterise the innate cellular mechanisms at play in the CRC tumour microenvironment (TME).

Method
Fresh samples of tumour and uninvolved tissue were obtained from patients with Stage II/III CRC undergoing surgical resection. We compared the cytokine/chemokine profile (n=50) from tumour (TCM) and uninvolved (NCM) tissue. Next, we analysed the composition of myeloid cells infiltrating the tumor tissue and uninvolved tissue employing flow cytometry. We then investigated the mechanism by which of tumour released soluble factors influence monocyte function.

Results
We found elevated levels of inflammatory mediators, CCL5 ($p < 0.0001$), CCL3, MMP-9, GDF-15, IL-1β, and TNF-α in TCM compared to NCM whereas significantly lower levels of IL-6 and CCL2 were detected. Hierarchical cluster analysis using the cytokine data identified 2 clusters. Cluster 2 had significantly higher levels of CCL2 ($p <0.30$), CCL3 ($p < .001$, TNF-α ($p < .033$), MMP-9 ($p < .007$) and IL-6 ($p < .000$). The proinflammatory signature of cluster 2 was associated with negative prognostic markers (stage and Lymphovascular invasion (LVI)). In the tissue we found a marked increase in two distinct myeloid subsets HLA-DRhiCD11chiCD14hi (monocyte) and CD11bhiCD15hi (neutrophil). In support of their potential immune-regulatory and proangiogenic function, we showed that the monocyte subset expressed ILT4, PDL1 and Tie-2. Furthermore, this subset expressed high levels of activation markers CD80, CD86 and CD40 and the chemokine receptor CCR5, the ligand for CCL3.
In vitro studies showed that TCM activated the mTOR pathway in monocytes whereas cancer cell line conditioned monocytes upregulated CD40 and PD-L1 surface expression. Finally we showed that CD40 ligation induced higher production of IL-6, TNF-α, and IL-1β in CCL conditioned monocytes compared to unconditioned monocytes.

Conclusions
We demonstrate that the TME recruits inflammatory monocytes via the chemokine-chemokine receptor network CCL3-CCR5, subsequently transforming them into a highly activated but immune-regulatory cell that favors tumor growth.

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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 Older People*: A course of treatment consists of two litres of MOVIPREP. A litre of MOVIPREP consists of one Sachet A and one Sachet B dissolved together in water to make one litre. This one litre reconstituted solution should be drunk over a period of one to two hours. This process should be repeated with a second litre of MOVIPREP to complete the course. A further litre of clear fluid is recommended during the course of treatment. The two litres of MOVIPREP may be consumed either as a 'divided dose', one litre the evening before the procedure and one litre in the early morning of the procedure, or as a 'single dose' of two litres the evening before the procedure or two litres in the morning of the procedure. For the 'divided dose' there should be at least one hour between the end of intake of fluid and the start of the procedure. For the 'single dose' in the morning of the procedure, there should be at least two hours between the end of intake of MOVIPREP and at least one hour between the end of the intake of any clear liquid and the start of the procedure. No solid food should be taken from the start of the treatment and until after the procedure. Patients should be advised to allow for the appropriate time to travel to the colonoscopy unit. *Children*: Not recommended in children below 18 years of age. **Contra-indications, warnings etc:** *Contra-indications:* Known or suspected hypersensitivity to any of the ingredients, gastrointestinal obstruction or perforation, disorders of gastric emptying, ileus, phenylketonuria, glucose-6-phosphate dehydrogenase deficiency, toxic megacolon which complicates very severe inflammatory conditions of the intestinal tract. Do not use in unconscious patients. *Warnings*: Diarrhoea is an expected effect. Administer with caution to fragile patients in poor health or patients with serious clinical impairment such as impaired gag reflex, or with a tendency to aspiration or regurgitation, impaired consciousness, severe renal insufficiency, cardiac impairment (NYHA grade III or IV), those at risk of arrhythmia, dehydration, severe acute inflammatory disease. Dehydration, if present, should be corrected before using MOVIPREP. The reconstituted MOVIPREP does not replace regular fluid intake and adequate fluid intake must be maintained. Semi-conscious patients or patients prone to aspiration should be closely monitored during administration, particularly if this is via a naso-gastric route. If symptoms indicating arrhythmia or shifts of fluid or electrolytes occur, plasma electrolytes should be measured, ECG performed and any abnormality treated appropriately. In debilitated fragile patients, patients with poor health, those with clinically significant renal impairment, arrhythmia and those at risk of electrolyte imbalance, the physician should consider performing baseline and post-treatment electrolyte, renal function test and ECG as appropriate. The possibility of serious arrhythmias, predominantly in those with underlying cardiac risk factors and electrolyte disturbance cannot be ruled out. If patients experience symptoms which make it difficult to continue the preparation, they may slow down or temporarily stop consuming the solution and should consult their doctor. MOVIPREP containing orange flavour is not recommended for patients with glucose and galactose malabsorption. MOVIPREP contains 56.2 mg of absorbable sodium per litre (caution in patients on a controlled sodium diet), 14.2 mg potassium per litre (caution in patients with reduced kidney function or patients on a controlled potassium diet). **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, pyrexia, vomiting, dyspepsia, hunger, thirst, sleep disorder, headache, dizziness, and rigors. *Uncommon or unknown:* Dysphagia, discomfort, abnormal liver function tests, allergic reactions including rash, urticaria, pruritus, erythema, angioedema and anaphylaxis, dyspnoea, electrolyte disturbances, dehydration, convulsions associated with severe hyponatraemia, transient increase in blood pressure, arrhythmia, palpitations, flatulence and retching. Refer to the Summary of Product Characteristics (SmPC) for full list and frequency of adverse events. **Overdose:** In case of gross accidental overdosage, conservative measures are usually sufficient. In the rare event of severe metabolic derangement, intravenous 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 25°C 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: +44 (0) 1895 826606 E-mail: medinfo@norgine.com MOVIPREP® is a registered trademark of the NORGINE® group of companies. **Date of preparation/revision:** July 2015. Ref UK/MPR/0715/0060

United Kingdom

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 826606.

Ireland

Adverse events should be reported to Medical Information at Norgine Pharmaceuticals Ltd on +44 (0) 1895 826606.

References:

1. Worthington J *et al*. Curr Med Res Opin 2008;**24**(2):481–88.

Date of preparation: July 2015.

NORGINE

UK/MPR/0715/0063

ABSTRACT 5 (146) ORAL PRESENTATION

Feasibility of same day Colon capsule endoscopy (CCE) in patients with incomplete colonoscopy.

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Introduction
Rates of incomplete colonoscopies (IC) range from 2-19%, requiring repeat procedures or radiological imaging. Same-day CCE may offer a more convenient and cost-effective mode of colonic examination post IC.

Aims/Background
To determine the feasibility of same-day CCE

Method
A prospective pilot study was performed.Any patient without a contraindication to CCE with an IC for reasons other than poor bowel prep was offered the test following an appropriate recovery time of 1-hour post IC.Informed consent was obtained. Upon ingestion of the capsule,where feasible,10mg of IV metoclopramide was given to overcome the antimotility effects of fentanyl. Standard booster protocol for CCE was administered. Patient demographics,procedure indication, sedation levels along with key CCE data including preparation quality, completion&positivity rates and adverse events were all recorded.

Results
To date,32 CCE have been completed. The mean age was 57 yrs.(22-83 yrs.) and 65%(21) were female. Indications for OC were;altered bowel habit 31%(n=10), Iron deficiency anaemia 25%(n=8),IBD 16%(n=5),PR bleeding 6%(n=2),abdominal pain 6%(n=2),polyp surveillance 6%(n=2),positive family history of CRC 6%(n=2) and abnormal imaging 3% (n=1). OC were incomplete due to excessive looping 41% (n=13), patient intolerance 31% (n=11) and severe diverticular disease 25% (n=8). The mean sedation used during OC was 5 mg midazolam (range 3-10mg) and 75mcg of fentanyl (range 50-100mcg). In all 84% (n=26) of CCE were complete, however full colonic views were obtained in 94% (n=32). Mean colonic passage time was 222 minutes and overall image quality was deemed to be excellent in 16% (n=5), good in 31% (n=10), adequate in 44% (n=14) and poor in 9% (n=3) of participants. Overall findings were normal 25% (n=8), polyps 38% (n=12), inflammation 22% (n=7), diverticular disease 25% (n=8), Angiodysplasia 3% (n=1). Amongst the patients who had polyps 7 required polypectomies and the remaining 5 were put on a surveillance programmes. Based on the CCE findings, 4 of the IBD patients required treatment escalation. In terms of adverse events one patient reported abdominal pain during the procedure and one patient retained the capsule.

Conclusions
CCE would appear to be feasible in the majority of patients and significantly detects colonic pathology.

ABSTRACT 6 (108) ORAL PRESENTATION

Bowelscreen, The National Screening Programme for Colorectal Cancer: Round 1: Achievements and Challenges

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Introduction
BowelScreen - The National Bowel Screening Programme for Colorectal Cancer, commenced in 2013 and completed the first round at the end of 2015. This is one of the first national programmes to employ the Faecal Immunochemical Test (FIT) as its primary screening modality.

Aims/Background
The aim and potential impact of the programme is a lifetime reduction in the incidence of colorectal cancer by 14% and a reduction in mortality from this disease by 36% (HIQA, Health Technology Assessment 2009)

Method
Individuals aged 60-69 were invited to participate in Round 1. Those with a positive FIT were offered a colonoscopy in one of 14 JAG approved screening colonoscopy units. All histology specimens were analysed in the local designated cancer centre. Any surgery required was likewise offered in the cancer centres.

Results
Participation rate was 40%, below the target of 45%, with males accounting for 38%. 5% of FIT returns were positive and of these 93% attended for colonoscopy. 82% of colonoscopies were offered within 4 weeks (standard > 90%). 4,194 colonoscopies (52.6%) yielded 11,904 adenomas of which 29% were deemed high risk (5 or more small polyps or at least 1 > 2cms). In addition 599 sessile serrated lesions (SSLs) were removed. Final staging of 518 cancers is awaited but early analysis suggests more than 50% will be within stage I and II. 51 stage I cancers have been treated by endoscopic resection alone

Conclusions
Round 1 of BowelScreen has delivered impressive results as regards the detection of early stage bowel cancer. Moreover the detection of an additional 1,200 individuals harbouring high risk adenomas bodes well for the aim of reducing the prevalence of colorectal cancer and becoming one of the most significant public health interventions in Ireland. The single biggest challenge facing the programme is colonoscopy capacity, a problem preventing its expansion into the 55-74 year age range.

ABSTRACT 7 (114) ORAL PRESENTATION

Cost Effectiveness of introduction of IBDoc faecal calprotectin post induction of biological agents

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Introduction
Traditionally in our unit all IBD patients started on anti-TNF therapy are followed up at 3 months in the clinic and we aim to do

a colonoscopy at 6 months to assess the mucosal healing.
Recently we have started using a relatively new technology, called IBDoc which allows testing the faecal calprotectin at home using a smart phone application and the results are automatically updated in our database

Aims/Background
Objective of this study was to evaluate the cost effectiveness of using IBDoc faecal calprotectin post induction of biological agents

Method
The data was collected retrospectively from our IBDoc data base. All patients that were commenced on anti-TNF therapy for IBD and trained in using IBDoc at home were included. IBDoc faecal calprotectin was tested at 3 and 6 month post induction of biological agents

Results
Total number included in the study was 131 patients. 40% had normal calprotectin at 3 month saving 53 follow up clinic visits (cost of clinical visit 140 euro), and 75% of them had a normal faecal calprotectin at 6 months saving 40 routine colonoscopy(cost of colonoscopy 654 euro).
78 patients had a raised faecal calprotectin at 3 month, of which 28% had a normal faecal calprotectin at 6 month saving 22 follow up colonoscopy.
In total 53 clinical visits and 62 colonoscopies were saved. At a cost of 40 euro per IBDoc, 37,488 euro was saved.

Conclusions
this study demonstrate a significant cost effectiveness of using IBDoc faecal calprotectin testing post induction of anti-TNF therapy, as well as reducing the waiting time for both clinic visits and colonoscopies

ABSTRACT 8 (158) ORAL PRESENTATION

A Multicentre Retrospective Study of Golimumab Therapy Outcome in Ulcerative Colitis

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Introduction
Golimumab (GLB) is a subcutaneous anti-tumour necrosis factor alpha (anti-TNF) therapy. Randomized controlled trials have demonstrated the efficacy of GLB in inducing and maintaining remission in ulcerative colitis (UC). Data are few on the efficacy of GLB as therapy for UC in routine clinical practice.

Aims/Background
To describe the outcome of Golimumab therapy for UC in routine clinical practice in Ireland.

Method
Six Irish centers participated and identified UC patients receiving GLB therapy for UC (n=77) Only subjects with 6 months of follow up were included (n=69). Primary endpoints were 3-month clinical response and 6-month corticosteroid free remission rates. Clinical response was defined as a decrease from baseline in partial Mayo score of at least 3 points and ongoing receipt of GLB. Clinical remission was defined as a partial Mayo score of less than or equal to 2 and continuing receipt of GLB. Secondary endpoints included rates of dose optimisation, dose intervention strategy, differences in outcome by maintenance schedule and adverse events.

Results
The study cohort comprised n=69 UC patients. Cohort baseline characteristics (continuous variables median [range]): Age 40.8 years [21.3 – 76.8]; 57% male; disease duration 5.8 years (0 – 29); baseline clinical Mayo subscore 6 [0 – 8]. Proportions on 5-ASA, immunomodulator and corticosteroids were 78%, 48% and 40% respectively. 63% were anti-TNF naïve; 27% and 10% having previous exposure to 1 and 2 anti-TNF agents respectively. Proportions receiving GLB 50mg and 100mg 4-weekly were 42% and 58% respectively. 3-month clinical response and 6-month corticosteroid free clinical remission rates were 45% and 49% respectively. 41% required GLB dose optimisation: 44% dose increase and 56% interval shortening. There was a non-significant trend toward a shorter time to GLB discontinuation in GLB 50mg compared with 100mg 4 weekly maintenance regimens: median time to discontinuation 11.8 versus 18.7 months, (p=0.11). Significant adverse events occurred in 3% of patients.

Conclusions
These real world clinical data demonstrate GLB is a safe and effective induction and maintenance agent for UC. GLB dose optimisation is frequently required. GLB 100mg 4-weekly maintenance regimen may be associated with a more sustained therapy response however this finding needs confirmation.

ABSTRACT 9 (164) ORAL PRESENTATION

An Steig-Stelara Treatment Effectiveness in Irish Gastroenterology; a multicentre retrospective analysis of treatment outcomes with Ustekinumab in Crohn's Disease.

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Introduction
A previous trial of Ustekinumab in Crohn's disease patients demonstrated a clinical response rate of 39.7% 1 with Phase 3 studies awaiting publication.

Aims/Background
To evaluate the Irish experience of Ustekinumab in Crohn's Disease (CD) 2011-2016

Method
A multicentre retrospective analysis of patients with CD treated with Ustekinumab was performed through the INITiative IBD Network.
Data collected included patient demographics, disease distribution, previous treatments, surgery, concomitant therapies, induction dose, escalation of therapy, surgery post-treatment, sustained benefit at 12 months.

Results
44 patients (15 male; 7 smokers) were included. Median age was 39.5 years (IQR 30.75-49.75years).Median duration of follow-up was 589 days (IQR 371-1114 days).
41 patients (93%) had prior Crohn's-related surgery, with 27 patients (34%) having more than 1 surgical procedure.
All patients had been treated previously with at least 1 anti-TNF agent. 22.7% of patients had failed therapy with 3 anti-TNF agents. Various induction regimens were utilised. All patients received subcutaneous induction dosing.The median cumulative induction dose was 225mg (range 135-270mg). 18.2% (n=8) were taking concomitant immunomodulators and 25% concomitant steroids at induction.
In 16 cases (36.4%) the dose or frequency of Ustekinumab was escalated.
12 patients had a sustained clinical benefit at 12 months.
21 patients of 44 (48%) had sustained benefit at 12 months; 2 patients subsequently discontinued therapy. The median duration of treatment for the entire cohort was 365 days (IQR 90-969 days).
11 patients had surgery while on Ustekinumab.
Failing 3 anti-TNF therapies was significantly associated with requiring surgery in the 12 months post-induction with Ustekinumab. (P=0.017)
In regression analysis escalation of therapy was significantly associated with sustained benefit at 12 months (p=0.017), while concomitant immunomodulators, steroids and cumulative induction dose were not.

Conclusions
In this study, Ustekinumab provided sustained clinical benefit to almost half of patients with medically-refractory Crohn's Disease. These data suggest that induction therapy with subcutaneous Ustekinumab may be an alternative to iv induction. The findings highlight that escalation of therapy is associated with sustained benefit at 12 months. As with anti-TNF therapy, dose optimisation appears to be critical in inducing and maintaining response with Ustekinumab.

ABSTRACT 10 (16W169) ORAL PRESENTATION

CD4+ and CD8+ T cells in Crohn's Disease show a dysfunctional and incongruent response to TCR ligation.

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Introduction:
The mechanisms underlying T cell dysregulation in Crohn's disease (CD) remain ill-defined.

Aims/Methods:
We compared the phenotype, cytokine profile and proliferative capacity of intestinal T cells obtained from patients with CD to those isolated from healthy ileum in an effort to identify the key factors controlling T cell dysregulation.

Results:
We found a marked increase in CD39+ T regulatory cell (Treg) frequency in inflamed tissue, suggesting altered T cell homeostasis in CD is not simply dependent upon the absence of Treg cells. Next we investigated the cytokine secretion profiles of gut-resident T cells. While CD4+ T cells of CD patients secreted high levels of Th17 and Th1 cytokines, we found comparable levels were produced by cells isolated from healthy gut. Counterintuitively, CD8+ T cells of CD patients consistently produced less IFNγ than controls. Finally, we found that patient CD4+ and CD8+ T cells proliferated robustly in response to anti-CD3. The CD8+ T cells were maximally stimulated with anti-CD3 alone and did not show increased proliferation when co-stimulated with anti-CD28, but upregulated PD-1 expression. Proliferation of patients' T cells was resistant to the suppressive effects of steroids or anti-TNF drugs in vitro. This may be due to elevated levels of pSTAT5a in these cells.

Conclusion:
Our findings of a dysfunctional CD4+ and CD8+ T cell response to TCR ligation provides novel information in CD pathogenesis and a possible avenue for new targeted therapies.

*ZH is supported by the AbbVie Inflammatory Bowel Disease Newman Fellowship

ABSTRACT 11 (102) ORAL PRESENTATION

Identification of novel PGE2 Receptor Antagonists that modulate angiogenesis and inflammation in Oesophageal Adenocarcinoma

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Introduction
Oesophageal adenocarcinoma (OAC) is the 7th leading cause of cancer deaths worldwide, with its incidence increasing. COX-2 is overexpressed in the progressive sequence from Barrett's oesophagus to OAC. While COX-2 inhibitors hold promise for prevention/treatment, they have been associated with cardiovascular toxicity. Downstream, prostaglandin E2 (PGE2) and its corresponding EP receptors are associated with angiogenesis and tumourigenesis in a number of cancers, including OAC.

Aims/Background
This study investigated PGE2 receptor (EP) antagonism as a novel approach for OAC prevention and/or treatment.

Method
The effect of selective EP blockade (EP1-4 antagonists) on blood

vessel formation was investigated in-vivo using a transgenic zebrafish model (TgEGFP fli-1). EP receptor expression was assessed by qRT-PCR and western analysis. An ex-vivo human 3D-explant model was established by culturing Barrett's and matched control patient tissue to investigate the effects of selected EP antagonists. Angiogenic and inflammatory protein secretions were assessed using multi-plex ELISAs and correlated with PGE2 expression

Results
The EP receptor antognists 1-4 all reduced vessel formation in-vivo in the zebrafish model. EP2 and EP4 were expressed in endothelial, Barrett's oesophagus and Oesophageal cancer cell lines. Explant culturing revealed significantly higher PGE2 levels in Barrett's tissue, relative to matched normal and was associated with inflammatory factors IL1-β, IL-2, IL-6, IL-10 (all $p<0.01$), and TNF-α ($p<0.0001$). Significant reductions in secretion of IL-2, IL-10, IL-13, and TNF-α were observed following selective EP2 antagonism ($p<0.05$).

Conclusions
Selective EP antagonism has anti-angiogenic and anti-inflammatory effects in-vivo. The ability of selective EP antagonists to reduce inflammatory cytokine secretion suggests they may be promising chemopreventative agents.

ABSTRACT 12 (124) ORAL PRESENTATION

Indications and Outcomes of Intestinal and Multivisceral Transplant at Addenbrooke's Hopsital Cambridge

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Introduction
Referrals to the Multivisceral Transplant service at Addenbrooke's have increased year on year since 2011 with 18 referrals then to 41 referrals in 2015. So far this year, there have been 29. Longstanding indications include complications of parenteral nutrition in patients with type 3 Intestinal Failure (IF-associated liver disease (IFALD), recurrent catheter-related infections and loss of vascular access), cirrhosis with extensive portomesenteric venous thrombosis precluding an isolated liver transplant and the need for extensive evisceration due to benign tumour

Aims/Background
We describe the indications and outcomes for Intestinal and Multivisceral transplant at Addenbrooke's Hospital, Cambridge, UK

Method
Data was collected prospectively on an internal database of patients transplanted from January 2006 to September 2016

Results
Between January 2006 and September 2016, 69 transplants were performed in 64 patients. 27 (42%) received a transplant for complications relating to intestinal failure, 14 (21%) received a multivisceral graft because an isolated liver transplant was not possible due to extensive portomesenteric venous thrombosis. An increasing indication is that of 'acute abdominal catastrophe' – 9 patients were transplanted for this. Other indications included desmoid tumours (4), re-transplant (6), short bowel and renal failure (2). The median length of hospital stay post transplant is 77 days. 7 patients had a proven episode of acute cellular rejection (ACR) within 90 days, 12 patients had an episode between 90 days and 1 year and 7 had ACR after 1 year. 3 grafts required removal due to rejection and all 3 patients have been re-transplanted. 1 year patient survival for SB recipients is 92%, for MMV is 89% and for MVT/LSB is 71%. 3 year patient survival for SB recipients is 83%, for MMV is 89% and for MVT/LSB is 53%.
Conclusions: Transplantation of intestinal-containing grafts is technically challenging. Recipients have a higher rate of complications compared to other solid organ transplants. Intestinal or Multivisceral transplant should be considered for certain patients who have suffered an abdominal catastrophe, are unable to have a liver transplant due to extensive portomesenteric thrombosis, or have complications arising from intestinal failure. Timely referral to a transplant centre and careful follow-up is essential to continuing to improve outcomes

ABSTRACT 13 (126) ORAL PRESENTATION

Tailored therapy versus standard triple therapy for first-line eradication of H. pylori infection

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Introduction
In many countries, including Ireland, eradication rates for standard clarithromycin-based triple therapy have fallen below the 80% deemed acceptable for a given treatment.
Aims/Background:To compare eradication rates of standard clarithromycin-based triple therapy with those of tailored therapy based on antimicrobial susceptibility as a first-line treatment for H. pylori.

Method
Treatment-naïve adult patients undergoing endoscopy were prospectively recruited. Biopsies from H. pylori-positive patients (assessed by CLO test or histology) were processed for culture and sensitivity testing by E-testing and genotyping using the GenoType HelicoDR assay (Hain). Patients randomly received either clarithromycin-based standard triple therapy or tailored treatment based on antibiotic sensitivities. A follow-up breath test was performed at least 8 weeks post-treatment.

Results
To date 760 patients CLO tests have been assessed and 165 (21.7%) were H. pylori positive. Infected patients were significantly younger (mean age 48.4 vs 52.8 years, $p=0.002$) and tended to be male

(51.5% vs 43.7%, p= 0.08). Of 165 H. pylori-positive patients, 102 (61.8%) were treatment naïve, 88 (86.3%) have been randomised and 80 (90%) have completed follow-up. Of 88, 59 (67%) have received standard triple therapy and 29 (33%) have received tailored therapy. In the tailored arm, 10 (34%) received levofloxacin-based triple therapy, 14 (48%) received a PPI and combination of antibiotics based on their sensitivities (e.g. levofloxacin, clarithromycin, rifampicin, tetracycline or metronidazole), 3 (10%) standard triple and 2 (7%) bismuth quadruple therapy. The eradication efficacy of tailored therapy by intention-to-treat analysis was higher at 69% (20/29) compared to 64% (n=38/59) for standard therapy (p=0.81). The eradication efficacy by per-protocol analysis was also higher, at 80% (20/25) for tailored versus 69% (38/55) for standard therapy (p=0.42). 55% (44/80) of samples from patients that completed the study were culture-positive and clarithromycin resistance was 50% (22/44) by E-test. Genotypic resistance data was available for 86% (69/80) patients and 47.8% (33/69) of strains were clarithromycin resistant by this method.

Conclusions
Overall eradication rates are disappointing. Tailoring therapy based on antibiotic susceptibilities is more efficacious than prescribing standard clarithromycin-based triple therapy. A possible reason for this is the high primary clarithromycin resistance rate observed in this study.

ABSTRACT 14 (127) ORAL PRESENTATION

Serum Angiopoietin-2 is an accurate capsule endoscopy screening tool for the detection of small bowel angiodysplasia

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Introduction
Small bowel angiodysplasia (SBA) accounts for 50% of cases of obscure gastrointestinal bleeding (OGIB). Treatments are limited however, an earlier diagnosis and directed therapy can significantly improve outcome. CE is the most sensitive diagnostic tool for SBA, however it is not widely available and the varied presentation of SBA makes it difficult to clinically prioritise patients for CE.

Aims/Background
To determine whether alterations in serum angiogenic factors are specific for SBA, and whether they could be used as a screening tool to prioritise patients for CE.

Method
Serum samples were collected from patients undergoing CE for OGIB and IDA over a 12 month period. Levels of Ang1, Ang2 and TNFα were measured using commercially available ELISA kits. Based on CE reports patients were divided into 3 groups–SBA, other bleeding causes, and normal small bowel. Results of each factor were expressed as a median and compared between groups. The potential for serum Ang1/Ang2 as a CE screening tool was explored using Receiver Operator Characteristic (ROC)curve analysis.

Results
120 patients were included, with 40 in each group. Median levels(pg/ml) of each factor according to diagnosis were; Ang2:SBA-3759, Vs other bleeding-2261($p<0.004$) and Normal-2620($p<0.003$), Ang1:SBA-40976 Vs other bleeding-44770($p=0.33$) and normal-47639($p=0.04$), TNFα:SBA-5.76 Vs other bleeding-9.76($p=0.12$) and normal-10.14($p=0.13$). As a CE screening tool for SBA a cutoff Ang2 level of 2600pg/ml, gave a sensitivity of 84% and negative predictive value of 87%. Although the positive predictive value for SBA was only 50%, of these false positives;50% had significant findings (including enteritis and a small bowel tumour) which would warrant an expedited CE, making the true false positive rate only 26%. Although the Ang1/Ang2 ratio was also specific for SBA over other conditions, the ROC was similar for Ang2 alone, conferring no additional benefit to the use of 2 markers.

Conclusions
Serum Ang2 levels are specifically elevated in patients with SBA compared to other causes of OGIB. In our cohort a cutoff level of 2600pg/ml would be an effective CE screening test at initial referral to prioritise patients likely to have SBA and other significant findings, with an earlier diagnosis potentially directing treatment and improving outcome.

ABSTRACT 15 (128) ORAL PRESENTATION

Paediatric Eosinophilic Oesophagitis in Ireland – A 10 Year Review of Incidence, Presenting Symptoms, Phenotype and Management at Diagnosis.

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Introduction
Eosinophilic oesophagitis (EoE) is a poorly understood, chronic immune-mediated condition caused by eosinophilic infiltration of the oesophagus. Limited international epidemiological data suggest incidence is increasing, however to-date no Irish national paediatric data are available.

Aims/Background
To establish the national incidence of paediatric EoE in Ireland from January 2006-December 2015, and to profile symptoms, phenotype, and management at diagnosis.

Method
Patients diagnosed with EoE were identified using endoscopy and histological records from the three nationally approved centres where paediatric endoscopy takes place – Our Lady's Children's Hospital Crumlin, Tallaght Children's Hospital and Limerick University Hospital. Incidence was calculated using 2011 census data from the Central Statistics Office. A retrospective chart review was performed collecting relevant data. Analysis was performed based on age (<6 years vs. ≥6 years) at diagnosis.

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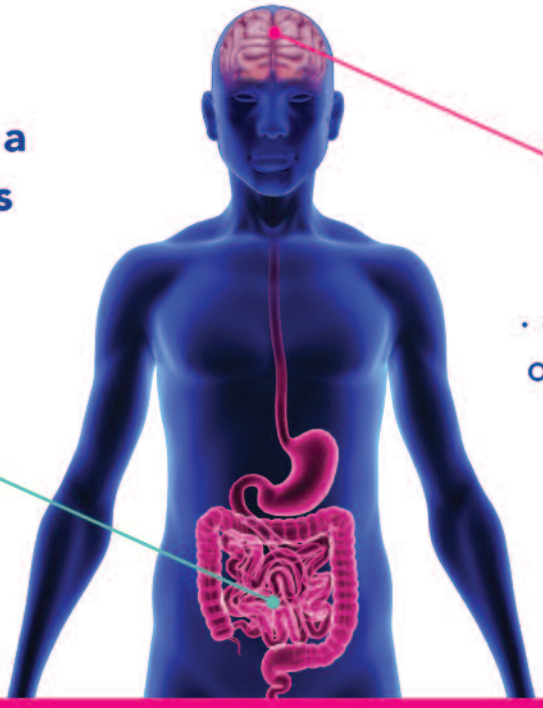

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† PAMORA: Peripherally-Acting Mu-Opioid Receptor Antagonist.

REFERENCES: 1. MOVENTIG: Summary of Product Characteristics

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Date of preparation: November 2016 **Code:** MOV/IRE/0005(1)a

Results
Overall, 358 children were diagnosed with EoE and full chart data was available on 339 patients (95%). An increase in incidence over time was observed from 2006-2015, from 2.0 to 3.3 per 100,000/year. Male:female ratio was 3:1, and 36% were <6 years at diagnosis. Presenting symptoms differed based on age. The most common symptom overall was abdominal pain (46%), occurring significantly more frequently in those ≥6 years (P<0.001); vomiting was significantly more common in those <6 years (P<0.001). Other presenting symptoms were dysphagia (25%), gagging (23%) and reflux (21%). An inflammatory phenotype was predominant (93%). The majority were treated with swallowed fluticasone propionate (78%) at diagnosis. Dietary manipulation and oesophageal dilation were not widely performed.

Conclusions
This is the first national population-based study of paediatric EoE in Ireland, showing increasing incidence and a male preponderance. Over one third were <6 years and there were marked age specific differences in presenting symptoms at diagnosis. Inflammatory phenotype was prevalent and pharmacological treatment was used most frequently. Further research is necessary regarding the outcomes of this national cohort.

ABSTRACT 16 (139) ORAL PRESENTATION

The Irish Helicobacter pylori Working Group consensus for the diagnosis and treatment of Helicobacter pylori infection in adult patients in Ireland.

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Introduction
Irish eradication rates for H. pylori are falling and the prevalence of antibiotic-resistant infection is rising. These trends call into question current management strategies.

Aims/Background
To establish an Irish H. pylori Working Group (IHPWG) to assess, revise and tailor current available recommendations.

Method
Experts in the areas of gastroenterology and microbiology were invited to join the IHPWG. Questions of relevance to diagnosis, first-line and rescue therapy using the PICO system were developed. A literature search was then performed. The "GRADE" approach was then used to rate the quality of available evidence and grade resulting recommendations. Consensus was defined as support by >90% of experts.

Results
Key resultant IHPWG guideline statements (S), the strength of recommendation and quality of evidence include; S2: The Urea breath test is the recommended non-invasive test for H. pylori. Strong & High. S3: A combination of histology taken from the antrum and corpus and a rapid urease test are recommended for invasive H. pylori testing. Strong & High. S4: A corpus and antrum biopsy sample should be taken for rapid urease tests. Strong & Low or Very low. S6: Post-eradication testing must be performed. If gastroscopy is not required, a urea breath test is recommended for post-eradication testing. Strong & High.
S8: Standard triple therapy for 7 days duration can no longer be recommended. Strong & Moderate. S9: 14 day clarithromycin-based triple therapy with a high-dose PPI is recommended. Bismuth quadruple therapy for 14 days is an alternative if available. Strong & Moderate.
S12: Second-line therapy depends on the first-line treatment and should not be the same treatment. The options are (a) 14 days levofloxacin-based therapy with high dose PPI, (b) 14 days clarithromycin-based triple therapy with high dose PPI, or (c) bismuth quadruple therapy for 14 days. Strong & Moderate. S13: Culture and antimicrobial susceptibility testing should be performed following 2 treatment failures. Weak & Low or Very low

Conclusions
These recommendations are intended to provide the most relevant current best-practise guidelines for the management of H. pylori infection in Irish adults, with a view to improving eradication and preventing the progression of H. pylori-associated disease.

ABSTRACT 17 (101) POSTER PRESENTATION

Retrospective study on achievability of R0 margin resection after polypectomy

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Introduction
Colonic polyps are removed endoscopically by various methods. The size and the type of the polyp generally decides the way in which a polyp will be removed. Diminutive polyps <1cm in size are usually removed by cold snare, pedunculated polyps are removed by hot snare whereas sessile and superficially elevated polyps are removed by endo mucosal resection technique (EMR). Irrespective of the method in which polyps are removed the goal of a polypectomy is to achieve a R0 margin meaning that the margin does not contain polypoid material.

Aim
We aimed to determine the achievability of R0 clear margin after various methods of polypectomy. We also wanted to look at if any method was superior to others in obtaining a R0 resection margin.

Methodology
Retrospective data of all polypectomies in a 6 month period from a single centre done by gastroenterologists were collected. Endoscopy notes and histology reports were assessed. The data was compiled in Excel. JASP software was used for statistical analysis. Data on size, morphology, location, dysplasia, histological type, polypectomy technique and margins were collected and analysed.

Results
We analysed 537 colonoscopies in which 613 polyps were removed. 213 had histological comment on margin clearance (34.7%). Definitive clear margins were achieved for n=138 (64.8%) polyps. Cold Snare achieved 45/69 (65.2%), Cold Forceps 14/24 (58.3%), EMR achieved 61/117 clear margin reports (52.1%), and snare caurtery achieved clear margins in 15/35 (42.8%). When polyp size was analysed it showed that 23/74 polyps (31.08%) which were <0.5cm had a positive margin, 30/83 (36%) of polyps sized 0.5-1cm had a positive margin while 11/29 (37.93%) polyps sized between 1-3cm had a positive margin.

Conclusion
Only a third of the histology reports had mention of margin of resection. 2/3rd of these polypectomy specimens had a R0 margin. Although cold snare of diminutive polyps had highest R0 margin clearance, no particular technique was superior to others in this retrospective analysis.

ABSTRACT 18 (103) POSTER PRESENTATION

Deoxycholic acid modulates integrin-av: implications for gastro-oesophageal reflux disease and Barrett's oesophagus

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Introduction
Erosion of oesophageal squamous epithelium as a consequence of gastro-oesophageal reflux disease (GORD) promotes re-epithelialisation with metaplastic columnar cells in Barrett's oesophagus (BO). Low pH and bile acids disrupt epithelial barrier function in patients with GORD but the underlying mechanisms are poorly understood.

Aims/Background
We investigated the contribution of deoxycholic acid (DCA) in modulating oesophageal cell adhesion and the mechanism underlying this process.

Method
Cellular adhesion was investigated using cell line models of squamous epithelium (HET-1A) and Barrett's oesophagus (QH), by examining adhesion to extracellular matrix proteins and integrin expression. Experimental findings were validated in human explant oesophageal biopsies, a rat model of GORD and in patient tissue.

Results
DCA exposure reduced adherence of HET-1A cells to the extracellular matrix protein vitronectin. DCA-reduced cell surface expression of integrins-α5, α6 and αv but not α3 or α4. Defects in endocytic recycling of integrin-αv was identified as a mechanism for its reduced cell surface expression. Increased expression of integrin-αv was observed in oesophagitis and Barrett's intestinal metaplasia compared to normal squamous epithelium. The metaplastic cell line QH was resistant to DCA-mediated loss of adhesion and reduction in cell surface expression of integrin-αv

Conclusions
We have demonstrated for the first time that DCA-mediated alterations in oesophageal cell adhesion is due to impaired endosomal processing of integrins. Barrett's epithelium had increased expression of integrin-αv and was resistant to DCA-mediated effects on cell adhesion and integrin-αv internalisation. This provides a novel mechanism for bile acid-mediated erosion of oesophageal squamous epithelium and promotion of Barrett's Oesophagus.These results suggest targeting bile acids as a therapeutic strategy for patients with GORD.

ABSTRACT 19 (104) POSTER PRESENTATION

Assessing the role of infliximab levels and antibodies in the management of Crohns Disease with loss of response

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Introduction
Infliximab is a commonly employed treatment for Crohn's disease. Recent evidence suggests that low serum trough levels are associated with worse clinical outcomes. An important cause of this is the development of antibodies to infliximab (ATI). No regional protocols currently exist in advising when to check levels or what changes to make based on the results.

Aims/Background
This study aimed to monitor the indications for checking infliximab trough levels and antibodies, assess the action taken on receipt of results and develop a greater understanding of this test's role in our future practice.

Method
A retrospective analysis using laboratory records was performed on the 25 tests performed in our centre from October 2014 to February 2016. Samples with infliximab trough levels <1µg/ml were tested for antibodies. Two levels were sent in patients with ulcerative colitis which were excluded.
Each patient's clinical records were reviewed to assess the management changes and clinical response following levels being checked.

Results
8/23 patients had low trough levels with detectable antibodies.
Seven of these were switched to adalimumab and the eighth patient was awaiting review at the time of data collection.

Of those patients that have switched to adalimumab three had improved symptoms.
13/15 patients who had normal trough levels (>1µg/ml) improved with either no change, increased dose or increased frequency of treatment with infliximab.

Conclusions
The presence of low serum infliximab levels with detectable antibodies to infliximab is a relatively common finding in patients with Crohn's who have had loss of response.
Those with trough levels <1µg/ml with detectable antibodies were switched to adalimumab.
The absence of antibodies was a good indicator of response to increased dose or frequency.

ABSTRACT 20 (105) POSTER PRESENTATION

Case Report on Ectopic Duodenal Varices: A rare cause of upper GI bleeding

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Introduction
Ectopic duodenal varices is a rare cause of upper GI bleeding. Bleeding from the varices can be massive and life threatening. There is no optimal treatment has been established.

Aims/Background
We described a case report on a 93-year-old man who presented with suspected upper GI bleeding during in-patient course.

Method
A 93-year-old priest was initially admitted with pneumonia. His past medical history includes early Alzheimer's disease, rheumatoid arthritis, polymyalgia rheumatica, heart block and hypertension. He took methotrexate, folic acid, aspirin, prednisolone and bisoprolol regularly. One week post admission, patient developed acute onset of coffee ground vomiting and melena. Vitally, patient was stable (BP 110/70, HR 60bpm). Haemoglobin dropped from 11.3 g/dL to 7.9 g/dL. Patient was transfused with 2 unit of packed red blood cells and treated with continuous intravenous pantoprazole infusion.

Results
He subsequently underwent oesophago-gastro-duodenoscopy (OGD), which revealed markedly tortuous varices over the second and third portions of duodenum. No evidence of bleeding. However, there were few red signs visible on the duodenal varix. Otherwise, OGD showed only mild reflux oesophagitis, with no evidence of oesophageal/gastric varices or portal hypertensive gastropathy. Patient received no endoscopic intervention. Patient was treated further with intravenous terlipressin for 3 days. Search for evidence of portal hypertension however was unsuccessful. No previous chronic liver disease (CLD) was documented. Patient denied any alcohol intake. Physical examination revealed no peripheral signs of CLD. Liver function test were normal, including the albumin, electrolytes, platelet and INR. Abdominal ultrasound demonstrated normal liver, spleen and portal flow.

Conclusions
Ectopic varices are dilated portosystemic collateral veins that found in uncommon locations (other than gastroesophageal region)1. Up to 5% of all variceal bleeds are caused by ectopic varices2, with duodenal varices being the most common culprit3. Causes of ectopic varices include portal hypertension (intrahepatic or extrahepatic), anomalies in the venous outflow vessels, vascular thromboses, surgical procedures involving abdominal organs/vessels, and familial1. However in our case, no recognised cause was found. In view of patient's advanced age and multiple comorbidity, we decided not to pursue on finding the aetiology of ectopic varices.

ABSTRACT 21 (106) POSTER PRESENTATION

Self-expanding metal stents for malignant gastric outlet obstruction

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Introduction
The insertion of self expanding metal stents (SEMS) has been established as an alternative to surgical gastrojejunostomy in some cases for the palliative management of gastric outlet obstruction (GOO) secondary to cancer. The procedure restores luminal patency and thus allow patients to eat and drink whilst relieving abdominal discomfort and vomiting. Peri-procedural risks include contents aspiration, perforation and stent blockage.

Aims/Background
The risks of stent insertion and the importance of a carefully selected patient population are recognised. This study was undertaken to audit our own institution's clinical practice and assess patient outcomes. The findings will help to drive an improvement in all aspects of this intervention.

Method
Endoscopic records were searched to identify all patients undergoing stent insertions for GOO since April 2012. As well as procedural details, electronic records were used to assess reasons for referral and patient outcome until death or the present day.

Results
Forty-nine patients were identified, with a median age of 67 (range 33 to 90). Gastric cancer (n=27) and pancreatic cancer (n=9) were the most common causes of GOO requiring stent insertion. Sedation levels appeared appropriate with no procedures abandoned for restlessness and no reversal agents used. Aftercare advice involving food and fluids was satisfactorily complete in 36 endoscopic reports. At the time of analysis 38 patients had died, with mean survival from SEMS insertion for gastric cancer 107.2 ±44.2 (95% CL) days and pancreatic cancer 47.4 ±13.1 (95% CL) days. 30 day mortality was 20.4% (10/49). Stent blockage was noted in seven patients, with three of these undergoing restenting. Localised perforations were noted in two patients, and significant gastrointestinal bleeding and contents aspiration in one each.

Conclusions
SEMS insertion is a valuable tool in the palliation of patients with malignant GOO however correct patient selection, procedural skill and aftercare are all vital. Our experience is comparable with the published literature. In order to drive improvement we must involve a multidisciplinary approach. Suggestions for development include standardising aftercare and centralising the service where feasible.

ABSTRACT 22 (107) POSTER PRESENTATION

Hepatitis C Treatment in Northern Ireland: Outcome of the 2015 Early Access Programme

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Introduction
The development of Direct Acting Anti-virals (DAAs) has been welcomed as a new era in the management of chronic Hepatitis C. These drugs however can be prohibitively expensive. Early Access Programmes have been used in the UK to allow treatment of those with advanced disease prior to NICE approval of the new therapies. Management of viral hepatitis in Northern Ireland is co-ordinated through the Liver Unit in the Royal Victoria Hospital, Belfast. The first Early Access Programme with oral DAA therapies was undertaken in the Liver Unit in 2015.

Aims/Background

Method
Funding was approved in March 2015 to offer DAA treatment to all patients with genotype 1 HCV compensated cirrhosis who had failed with or had contraindications to the use of interferon based therapy. Cirrhosis was confirmed by prior liver biopsy or Fibroscan >11.5kPa. All patients were monitored for side effects and complications during treatment. The primary endpoint was a sustained virological response (SVR) measured at week 12 post-treatment.

Results
15 patients (13 male, mean age 50 years) met the Early Access Programme criteria at the end of March 2015 and were subsequently treated. 14 patients had a previous treatment failure and 1 was ineligible for interferon based treatment. All of the patients had Hepatitis C genotype 1 (12 patients had genotype 1a and 3 patients had genotype 1b).
5 patients received treatment with ombitasvir, paritaprevir, ritonavir, dasabuvir (Abbvie 3D) and ribavirin. 10 patients were treated with sofosbuvir, ledipasvir (Harvoni) and ribavirin.
1 patient decompensated after three weeks treatment necessitating cessation of therapy. 1 patient stopped taking treatment at week 13 of 24 and was subsequently lost to follow up (HCV PCR negative during treatment but SVR 12 not done).
The remaining 13 (87%) patients completed treatment and achieved SVR 12.

Conclusions
The early access programme with oral DAAs in Northern Ireland was successful with all patients who completed treatment achieving an SVR. Intention to treat SVR12 was 87% in a difficult to treat cirrhotic population with 93% prior treatment failures.
One incident of liver decompensation highlights the infrequent but serious risks associated with DAA therapy in cirrhotic patients.

ABSTRACT 23 (109) POSTER PRESENTATION

Vaccination routines during Anti TNF treatment in IBD patients attending St Luke's Hospital Kilkenny – A single centre Audit.

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Introduction
Inflammatory bowel disease (IBD) is associated with a greater predisposition to infections, many of which are preventable with vaccines. Anti-TNF agents used to treat IBD may result in severe infections due to the generalized immunosuppression. Accordingly, international guidelines now recommend that all patients are screened for latent infections prior to initiation of anti-TNF therapy. The European Crohn's and Colitis Organisation (ECCO) guidelines suggest that every patient with IBD should be considered for five following vaccines; Trivalent Inactivated Influenza vaccine (TIV), Pneumococcal, Hepatitis B, Varicella vaccine (VZV) and Human Papilloma virus (HPV). However, clinical experience indicates that vaccination guidelines are challenging to implement in practice.

Aims/Background
An audit to find out whether our IBD patients receive adequate information about vaccinations in routine clinical settings.

Method
We identified 68 IBD patients randomly from our database. All these patients were on biological agents. Vaccination details were obtained by a questioner on phone. We asked about Hep B, Influenza and pneumococcal vaccination status.

Results
37(55%) (M = 22, F= 15) of 68 patients responded. Median ages of responders were 36.5 yrs (15yrs to 72yrs). 28/37 (75%) were on Adalimumab, 6 (16%) were on Infliximab and 3 (8.15%) on Vedolizumab.
Only 17/37 (46%) patients received at least one vaccination. 17 received TIV, 5 received TIV plus Pneumococcal, 3 received Influenza + pneumococcal and Hep B vaccines (All three are healthcare workers) and only one patient received Influenza Plus Hep B vaccine. Main reasons not to receive vaccination; no vaccination advised by health care professionals = 19, one patient refused because time constraints.

Conclusions
Our results showed that less than half of our IBD cohort received any vaccination against common opportunistic infections. Majority of them did not receive any advice at any stage. Following recommendations are proposed.
· Increase awareness of vaccination importance among Gastroenterology team and specialist IBD nurse.
· All IBD patients specifically on Immunomodulators / Biologics therapy, should be given written information about vaccination.
· Reaudit in 6 month's time to determine if relevant information increases adherence to vaccination guidelines.

ABSTRACT 24 (110) POSTER PRESENTATION

Stool Cultures in Inflammatory Bowel Disease Flares: A Review of Inpatient Stool Sampling in a Regional Hospital

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Introduction
Immunosuppression has become the cornerstone of management of inflammatory bowel disease (IBD). With increased use of

immunomodulators, concern exists regarding increased risk of infection in IBD patients. C. difficile has become particularly problematic in the hospital setting resulting in a spectrum of effects from asymptomatic carriage to fulminant colitis. RCPUK recommends that all IBD patients with diarrhoea should have stools sampled for standard cultures and C.difficile toxin. ECCO guidelines also recommend screening for C. difficile at every IBD flare.

Aims/Background
This study aimed to establish if stool samples were obtained from IBD patients in Naas General Hospital at the time of a flare, and to determine the percentage of flares in which an infection was identified.

Method
We searched the hospital inpatient enquiry system to identify all patients admitted to hospital between July 2014 and July 2016 with a primary diagnosis of 'Crohn's Disease' or 'Ulcerative Colitis'. We reviewed each patient's file and used the laboratory reporting system to check if stool samples were sent during admission. Samples sent from General Practice were also available on the system. Cases where samples were sent from the community in the days preceding admission were recorded as compliant with guidelines. We recorded positive stool culture results.

Results
A total of 115 admissions due to IBD flare were recorded. 28 (24%) patients were admitted under surgical teams and 87 (76%) under medical teams. A total of 57 patients (49.5 %) had stool samples sent. 28.5% (n=8) of surgical patients and 56% (n=49) of medical patients had samples sent. 2 cases of campylobacter and 1 case of C.difficile were identified.

Conclusions
We know that enteric infection is a relatively common cause of disease flares and the incidence of C. difficile infection is rising in the general population and in IBD patients. Only 3 positive stool cultures were identified in our patient population. Since the frequency of our stool testing fell below the recommended standards, it is possible that a number of infectious cases were missed. This highlights the need for increased focus on stool testing in IBD patients at the time of admission to hospital to optimise management.

ABSTRACT 25 (112) POSTER PRESENTATION

Appropriateness of Direct Access Endoscopy Referrals

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Introduction
Direct Access Endoscopy is defined as provision of an endoscopic procedure by direct request without prior hospital consultation. Ever since its inception in most Irish hospitals, there has been an increased demand for direct access endoscopy, with a significant impact on waiting times. Although direct access is needed to meet the increasing demand for endoscopy, studies suggest a link between such a system and inappropriate use.

Aims/Background
To improve the effectiveness and quality of the direct access endoscopy services provided at Our Lady of Lourdes Hospital Drogheda & Louth County Hospital Dundalk.

Method
We performed a retrospective study of 102 referrals received for direct access endoscopy at Our Lady of Lourdes Hospital & Louth County Hospital over a 6-month period to determine their appropriateness based on the American Society for Gastrointestinal Endoscopy (ASGE) guidelines. The diagnostic yield of the service was measured as well as discrepancies between referral indications & symptoms reported by patients at triage.

Results
131 procedures were performed from the 102 referrals, including 57 OGDs, 66 full colonoscopies and 8 flexible sigmoidoscopies. The patients ranged between age 18 – 86, 45/102 (44.1%) were below 50 while 57/102 (55.9%) were above 50. 34/102 (33.3%) were males with 68/102 (66.7%) females.
The most common indications for OGD were Dyspepsia (35.1%) & Oesophageal reflux (38.6%), while the most common indications for colonoscopy were chronic IBS symptoms/chronic abdominal pain (43.2%), and Unexplained GI Bleed (40.5%).
Of the 102 referrals, 75/102 (73.5%) were appropriate while 27/102 (26.5%) were inappropriate. The endoscopic findings of the inappropriate referrals were insignificant.
In relation to diagnostic yield, 36.8% of the OGDs were normal as was 63.7% of the colonoscopies. 27/102 (26.5%) of the referrals showed discrepancies between referral indications for endoscopy and symptoms reported by patients at triage.

Conclusions
Although our study shows that most of the referrals received were appropriate based on the ASGE guidelines, the diagnostic yield for significant pathologies was low. Several key studies on direct access endoscopy have shown that the more appropriate an endoscopy referral, the higher the diagnostic yield. Finally, our study also highlighted discrepancies between referral indications and reported symptoms

ABSTRACT 26 (115) POSTER PRESENTATION

Pregnancy outcomes in the post liver transplant setting: The Irish experience.

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Introduction
Successful liver transplantation can lead to restoration of fertility in women of childbearing age. Studies have shown largely favourable pregnancy outcomes {Westbrook et al 2015, Parhar et al 2012} in liver transplant recipients, however, concern remains regarding maternal and foetal complications and the optimal management of these high risk patients.

Aims/Background
We sought to evaluate maternal and foetal outcomes of pregnancy, post liver transplant over a 14 year period in the National Liver Transplant Unit (NLTU).

Method
We conducted a retrospective study of all self-reported pregnancies in patients transplanted in the NLTU 1992 to 2016. Information was collected regarding the following clinical parameters: transplant indication, gestational age, number of pregnancies, immunosuppression, pregnancy induced hypertension(PIH), pre-eclampsia, infections, venous thrombosis(VT), miscarriages, caesarean section, prematurity, birth weight and congenital anomalies.

Results
31 pregnancies were reported in 13 women. Median age at delivery 28.5years(18-38). Live birth rate 67.7%(n=21).
Maternal complications: PIH (14.3%), pre-eclampsia (4.8%), VT (4.8%), liver decompensation post-partum (9.5%) and infections (14.3%). Re-transplant occurred in 3(14.3%) patients post-partum, one within a year of delivery. Mortality amongst this cohort was 30.77%(n=4). Deaths occurred from 8-96months post-delivery. No patient died as a direct result of pregnancy.
Foetal complications: miscarriage in 10(32.3%), prematurity in 9(42.9%) and low birth weight in 6(28.6%). 16(76.2%) were delivered by caesarean section. NICU admissions in 5(23.8%). No congenital abnormalities occurred. One child born premature had respiratory distress syndrome.
All patients with PIH/pre-eclampsia were on tacrolimus (P = 0.583). Patients on cyclosporine were more likely to get infections (P = 0.055); have higher chances of re-transplant post-pregnancy (P = 0.055) and higher mortality (P = 0.055). Six miscarriage occurred on tacrolimus (P= 0.014, LR 10.38). C-sections was overall more prevalent in this cohort and more likely on cyclosporine (P = 0.04).

Conclusions
Our study showed high rates of maternal and foetal complications in liver transplant recipients with a significantly higher rate of miscarriage and incidence of C-section than the general population. This highlights the importance of adequate pre-conception counselling, including optimal timing of pregnancy and appropriate management by a multidisciplinary team including a high risk obstritian and a transplant hepatologist.

ABSTRACT 27 (116) POSTER PRESENTATION

Irritable bowel syndrome: Evidence of altered cortisol awakening response in females

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Introduction
Irritable bowel syndrome (IBS) is a female-predominant stress-related gastrointestinal disorder with a high psychiatric comorbidity. Previous evidence (e.g. Kennedy et al., 2014) has indicated that irritable bowel syndrome is associated with an altered cortisol awakening response. This suggests altered hypothalamic-pituitary-adrenal axis (HPA axis) activity in this stress-related gastrointestinal disorder. However, heterogeneity in IBS study populations may contribute to differing findings reported across research studies. It is thus currently unclear whether altered HPA axis activity is a feature of IBS per se or related to comorbid depression and anxiety.

Aims/Background
The current research aims to assess the nature of the cortisol awakening response in a cohort of females with IBS compared to healthy controls.

Method
Saliva samples were collected from females with IBS without comorbid depression or anxiety (N = 9) and healthy controls (N = 15) using salivettes at four timepoints (waking, 30 minutes, 45 minutes and 60 minutes after waking) on two mornings (approximately one week apart). Salivary cortisol levels were analysed using enzyme-linked immunosorbent (ELISA) assays.

Results
There was evidence of an altered cortisol awaking response in IBS, and this was most apparent in week 2, where IBS patients were more likely than controls to display peak cortisol levels at 45 minutes (p = .046) and less likely at 30 minutes (p = .058).

Conclusions
The current results offer further evidence of altered HPA axis activity in irritable bowel syndrome, although further research is required into the stability of these changes over time.

ABSTRACT 28 (117) POSTER PRESENTATION

Too Frail for Surgery? Validity of a frailty index in Major Colorectal Surgery

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Introduction
Frailty is increased vulnerability from accumulating morbidities in mulitple organ systems. Recent evidence suggests objective measures of frailty may better predict outcomes compared to chronological age.

Aims/Background
The authors aim to demonstrate the validity of a frailty index in predicting negative post-operative outcomes in patients undergoing major colorectal surgery.

Method
A retrospective review of a prospective colorectal resection database was studied. Patients under the age 65 were excluded, with 205 patients eligible for study.
Patients were assessed using a validated National Surgical Quality Improvement Database (NSQIP) Frailty Index (FI). 11 variables were measured. FI score calculated by applying a score of 1 for each variable and dividing by 11. A score of >0.25 was diagnostic of frailty and patients were grouped. Endpoints compared were ICU stay, post-op complications and 30 day post-op mortality. FI endpoints were compared to ASA grade and P-Possum CR mortality index.

Results
205 eligible patients, 43 (21%) were frail and 162 (79%) were not frail. Frail patients graded ASA >/=3 (21%) while non-frail patients

graded ASA</=2 (79%).
9 (20%) frail patients had benign disease. 34 (80%) had malignant disease. 34 (26%) non-frail patients had benign disease. 129 (74%) had malignant disease [p=0.5, NS]

3 (7%) frail and 10 (6%) non-frail patients required ICU stay(p=NS). P-Possum mortality in these groups was 48% versus 8.6 (p<0.05).

17 (40%) frail and 42 (26%) non-frail patients had post-op complications (p<0.05). a P-Possum mortality in these groups was 23% versus 6.12% (p<0.05).

2 (5%) frail patients and 4 (2.5%) non-frail patients died within 30 days of surgery (p=NS). P-Possum mortality in these groups was 43% versus 7% (p=NS).

Conclusions
These data demonstrate frailty as a reliable predictor of poor outcomes and mortality in patients undergoing major colorectal surgery. Similar trends are noted when applying ASA grade and P-Possum CR Mortality to both frail and non-frail groups. This has great significance in dealing with an increasingly aged population requiring major colorectal surgery.

ABSTRACT 29 (118) POSTER PRESENTATION

Colo Right Ureteric Fistula: a very rare complication in colorectal surgery.

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Introduction
Ureteric injury is a recognised complication of abdominal surgery involving mobilisation of the large bowel.However, the incidence of colo-ureteric fistulae after bowel surgery is extremely rare.

Aims/Background
We aim to present a unique incidence of a right-sided colo-ureteric fistula in the setting of an open pelvic surgery. We hope to advocate a for a conservative management approach.

Method
We performed an extensive literature review of right-sided colo-ureteric fistulae. Using imaging, laboratory findings and progress notes, we present this unique case for the purposes of furthering education in pathology of the GI tract.

Results
A sixty-five year of male presented by GP referral for a colonoscopy with new onset tenesmus and constipation. A recto-sigmoid tumour was identified and biopsied at colonoscopy and staging imaging demonstrated T3N0M1. He underwent an open anterior resection and primary anastamosis.
Patient developed a right-ureter leak post-operatively, which was treated conservatively with a right-sided ureteric stent. Repeat imaging demonstrated improvement, catheter was removed and patient discharged.
Two days later, the patient was re-admitted febrile and hypotensive. Imaging demonstrated a fistula between his right distal ureter and colonic anastamosis.

Conclusions
Ureteric injury during pelvo-sigmoid dissection and colo-vesicular fistulae during anastamosis are recognised complications in left colorectal surgery.
Colo-ureteric fistulae, particularly of the right ureter are very rare. An extensive literature review yielded one documented case of a right colo-ureteric fistula caused during rectal surgery. The other cases were caused mainly by acute diverticulitis and impacted renal stones, with single incidences in TCC and Hodgkins lymphoma.
Urosepsis is typically the primary sign, with urinary system contamination after fistulation occurs.
Diagnosis can be difficult given the rarity of these complications. Typical radiological features on CT pyelogram demonstrate air in the urine collecting system and contrast extravasting into the rectum.
Management is multidisciplinary and on a case-by-case basis. The key to early management is aggressive anti-microbrial therapy and decompression of the urinary system with catheter and/or nephrostomy placemen. When stable, surgical management is the optimal option, with permanent ureteric stents for patients unfit invasive treatment.
We report a unique right-colo-ureteric fistula after open recto-sigmoid resection.

ABSTRACT 30 (119) POSTER PRESENTATION

Indications for Oesophago-gastro-duodenoscopy in CUH Endoscopy Suite.

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Introduction
Endoscopy is central in the diagnosis of gastrointestinal (GI) disease. It has diagnostic, therapeutic and preventative roles. These procedures are invasive with the potential for causing significant adverse events. Therefore, the indications and potential outcomes need to be weighed prior to performance.

Aims/Background
We sought to review oesophago-gastro-duodenoscopies (OGDs) performed at our endoscopy unit to evaluate their appropriateness and outcomes. Dose of sedative medications used per procedure was also recorded.

Method
The most recent one hundred OGDs performed were reviewed. A high dose of sedation was defined as > 5mg of Midazolam and/or use of opioids.
Standards: (1) Guidelines for the Implementation of a National Quality Assurance Programme in GI endoscopy, conjoint board RCPI and RCSI, (2) The American Society for Gastrointestinal Endoscopy (ASGE) guidelines, (3) The British Society of Gastroenterology endoscopy and sedation guidelines.

Results
52 female and 48 male, with average age 56.73 years. 41 patients were under 50 years of age, with 29 over 70 years. 37 received a high dose of sedation.
The main indications were abdominal pain (23%), dyspepsia (20%), dysphagia (15%), surveillance (15%), anaemia (14%), weight loss (4%) and bleeding (2%).
25% were normal. The most common findings were gastritis and

Empower Crohn's patients to live life their way[1]

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Conor Byrne

Prescribing Information

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

Refer to Summary of Product Characteristics (SmPC) for full information.

Presentation: Each 0.4 ml single dose pre-filled pen or pre-filled syringe contains 40mg of adalimumab. Each 0.8 ml single dose vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA), adults: In combination with methotrexate (MTX) for moderate to severe, active RA with inadequate response to disease-modifying anti-rheumatic drugs (DMARDs) including MTX. In combination with MTX for severe, active and progressive RA when not previously treated with MTX. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Reduces rate of progression of joint damage on X-ray and improves physical function, in combination with MTX. Polyarticular juvenile idiopathic arthritis (pJIA) paediatrics 2 years and above: In combination with MTX, for active pJIA with inadequate response to one or more DMARDs; or monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Enthesitis-related arthritis (ERA), paediatrics 6 years and above: For active ERA with inadequate response to or intolerance to, conventional therapy. Psoriatic arthritis (PsA), adults: For active and progressive PsA with inadequate response to DMARDs. Reduces rate of progression of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function. Ankylosing spondylitis (AS), adults: For severe active AS with inadequate response to conventional therapy. Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: For severe nr-axSpA with objective signs of inflammation (elevated CRP and / or MRI), and an inadequate response to, or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs). Crohn's disease (CD), adults: For moderately to severely active CD with inadequate response, contraindication or intolerance to corticosteroid and/or an immunosuppressant therapy. Crohn's disease (CD), Paediatrics 6 years and above: For moderately to severely active CD with inadequate response, contraindication or intolerance to conventional therapy. Including primary nutrition therapy and a corticosteroid, and/or an immunomodulator. Psoriasis (PS), adults: For moderate to severe chronic plaque psoriasis who are candidates for systemic therapy. Psoriasis, paediatrics 4 years and above: For severe chronic plaque psoriasis with inadequate response, or if topical therapy and phototherapies are inappropriate. Hidradenitis suppurativa (HS), adults: For active moderate to severe hidradenitis suppurativa (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Ulcerative colitis (UC), adults: For moderately to severely active UC with inadequate response, contraindication or intolerance to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Uveitis, adults: For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. **Dosage and administration:** Specialist physicians experienced in the diagnosis and treatment of the condition, to initiate and supervise treatment. Ophthalmologists to consult with an appropriate specialist before initiation of treatment. Provide patients with special alert card. Patients may self-inject after proper injection training, with physician approval and appropriate medical follow-up. Optimise other concomitant therapies. RA adults: 40mg dose every other week. Concomitant MTX should be continued. During monotherapy patients may require 40 mg each week if they experience a decrease in clinical response. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Consider need for dose interruption, e.g. before surgery or if serious infection occurs. Re-introduction after 70 days dose interruption gave same magnitudes of clinical response and similar safety profile as before dose interruption. pJIA, paediatrics 2 years and above; pJIA, paediatrics 2-<4 years: 24mg/m² body surface area up to 20mg maximum single dose every other week (see SmPC for height/weight dosing chart). pJIA, paediatrics 4-12 years: 24mg/m² body surface area up to 40 mg maximum single dose every other week (see SmPC for height/weight dosing chart). pJIA, paediatrics 13 years and above: 40mg every other week regardless of body surface area. Treatment beyond 12 weeks reconsidered if no clinical response in that time. ERA, paediatrics 6 years and above: 24mg/m² body surface area up to a maximum single dose of 40mg every other week. (see SmPC for height/weight dosing chart). PsA, AS and nr-axSpA, adults: 40 mg every other week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD: Adults: Induction: 80mg at Week 0 followed by 40mg at Week 2. For a more rapid response, 160mg at Week 0 (either as 4 injections in 1 day or 2 injections/ day for 2 consecutive days), 80mg at Week 2; risk of adverse events higher during induction. Maintenance: 40mg every other week. If decrease in clinical response, can increase dose to 40 mg weekly. Corticosteroids may be tapered in maintenance phase in accordance with clinical guidelines. Patients with no response by Week 4 may benefit from continued therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above<40Kg: Induction: 40mg at Week 0, 20mg at Week 2. For a more rapid response: 80mg at Week 0 (2 injections in 1 day), 40mg at Week 2; risk of adverse events higher during induction. Maintenance: 20mg every other week. If insufficient response, consider 20mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above ≥40Kg: Induction: 80 mg Week 0, 40 mg at Week 2. For a more rapid response: 160 mg at Week 0 (4 injections in 1 day or 2 injections/day for 2 consecutive days), 80 mg at Week 2; risk of adverse events higher during induction. Maintenance: 40 mg every other week. If insufficient response, consider 40 mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Psoriasis, adults: 80mg induction dose at week 0, 40mg every other week from week 1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. Beyond 16 weeks, patients with inadequate response can increase dosing frequency to 40 mg every week. If adequate response is achieved with an increased dosing frequency, dose may subsequently be reduced to 40 mg every other week. If there is inadequate response to the increased frequency, carefully reconsider treatment. Psoriasis, Paediatrics 4 years and above: 0.8 mg per kg body weight (maximum of 40 mg/dose) weekly for the first 2 doses and then every other week (see SmPC for weight dosing chart). Treatment beyond 16 weeks should be reconsidered if no response in that time. HS: Adults: 160mg initially at Day 1 (four 40mg injections in one day or two 40mg injections per day for two consecutive days), followed by 80 mg two weeks later at Day 15 (two 40 mg injections in one day). Two weeks later (Day 29) continue with a dose of 40 mg every week. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions should be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Reintroduction after interruption: 40 mg every week. Evaluate periodically the benefit and risk of continued long-term treatment. UC: Adults:

[1]Not a real patient.

Reference: 1. Colombel J F, Sandborn W J, Rutgeerts P, et al Adalimumab for maintenance of clinical response and remission in patients with Crohn's disease: the CHARM trial. *Gastroenterology* 2007; 132 (1): 52-65.

Date of Preparation: August 2016 88-HUG16018/8

Induction: 160mg at week 0 (4 injections in 1 day or 2 injections / day for 2 consecutive days) and 80mg at week 2. Maintenance: 40mg every other week. During maintenance, corticosteroids may be tapered in accordance with clinical practice guidelines. If insufficient response, consider 40mg every week. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time. Uveitis: Adults: 80 mg induction dose at week 0, 40 mg every other week from week 1. Experience of initiating treatment with Humira alone is limited. Treatment can be initiated in combination with corticosteroids and/or other non-biologic immunomodulatory agents. Two weeks after initiating treatment, concomitant corticosteroids may be tapered in accordance with clinical guidelines. Evaluate on a yearly basis, the benefit and risk of continued long term treatment. **Contraindications:** Active tuberculosis (TB), severe infections (e.g. sepsis), and opportunistic infections; moderate to severe heart failure (NYHA class III/IV);hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings:** Clearly record trade name and batch number of administered product to improve traceability of biological medicinal product. ***Infections:*** Patients are more susceptible to serious infections especially if impaired lung function. Monitor for infections, including TB, before, during and for 4 months after treatment. Do not initiate treatment with an active infection, until it is controlled. Consider risk/benefit prior to treatment in patients exposed to high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections. **Serious infections:** Serious infections, including those with hospitalisation or death reported in patients receiving treatment. **TB:** Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (disseminated) reported. Screen all patients before therapy initiation for active or latent TB. If active TB is diagnosed, Humira therapy must not be initiated. If latent TB is suspected, consult a physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Humira. Despite prophylaxis TB reactivation has occurred on Humira. ***Other opportunistic infections:*** Opportunistic infections observed in patients receiving Humira. Stop treatment in patients with signs and symptoms of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients. ***Hepatitis B Reactivation:*** Reactivation has occurred in chronic carriers (i.e. surface antigen positive) tested for HBV infection before initiating treatment. HBV carriers should consult with a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of Humira. If reactivation occurs stop treatment and initiate appropriate anti-viral and supportive treatment. ***Neurological events:*** Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders and consider stopping treatment if these disorders develop. Rare association with new onset or exacerbation of symptoms and/or radiographic evidence of central and peripheral demyelinating disease. Known association between intermediate uveitis and central demyelinating disorders. Evaluate patients with non- infectious intermediate uveitis before therapy initiation and regularly during treatment to assess for pre existing or developing central demyelinating disorders. ***Allergic reactions:*** Reports of serious allergic reactions including anaphylaxis received. For serious allergic or anaphylactic reaction stop Humira immediately and initiate appropriate therapy. ***Malignancies and lymphoproliferative disorders:*** A possible risk of malignancy, including lymphoma and leukaemia, in all patients including paediatric patients, treated with TNF antagonists. Monitor all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment for non-melanoma skin cancer prior to and during Humira therapy, caution in COPD patients, and in patients with increased risk of malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Humira (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk for developing dysplasia or colon cancer is unknown. Patients with UC, prior history of dysplasia or colon carcinoma to be screened for dysplasia before therapy and during treatment. ***Haematologic reactions:*** Adverse events of the haematologic system reported with Humira. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias. **Vaccinations:** Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to Humira treatment. **Congestive heart failure:** See contraindications. Caution is advised in mild heart failure (NYHA class I/II). Discontinue treatment for new or worsening symptoms of congestive heart failure. ***Autoimmune processes:*** Autoimmune antibodies may form. Stop treatment if development of a lupus-like syndrome with positive antibodies against double- stranded DNA. **Surgery:** Consider the long half-life of Humira for planned surgical procedures. Closely monitor for infections. ***Small bowel obstruction:*** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture requiring surgical treatment. **Elderly:** Serious infections were higher in patients over 65 years of age, some of whom had fatal outcomes. Consider risk of infection. **Interactions:** Combination of adalimumab with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Fertility, pregnancy and lactation:** Not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. Women must not breast-feed for at least five months after the last treatment. **Side Effects:** *Very common* ≥ 1/10: Infections, leucopaenia, anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction. **Serious, including fatal, side effects have been reported** including infections/sepsis, intestinal perforation, opportunistic infections, TB, endemic mycoses, demyelinating disease, malignancies including lymphoma (including hepatosplenic T-cell lymphoma), leukaemia and skin cancer (including melanoma and merkel cell carcinoma), cytopenias, worsening heart failure, myocardial infarction, pulmonary embolism, pleural effusion, pulmonary fibrosis, cerebrovascular accident, interstitial lung disease, lupus, Stevens-Johnson syndrome, angioedema, anaphylaxis, sarcoidosis, hepatitis, liver failure and worsening of symptoms of dermatomyositis. **Prescribers should consult the SmPC for the complete list of reported side effects. Legal Category:** POM. **Marketing Authorisation Numbers/Presentations**: Vial: EU/1/03/256/001; Pre-filled Syringe EU/1/03/256/013; Pre-filled Pen: EU/1/03/256/017. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24. **HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie.**
Date of revision of PI: June 2016 PI/256/017

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hiatus hernia. Malignancy and ulcers were seen in 3 OGDs each, 5 patients had varices and 7 Barretts oesophagus.
For abdominal pain, 60% had gastritis and 26% were normal. For dyspepsia, 40% had gastritis and/or hiatus hernia and 53% were normal. For dysphagia, 60% had gastritis and 20% were normal, and for anaemia 50% were normal. For those with bleeding, both had ulcers.

Conclusions
OGDs are being performed frequently for dyspeptic symptoms. Guidelines suggest endoscopy be reserved for those over 50 years, with symptoms suggesting complicated disease, alarm features or following treatment failure.
High doses of sedation are being frequently used. A maximum of 5mg Midazolam is recommended, as higher doses are associated with adverse events.
We may be able to free much- needed endoscopy slots by further adapting to the described standards and improve care by re-auditing the services.

ABSTRACT 31 (122) POSTER PRESENTATION

An audit of screening for alcohol misuse in adult inpatients in a District General Hospital.

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Introduction
Alcohol related harm is estimated to cost society £900 million every year in Northern Ireland. Despite the economic, physical and social impact it is estimated that only 9% of the in need population are treated for alcohol problems. Among adults 16–64 years of age, 23% are thought to drink at hazardous or harmful levels equating to approximately 400000 people in NI (DH 2006).
The National Confidential Enquiry into Patient Outcome and Death into alcohol related liver disease in 2013 recommends screening all patients presenting to hospital for alcohol misuse.
Currently in our institution the admission pro-forma has space to document units per week of alcohol concerned only. NICE recommends use of a validated questionnaire to screen patients such as AUDIT-C or SADQ.

Aims/Background
To assess our current practice of alcohol intake documentation and to use the AUDIT-C questionnaire to screen patients for hazardous drinking, who may have been otherwise missed in an unselected inpatient population.

Method
50 acute medical and surgical admissions were assessed on the wards over one week. Their charts were reviewed for admission alcohol documentation and an AUDIT-C questionnaire was performed by two medical students.
Patients from residential and nursing homes were excluded.

Results
29 Women (58%) and 21 (42%) men took part in the study, the population had an average age of 59.
20% (n=10) of patients had a positive AUDIT-C score of 5 or greater indicating potentially harmful drinking. Of this cohort 60% (n=6) did not have any alcohol intake documented on admission.

Conclusions
This study suggests our current alcohol screening practice is inadequate and we are missing a vital opportunity to identify and educate those drinking at potentially harmful levels. By including the AUDIT-C in our admission proforma we could identify more of this population and offer an effective intervention which could come in the form of advice from the admitting doctor or a brief intervention from Alcohol Liaison services dependent on their alcohol use and history of alcohol.

ABSTRACT 32 (123) POSTER PRESENTATION

Colonoscopy correlation of abnormal abdominal and pelvic computed tomography: Do all need colonoscopy?

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Introduction
Abdominal/pelvic computed tomography (CT) often reported findings suspicious for bowel pathology; such as bowel wall thickening, lymphadenopathy, fat stranding and filling defect. Nearly all patients will subsequently undergo colonoscopy, which inevitably increases the volume of colonoscopies performed.

Aims/Background
To investigate how well the abnormal abdominal/pelvic CT correlated with the follow up colonoscopy, and to justify the need for colonoscopy referral.

Method
Consecutive colonoscopies performed at endoscopy unit Galway University Hospital from May 2013 to December 2014 were examined. Colonoscopies indicated for abnormal CT were extracted and retrospectively analysed. Data were obtained from endoscopic database and hospital's imaging system.

Results
Of 3,412 colonoscopies, 57 patients (2%) met the inclusion criteria. 29 were male (51%) and the mean age was 64 ± 16. All patients were divided into 4 subgroups based on the CT finding and suspected pathology. 14 patients (25%) were referred for colonoscopy for suspected colitis/terminal ileitis, 13 patients (23%) for suspected colorectal tumour and 5 patients (9%) for suspected primary colorectal malignancy (liver metastasis or peritoneal carcinomatosis on CT). Majority (44%, n=25) were referred due to solitary finding of wall thickening on CT. Of the 14 suspected colitis/terminal ileitis, 6 (43%) were confirmed to have colitis/terminal ileitis while 1 case (7%) turned out to be neoplastic lesion. Of the 13 suspected colorectal tumour, 1 (8%) was confirmed of the diagnosis. All colonoscopies for suspected primary colorectal malignancy revealed no abnormality. In patients with wall thickening on CT as the only finding, 19 (76%) had normal colonoscopy, 4 (16%) were diagnosed with diverticulosis and 2 (8%) had neoplastic lesion. Overall, CT and colonoscopy were concordant for specific pathology in 18% of the cases (n=10).

Conclusions
Colonoscopy referral will remain a dilemma for the physicians. As our study demonstrated, CT did not correlate well with the colonoscopy. However, even though most of the colonoscopies revealed no abnormality, it can occasionally revealed unexpected finding. 2 out of 4 neoplastic lesion cases were detected based on

only solitary finding of wall thickening on CT. Therefore, need and timing for colonoscopy should be individualised after considering multiple factors such as age, comorbidity, family history, symptoms and other investigations.

ABSTRACT 33 (125) POSTER PRESENTATION

Underutilization of nonradiating imaging modalities in the assessment of Crohn's patients

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Introduction
Diagnosis and treatment of inflammatory bowel disease (IBD) necessitates repeat biochemical, endoscopic and radiological evaluation for monitoring of disease activity and complications. Repeat imaging confers a significantly increased risk of radiation exposure in our IBD patients which is concerning for radiation associated malignancy. Ultrasound and Magnetic resonance imaging can be used to diagnose active disease and assess complications, use may be limited be availability and expertise

Aims/Background
The aim of this study was to capture the use of imagining modalities in the assessment of patients admitted with a flare or complication of their underlying Crohn's disease and to highlight alternatives to minimize radiation exposure.

Method
We reviewed the medical records of patients admitted to Beaumont Hospital for management of Crohn's. Charts were reviewed to identify if diagnostic imaging was performed, the indication for imaging, the modality of imaging and whether an alternative imaging modality could have been considered.

Results
We identified 107 patients admitted between January 2014 and March 2016, 12 were excluded from analysis due to incomplete data. 47% were male, age range 17-77,data was skewed towards a younger age group (81% of males younger than 46, 86% of females younger than 56).
A plain film of abdomen (PFA) was obtained in 76% of patients , computerised tomography (CT) in 52%, 39% underwent magnet resonance imaging (MRI) and 4% had an ultrasound (US). Capsule endoscopy is not readily available in our institution, therefore none of the admitted patients underwent small bowel capsule evaluation. Worryingly of those who had a CT 19 had previously had 2 or more prior CT scans, one particular patient had 7 prior CT scans. On review of the indications for CT, US or MRI would have been appropriate in approximately 60% of the patients.

Conclusions
We recommend considering alternative imaging modalities in the assessment of IBD patients to minimize radiation exposure, in particular ultrasound appears to be underutilized in our department.

ABSTRACT 34 (129) POSTER PRESENTATION

The identification of novel putative angiogenic factors in small bowel angiodysplasia

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Introduction
Small bowel angiodysplasias (SBAs) account for over 50% of cases of obscure gastrointestinal bleeding and have a poor outcome. The development of effective treatments is impeded by the inability to define specific therapeutic targets due to the unknown pathophysiology of SBA formation. We have previously identified abnormalities in the Angiopoietin pathway in tissue and serum of patients with SBA compared to controls, however as angiogenesis is controlled by a multitude of pro and anti-angiogenic factors this is likely to only be one of many potential therapeutic targets for SBA.

Aims/Background
To perform a broad assessment of putative angiogenic factors in the serum of SBA patients compared to non-bleeding controls.

Method
Serum samples were collected from patients with SBA and healthy controls with an entirely normal upper, lower and small bowel endoscopy. Using commercially available human angiogenesis antibody array profiler kits the relative levels of 55 angiogenesis related proteins were measured. The median relative level of each factor was then compared between SBA patients and controls.

Results
13 samples were analysed:7 SBA and 6 controls. In the SBA group 86%(n=6) were male, mean age 72years Vs controls: 50%(n=3) male, mean age 43years. Of the 55 angiogenic factors measured, significantly lower levels of 4 factors were found in patients with SBA vs controls. Of these Angiopoietin-1 (640 vs1966)($p<0.004$) and Platelet derived growth factor(AA)(489 vs1245)($p<0.009$) are stimulators of angiogenesis, and Endostatin(520vs 673)(2144 vs 4019)($p<0.03$) and TIMP1(metallopeptidase inhibitor-1)($p<0.04$) are both angiogenesis inhibitors. Trends of higher levels of Angiopoietin-2 and TIMP4 were also noted; however these were not statistically significant. There were no differences in the levels of factors previously suggested in the literature to be associated with SBA:Vascular Endothelial Growth Factor, Fibroblast Growth Factor or soluble Endoglin.

Conclusions
This angiogenic array assessment has confirmed our previously reported association between SBA and abnormalities in the Angiopoietin pathway and has newly identified 3 further factors associated with SBA, which will direct further cellular based work to elucidate the pathophysiology of SBA. As both PDGF and Endostatin are both currently available as medical therapies, further work to establish their role in SBA may yield exciting advances in the treatment of SBA.

ABSTRACT 35 (130) POSTER PRESENTATION

Outcomes following endoscopic mucosal resection (EMR) of large polyps: a single centre experience

Author(s)
Coffey L, Gibson DJ, Leyden

Department(s)/Institutions
Mater Hospital

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UNITED KINGDOM – Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals Ltd on 01895 826606.

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UK/XIF5/0416/0201(1)
Date of preparation: October 2016.

NORGINE

Introduction
Colonic EMR for large polyps is a rapidly expanding field. Within Ireland, it is only performed in a limited number of tertiary referral centres. It significantly reduces patient morbidity and cost compared to surgical resection.

Aims/Background
To audit EMR for large adenomas in a single centre, and compare to international standards

Method
Retrospective review of all colonic EMRs for polyps greater than 2cm. All procedures were performed by a single endoscopist. A standard piecemeal EMR technique was performed in all cases using a stiff snare. EMR solution consisted of normal saline, methylene blue and 1:200000 adrenaline. Following excision, APC was applied to any polyp remnants and edge of resection site. In all cases, a 3 month follow up colonoscopy was performed, unless the patient underwent surgery.

Results
During a 2 year period, 33 procedures were performed. Median age was 65 years (IQR 61-71). Referral source was BowelScreen in 13 cases (39%), other consultant in 19 (58%), and GP in 1 case (3%). Median procedure duration was 69 minutes with an IQR of 42-94 minutes. Polyp size ranged from 20mm-45mm with a median of 25mm. Clips were applied in 19 cases (number ranging from 2-8). Histology confirmed tubulovillous adenoma in 25 cases (7 high grade dysplasia), 5 sessile serrated adenomas and 1 patient had tumour in situ (pT3N0). Complication rates were low: 1 patient had pain requiring admission; 1 patient had a localised perforation, successfully managed conservatively and 1 patient had a delayed bleed. Follow-up colonoscopy was completed in 22 cases, and awaited in 10. Residual adenoma was detected in 2 cases(9%).

Conclusions
Large polyp EMR is complex and requires significant time and resource allocation. This needs to be considered in providing a successful and streamline service going forward.

ABSTRACT 36 (132) POSTER PRESENTATION

A snap-shot review of small bowel capsule endoscopy in the setting of Inflammatory Bowel Disease

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Introduction
Evaluating small bowel involvement in the diagnosis of Crohn's Disease, CD, is part of the standard work up for all new diagnosis. While this previously took the form of radiological imaging by CTE, MRE or small bowel follow through, small bowel capsule endoscopy, SBCE, now offers an additional means to diagnose and evaluate small bowel Crohn's Disease.

Aims/Background
To review the diagnostic yield of SBCE in the setting of IBD.

Method
As part of a small bowel capsule endoscopy service review in Tallaght hospital, to date, 286 SBCE for diagnosis/assessment of small bowel CD have been included. Patients were categorised as known CD or suspected CD. Small bowel pathology was recorded. Rates of capsule retention and subsequent 30 day retention rates were analysed.

Results
The total cohort comprised of 286 SBCEs. Demographics included; median age – 41 years, female – 174(60.8%). 48 and 238 patients had CD and suspected CD, respectively. 108/286 SBCES were reported as normal which comprised of 14.5% of CD cohort compared to 42.4% of suspected CD patients. Positive findings included – ileitis 94/286(32.8%), strictures 17/286(6%), fistulas 3/286(1%),gastritis 43/286(15%), non-specific enteritis 41/286(14%), polyps 6/286(2%), submucosal lesion 4/286(1%) and fresh blood 4/286(1%). 16(2%) capsules in total were retained at time of reporting – 9 were retained in the small bowel and 7 were retained in the stomach. 8/16(50%) had a previous successful patency capsule. Subsequent follow up available of 12/16 patients confirmed subsequent spontaneous passage of capsule.

Conclusions
The diagnostic yield for SBCE is higher in patients with known CD than suspected CD patients. However, over 50% of patients with suspected CD had pathology on SBCE. The rate of capsule retention was relatively low with no retrieval of capsule required by either double balloon endoscopy or laparotomy to our knowledge. SBCE is a useful and safe tool for the assessment of small bowel pathology in addition to radiological imaging.

ABSTRACT 37 (133) POSTER PRESENTATION

Measures of predicting inflammatory and fibrotic strictures in Crohn's Disease patients using biochemical markers and Magnetic Resonance.

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Introduction
Small bowel (SB) Crohn's disease (CD) strictures can comprise of both inflammatory and fibrotic elements. Ideally, an accurate tool to discriminate fibrosis and inflammation would be clinically useful to guide therapy. To date no specific tool has been developed. Lesions with a dense fibrotic matrix are known to exhibit delayed gadolinium enhancement on MRI. The role of delayed enhancement in assessment of SB CD strictures is unclear.

Aims/Background
Determine the feasibility of MRE SB stricture assessment with early (70s) and late (7mins) phase post gadolinium imaging.

Method
Retrospective review of 88 consecutive MREs with known and suspected SBCD. Demographics, MRE findings, biochemical markers and inpatient versus outpatient imaging were recorded. Patients with stricturing disease were further assessed regarding current and subsequent therapy and outcome.

Results
Median age 38 years; male n=38 (43.5%), 49 known and 39 suspected CD. In total, 42/85 (49%) MREs were normal, 14(28.6%) and 28 (72%) amongst the known and suspected CD cohort. Ileitis,

strictures and fistulas were found in 21(23.8%), 23(26.1%) and 1(0.01%) patients, respectively. While there was no difference in mean Hb between patient groups (Normal, Inflammatory and Stricturing CD); HB 13.2g/dl, 12.4 g/dl and 12.2 g/dl, both albumin and CRP were statistically different between normal subjects and those with disease; albumin 42g/L v 39.2g/L (p <0.05 95%CI -0.39 – 0.00) and v 36.9g/L (p <0.03 95%CI -0.4 - -0,03). CRP 3.6mg/L v 48.8 mg/L (p <0.02 95%CI -82.6 - -7.8) and v 36.3 mg/L (p <0.003 95% CI -0.74- - 0.16). However neither parameter could differentiate between inflammatory and stricturing disease. Inpatients were more likely to have strictures 11/23(49%0 v 12/65(18%)(p <0.005).

Stricture Cohort: median age = 40 years, male n=10(43%). 21/23 had CD and 2/23 suspected CD. 8/23 were classified as having delayed enhancement and predominantly fibrotic changes. There was no significant difference between biochemical markers depending of MRE classification as inflammatory versus fibrotic changes. To date, 6/23(17%) patients failed medical therapy and required surgical intervention.

Conclusions
Unlike biochemical markers, MRE may be a useful means to differentiate between inflammatory and structuring disease. Further study is required to assess the long-term predictive value.

ABSTRACT 38 (134) POSTER PRESENTATION

Review of endoscopy for Dyspepsia in St Luke's hospital Kilkenny

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Introduction
Dyspepsia is defined as a group of symptoms that alert doctors to consider disease of the upper GI tract. These symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, nausea or vomiting.
Upper GI endoscopy is indicated for patients with dyspepsia and having alarm signs like- Upper GI bleeding, Age>55yrs, Weight loss, Anaemia, Dysphagia, Recurrent vomiting, Family hx of Upper GI cancers. As per NICE guidelines, dyspepsia without alarm features has to be managed with empiric trial of PPi and non-invasive tests for H.pylori.

Aims/Background
Our aim was to review number of endoscopies done for dyspepsia without alarm features. We also aimed to review the findings on endoscopy for this cohort of patients.

Method
We reviewed the endoscopy reports from the last 100 OGDs done in our endoscopy department in July/August, 2016. Patient characteristics, indications and findings on OGD were recorded.

Results
There were all the necessary details available on 94 patients. There were alarm symptoms present in 52 patients, i.e. 42 patients that did not have any alarm signs/ symptoms. Data on these 42 patients was further analysed (Male=13 /Female=29). Average age was 55.8years (24 to 84years). CLO test was done on all except one – Only 4 patients had CLO test positive. OGD findings in this cohort did not show any malignancy, barrett's oesophagus, gastric ulcer or duodenal ulcer. 10 were normal, 28 showed mild gastritis or oesophagitis, 3 showed moderate gastritis and only one had a lower oesophageal ulcer associated with reflux oesophagitis (CLO test was positive in this patient).

Conclusions
Endoscopy in patients with dyspepsia without alarm features has a very low yield for any significant findings. This is associated with unnecessary risks for the patient and additional costs for the health system.
This could be easily avoided by introducing referral guidance for endoscopy for dyspepsia and provision of non-invasive testing for H.pylori like stool antigen test.

ABSTRACT 39 (135) POSTER PRESENTATION

Oesophageal cancer: Commonly familial, possibly heritable

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Introduction
Oesophageal cancer(OC) accounts for 400 deaths in Ireland per year. Prognosis remains poor, and improved prevention is needed.

Aims/Background
Familial clustering has been described however, The Nordic Twin Study of Cancer does not support a strong hereditability. We investigated familial OC over a decade in Ireland.

Method
The independent records of two national referral services were reviewed: an oesophageal surgery database and a hereditary cancer genetics database. Demographic Factors including family history of OC were recorded from the surgical database. Families containing a single OC diagnosis were identified in the genetics database. Age at diagnosis and additional cancer diagnoses in the family were recorded.

Results
1238 patients with OC were seen at St. James' Hospital from 2005-2015.
• 826(67%)males, 412(33%) females.
• 641 patients (51%) had a family history of malignancy.
• 78(6.3%) reported a family history of OC, 6 (7.6%) of whom had two or more first degree relatives with OC and 10 (13%) had both a first degree and second degree relative with OC.
• More male relatives were diagnosed with OC than female (59% vs 41%).
• The majority (24%) with a family history were diagnosed at Stage III, the majority (29%) without a family history were diagnosed at Stage II.
• Median age for men was 66 in both those with and without a family history of OC.
• Median age of women was 5 years younger in those with a family history than those without (65 vs 70 p = 0.28)
• Prevalence of Barrett's oesophagus was higher in those with Family history than those without.(11.5% vs 8% p=0.27).
• Alcohol excess was lower in those with a family history than those without(16% vs 21% p=0.32).
1840 pedigrees from the genetic database were reviewed. No pedigree contained a Proband with OC.4.5%(n = 84) included at

least one family member with OC. The median age at diagnosis was 64. Breast, colorectal and gastric were the most commonly associated cancers.

Conclusions
More than half of patients presenting with OC report a family history of cancer, with likely hereditary and environmental components. OC patients are rarely referred for genetic assessment, possibly due to treatment related morbidity and poor clinical outcome.

ABSTRACT 40 (136) POSTER PRESENTATION

Refractory Coeliac Disease with a lesion (Video Presentation)

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Introduction
70 year old female, admitted to hospital in April 2016, with blurred vision, and pre-syncope. Diagnosed with retinal artery occlusion. Background history of coeliac disease, diagnosed 10 years ago. Clinically well, on gluten free diet. Whilst inpatient noted to be anaemic, with a haemoglobin of 8.8g/dl, MCV 85fl, ferritin level of 5ug/l. OGD showed normal duodenum. Ileo-colonoscopy showed left sided diverticular disease. Received iron transfusion, commenced on aspirin, discharged home with gastroenterology follow-up.

Aims/Background
At follow-up review in July, patient was complaining of fatigue, shortness of breath, and 5 kg weight loss. Results of duodenal biopsies showed mild villous blunting, partial villous atrophy, increased IEL's (>40/1000). This was felt consistent with coeliac disease (Marsh IIIa). Tissue transglutaminase level 0.3. Repeat Haemoglobin was 7.4 g/dl. Patient was felt to have refractory coeliac disease, type 1 or 2, and was admitted for blood transfusion, further investigations.

Method
Immunophenotyping of duodenal biopsies showed no evidence of clonality (Intraepithelial lymphocytes were CD3 positive with no loss
of CD8 expression). Clinical picture felt to represent Type 1 refractory coeliac disease and patient was booked for small bowel video capsule endoscopy, to evaluate for possible lesion/ulcerative jejunitis

Results
Video presentation: Showing jejunal lesion.
Push enteroscopy confirmed an ulcerated, strictured lesion, in proximal jejenum. Clinical suspicion was of lymphoma, in context of refractory coeliac, despite immunophenotyping suggesting type 1 disease.
Histology showed fragments of small intestinal mucosa with adenomatous changes, ulceration, high grade dysplasia. No evidence of invasive malignancy. This was felt to be malignant lesion, based on endoscopic appearances. CT/MRI showed irregular mucosal thickening in segment of proximal jejenum, with associated mesenteric lymphadenopathy, consistent with extramural extension. No distant disease.
Plan is for MDT discussion, with view to surgically resecting lesion

Conclusions
Patients with coeliac disease, have increased risk of small bowel adenocarcinoma compared to general population (as well as lymphoma).Other risk factors include Crohn's, polyposis syndromes, eg Peutz-Jeghers syndrome.
Pathway not fully understood but felt to be part of adenoma-carcinoma sequence. This case emphasises the need for screening and investigating anaemia in elderly patients, particularly in those with coeliac disease. Screening options include capsule endoscopy or MRI.

ABSTRACT 41 (137) POSTER PRESENTATION

Vedolizumab for the treatment of anti TNF refractory IBD

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Introduction
Vedolizumab is a humanized monoclonal antibody to gut specific adhesion molecule α4β7 integrin and selectively blocks Lymphocytes migration to gastrointestinal tract. This gut specific treatment has the potential to reduce systemic side effects

Aims/Background
The aim of our study was to evaluate the effectiveness and safety of Vedolizumab in a cohort of consecutive anti TNF refractory IBD patients.

Method
We evaluated the efficacy of Vedolizumab, side effects, history of prior bowel surgery and steroids free remission. Patients received 300mg Vedolizumab at 0, 2, 6 and 8 weeks. We also checked patient's fecal calprotectin before and after Vedolizumab induction.

Results
24 patients (15 males and 9 females, 20 Crohn's disease and 4 ulcerative colitis) received Vedolizumab between June 2015 and September 2016. All patients were on anti TNFs with or without thiopurines before Vedolizumab and 10 patients (42%) had prior bowel surgery for IBD.

Before induction, 21 /24 patients (87.5%) were on maintenance systemic steroids, as compared to 6/24 patients (25%) after being on Vedolizumab for more than 12 weeks. Pre and post Vedolizumab fecal calprotectin was available on 15/24 patients, and in 12/15patients (80%) there was decline and in 3/15 patients (20%) fecal calprotectin raised. There was statistically significant improvement in post Vedolizumab fecal calprotectin level (P =0.024). There were no infusion reactions and one patient developed intra-abdominal collection.

Vedolizumab was discontinued in 1 patient due to poor response requiring surgical intervention and 1 patient is currently off it due to intra-abdominal collection. 2 patients had bowel surgery (one total colectomy and one small bowel resection) after commencement of Vedolizumab.

ABSTRACT 42 (138) POSTER PRESENTATION

Adherence to European Society of Gastroenterology Endoscopy (ESGE) Polypectomy Guidelines : Retrospective experience from a tertiary Irish Hospital

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Introduction
Colorectal cancer (CRC) accounts for up to 11% of all cancers in women and 14% of men in Ireland, and is the second most common cancer across sexes. The adenoma -carcinoma sequence of colorectal carcinogenesis lends itself to screening with the aim of complete excision of polyps. It has been estimated that incomplete resections of polyps are involved in 19-31% of interval cancers. ESGE guidelines state that polyps 5mm or greater should be removed by snare resection.

Aims/Background
The aim of this study was to investigate polypectomy techniques and to assess adherence to guidelines. We also investigated the differences between subspecialty and consultants versus trainees.

Method
The study included all patients who underwent colonoscopy in Tallaght Hospital between January 2012 and December 2015. From this, a list of patients with colonic polyps was compiled. Demographics and other information including number and site of polyps, resection and retrieval rates, method of resection and specialty of endoscopist.

Results
11,400 colonoscopies were performed during the study period. To date, the records of approximately 6000 (53%) procedures have been reviewed. 687 (11.5%) patients were identified with polyps, with 298 females (43.4%), 389 males (56.6%) and a mean age of (60.62 years). Indication for colonoscopy included symptoms (47.2%), polyp surveillance (22.3%), CRC cancer screening (9.2%), family history of CRC (4.4%) IBD surveillance (3.8%), with no indication noted in 12.95%. The mean number of polyps per patient was 2.2. 47.7% of patients had one polyp identified. In 52.5% (n=361), polyps were left-sided, and were right-sided in 23.1% (n=159). In all 15.72% of polyps >5mm were resected by forceps and not by snare resection. Non-adherence to guidelines was 17.56% and 17.3% in medical and surgical trainees respectively. Medical (12.3%) and surgical (12.1%) consultants had a higher adherence rate.

Conclusions
Guidelines have yet to be universally implemented .Our study shows a non-adherence rate of 12 – 18%. The low polyp detection rate likely represents the varied case mix.. A greater emphasis on ESGE guidelines could improve awareness and enhance compliance which is suboptimal. A follow up study to determine the effect on interval cancers in these groups is planned.

ABSTRACT 43 (140) POSTER PRESENTATION

The natural history of paediatric sclerosing cholangitis in a national cohort.

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Introduction
Autoimmune sclerosing cholangitis (SC) is a rare disorder of unknown aetiology, with a strong association with inflammatory bowel disease (IBD). SC-autoimmune hepatitis overlap (SC/AIH) is also seen in children and young adults.All affected Irish children are followed at the National Centre for Paediatric Gastroenterology (NCPG), Crumlin, Dublin.

Aims/Background
To study the trends and outcomes of paediatric SC and SC/AIH in the Irish paediatric population.

Method
A retrospective review of all patients with SC and SC/AIH overlap attending the NCPG from 01/2000 – 02/2016 was undertaken. Data from histology, radiology, biochemistry, clinical phenotype and outcomes was extracted for analysis.

Results
Twenty-eight patients with SC or SC/AIH overlap were identified over the 16 year period. Median age at diagnosis was 12 years (2-17 years). The majority (17/28) had SC/AIH overlap (M:F 1.1:1). In contrast, more males than females had SC (M:F 4.2:1). Of the 22 patients that had IBD, 18 had ulcerative colitis and there was equal representation of SC and PSC/AIH. Histology-proven SC was seen in 60% and 41% of patients had a positive MRCP. ANA and SMA were positive in 72% and 48% of patients respectively, with both tests positive in 8 patients. Long-term ursodeoxycholic acid therapy was used in the management of 75% of patients (n=21), and prednisolone was used in 9 of the SC/AIH patients. Regarding clinical outcomes, 15 patients had already transitioned to adult gastroenterology services, one of whom since developed cholangiocarcinoma at 17 years of age (7 years post SC diagnosis). One paediatric patient developed portal hypertension with oesophageal varices at 12 years of age (3 years and 6 months post SC diagnosis).

Conclusions
Though rare overall, more children had SC-AIH overlap than SC alone. Comorbid IBD was notable. There was a limited correlation between MRCP and histology findings. Clinically significant liver disease occurred in only one patient younger than 17 years of age. Prospective outcomes data collection following adult transition should be considered.

ABSTRACT 44 (142) POSTER PRESENTATION

Faecal Microbiota Transplant: A case series

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Introduction
Clostridium difficile infection (CDI) is a major cause of morbidity and mortality for hospitalised patients. In 2015 Ireland had a CDI rate of 38.8 per 100,000 population. Patients usually respond to existing antimicrobial therapies however, recurrent infection develops in up to 30% of patients. Faecal microbiota transplant (FMT) has become increasingly recognised as a therapy for multiple recurrent CDI with an efficacy rate of approximately 90%. The first report of FMT for the treatment of pseudomembranous colitis dates back to 1958 and has been sporadically used thereafter.

Aims/Background
We describe three patients with refractory/recurrent clostridium difficile infection treated at our hospital with faecal microbiota transplant.

Method
This case series of consecutive patients with refractory/recurrent clostridium difficile infection treated with transplanted stool.

Results
Our study comprised of 3 women with a mean age of 76.6 years (64-84yrs). Two of our three patients had recurrent infection and one patient had severe refractory infection. Donor stool was sourced from Openbiome, MA, United States and was administered via colonoscopy. Two out of three patients (66.6%) experienced an immediate clinical response to faecal transplantation. One of our three patients failed treatment due to concomitant severe ulcerative colitis requiring colectomy. There were no reported adverse side effects.

Conclusions
Faecal transplantation via colonoscopy proved to be effective and safe in the management of recurrent clostridium difficile infection with a success rate of 66.6%. It continues to represent a promising strategy in the management of recurrent clostridium difficile infection in our patients.

ABSTRACT 45 (143) POSTER PRESENTATION

Paediatric Acute Severe Ulcerative Colitis in The Era Of Infliximab - A Retrospective Review

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Introduction
Paediatric acute severe ulcerative colitis (ASC) is an emergent condition with IV corticosteroids as the mainstay of treatment. Prior to the introduction of second line treatments, surgery was a common outcome in steroid refractory disease. Infliximab has been recommended as a second line treatment although limited data is available on the long term efficacy of infliximab in maintaining remission and avoiding surgery in this cohort.

Aims/Background
• To describe the clinical course of patients who commence infliximab for steroid refractory ASC.
• To report factors associated with maintenance of remission in these patients.

Method
A retrospective chart review of all patients admitted to Our Lady's Children's Hospital, Crumlin (OLCHC) between 31st December 2010 - 31st December 2015 with an episode of ASC (measured as a PUCAI ≥65) requiring infliximab was conducted. Clinical and laboratory data were recorded from admission to maximal follow up with two end points defined as remission (PUCAI ≤10) or Colectomy at maximal follow up. The patients were classified according to age based on the Paris Classification of Paediatric Inflammatory Bowel Disease (A1a <10 years, A1b 10 to <17 years).

Results
Thirty-three patients (median age 12.3 years, 58% females) fulfilled our criteria. 20 (61%) were in remission on infliximab at follow up (3/20 weaned off successfully, 1/20 ceased infliximab use after a severe infection requiring a colectomy). Of those not in remission, 8 (24%) required colectomies, 2 were managed with Adalimumab and 3 maintained on infliximab. Median PUCAI on day 5 of IV corticosteroids and at commencement of infliximab were 60 and 55 respectively. Age at diagnosis was significantly associated with remission (p =0.01). Six of seven A1a patients (86%) were in remission compared to A1b patients [12/26, (46%)]. A longer interval between date of diagnosis and infliximab commencement was associated with remission (mean 12.26 months vs 6.04 months, p=0.04). Gender, disease location and PUCAI scores were not significantly associated with remission or colectomy rates.

Conclusions
Remission may be more likely in younger patients and those with established versus new presentation of UC. PUCAI values during ASC episodes, gender or disease location did not predict the outcome on infliximab therapy.

ABSTRACT 46 (144) POSTER PRESENTATION

Indications For Gastroscopy, Are The Bsg Indicators Too Restrictive?

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Introduction
The British Society of Gastroenterology (BSG) council oulined indications for gastroscopy in March 2013. However, the guidance is not fully inclusive and ultimately clinical judgement is required to determine whether endoscopy is indicated.

Aims/Background
To assess the indications for gastroscopy in our unit.

Method
Prospective consecutive data were recorded from December 2015 to March 2016. 120 patients from 3 endoscopy teams (40 patients each) were studied. The indications for gastroscopy were then reviewed to see if the met the BSG criteria.

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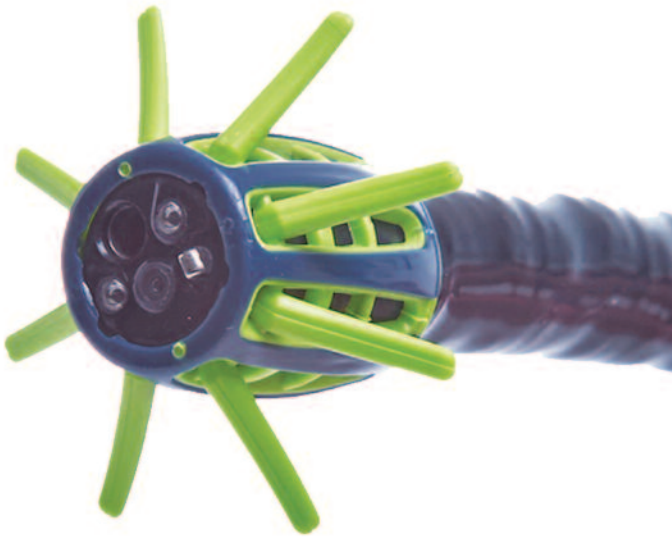

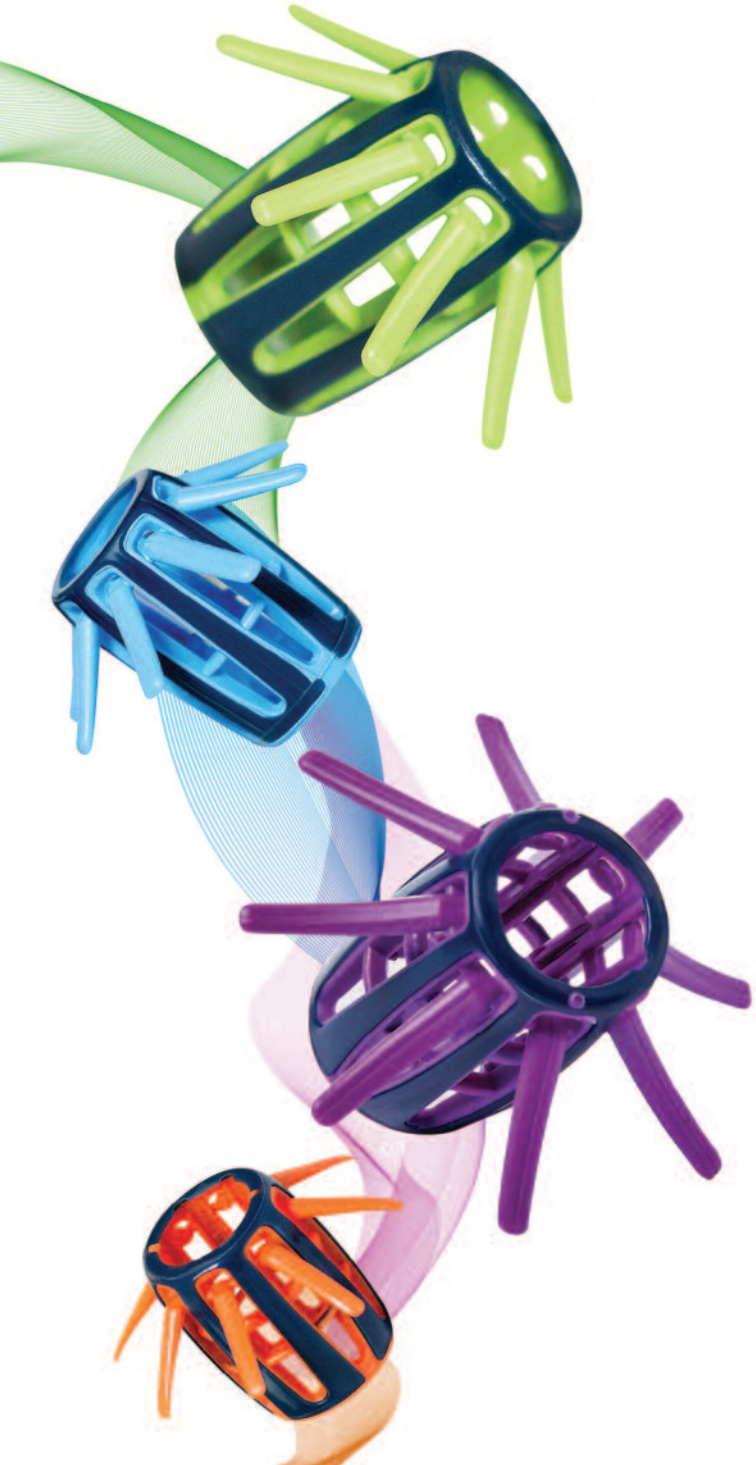

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Results
The main indications for gastroscopy in the study population were dysphagia and persistent reflux despite treatment 20 (17%) each. Group A conisted of the 20 out of 120 (17%) patients who did not meet the BSG criteria. Group B consisted of the remaining 100 patients. The majority of group A, 16/20 (80%) complained of upper abdominal / epigastric pain. The main statistically significant differences between groups A and B were, age and endoscopy team. The rate of patients not meeting the criteria by team were 22.5%, 25% and 2.5% ($p<0.01$, Fisher's exact test). The median (IQR) age for group A was 37 (25-49) years in comparison to 50.5 (41-61) years for group B, ($p <0.01$, Wilcoxon rank sum test). The most serious pathology diagnosed in Group A patients was a duodenal stricture.

Conclusions
17% patients did not meet the BSG criteria for indications for gastroscopy. The majority of these patients complained of upper abdominal pain.

ABSTRACT 47 (145) POSTER PRESENTATION

Progression from acute Hepatitis B infection to chronic Hepatitis B is more frequent in older adults in Northern Ireland

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Introduction
The rate of progression of acute Hepatitis B (HBV) to chronic disease is quoted as <10%.

Aims/Background
The objective was to determine the rate of progression of acute to chronic HBV in Northern Ireland (NI) , assessing the influence of age, gender and biochemical parameters. A secondary aim was to determine whether those developing chronic HBV were referred for specialist assessment.

Method
All "acute" HBV cases diagnosed in NI between 2011 and 2015 were reviewed. Inclusion criteria: 1). positive HBsAg and positive HBV core IgM; 2). in the absence of positive HBV core IgM, positive HBsAg with a recent negative HBsAg.
Patient age, HBsAg, HBV core IgM, peak bilirubin and peak ALT were recorded, along with date and result of repeat HbsAg testing.
Mann-Whitney U test was used to compare mean age, peak ALT and bilirubin between clearing and non-clearing groups. Fisher's exact test was used to compare progression to chronicity according to gender and age less than or greater than 50yrs.

Results
Of 80 identified cases, 4 incorrectly categorised cases were excluded. Of the remaining 76, (15 female (mean age 37.27yr), 61 male (mean age 48.59yr)) follow-up data was available for 71 patients. All female patients cleared HBV. 42 males cleared HBV ($p=0.0313$).
Overall the chronicity rate was 18.42% The mean age of those clearing the virus was 43.88 years, versus 55.64 years for the chronic progressors (Mann-Whitney U test, $z= -2.68$, $p=0.0037$). Clearance rate was 83.72% in patients aged <50yrs and 63.64% in patients ≥50yrs ($p=0.0068$).
Mean peak ALT (U/L) and peak bilirubin (uMol/L) for the clearing group were 2130 and 174 respectively compared to 656 and 100 for the non-clearing group ($z= -3.51$, $p=0.0002$, $z= -2.35$, $p=0.009$).
All non-clearing patients were appropriately referred.
Conclusions
Our results suggest a significantly higher than expected rate of progression from acute to chronic HBV with the risk being significantly higher for those over 50yrs.
These findings suggest a need to revise information provided to older patients with acute HBV regarding the likelihood of progression to chronic infection.

ABSTRACT 48 (147) POSTER PRESENTATION

The Utility of Post-Chemotherapy PET-CT Scans in Resectable Oesophageal Adenocarcinoma

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Introduction
The incidence of oesophageal adenocarcinoma (OAC) in the UK has risen by 6 fold in the last 40 years to be the highest in Europe. Patients diagnosed with OAC are deemed suitable for oesophageal resection following an initial PET-CT scan which can detect occult metastatic disease in up to 13% of cases. However, some patients experience progression of their rumours whilst on chemotherapy and so our centre carries out PET-CT scanning following chemotherapy to assess response and confirm resectability.

Aims/Background
We sought to examine the utility of post-chemotherapy PET-CT scanning in selecting patients for oesophageal resection

Method
Clinico-pathological staging data and treatment outcomes were collected for all patients receiving neoadjuvant chemotherapy with a view to progressing to surgical resection for OAC at The Northern Ireland Cancer Centre between 2011-2013. All patients selected for potentially curative pathway were included and were planned to receive pre- and post-chemotherapy PET-CT scan.

Results
110 patients were identified (90 male, 20 female) with a median age of 64.7 (range 32-82) who were treated with neo-adjuvant epirubicin, cisplatin and 5-fluorouracil chemotherapy. A total of 21 patients (19.1%) did not receive a resection for the following reasons; their disease being unresectable at laparotomy (n=8, 7.3%), being reassessed as unfit for surgery (n=4, 3.6%), death during neo-adjuvant therapy (n=1, 0.9%), metastatic disease identified on post-chemotherapy PET-CT (n=8, 7.3%). Patients who did not progress to surgery were significantly older ($p=0.019$) but did not display any difference in their clinical T/N stage or tumour differentiation compared to patients who received a resection

Conclusions
Post-chemotherapy PET-CT scanning identifies a cohort of patients no longer suitable for radical oesophagectomy and further adds to patient selection algorithms

ABSTRACT 49 (148) POSTER PRESENTATION

DUBLIN (Degree of Ulcerative colitis Burden of Luminal INflammation) score, a simple method to quantify inflammatory burden in Ulcerative Colitis

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Introduction
Endoscopic disease activity scores, such as the Endoscopic Mayo score, are validated and reproducible scoring systems used to grade endoscopic severity in ulcerative colitis (UC). However UC activity scores do not incorporate any measure of extent of disease. The need to quantity inflammatory burden in UC in order to tailor therapy appropriately is increasingly recognised.

Aims/Background
To determine the feasibility of using a composite score of disease extent and severity to quantify UC inflammatory burden.

Method
A retrospective analysis of the results of all faecal calprotectin (FC) results between Jan 2015 an June 2016 was performed. UC patients with contemporaneous endoscopic evaluations and FC measurements were included. Degree of Ulcerative colitis Burden of Luminal INflammation or DUBLIN score was calculated as a product of the Endoscopic Mayo Score and the extent score (E1-3) of the Montreal Classification of Disease. Correlation with FC, an objective non-invasive marker of inflammatory burden was performed and ROC curves were compared.

Results
279 FC results from 181 patients with confirmed UC were included. The median FC result in patients with pancolitis was 186 ug/L (IQR 23-1108ug/L) compared to 77.5ug/L (IQR15-833 ug/L) and 32ug/L (IQR 15-432ug/L) in those with left sided and proctosigmoiditis & proctitis respectively.
N=70 patients were identified with contemporaneous colonoscopy and FC measurements. Median age of these patients was 36.5 years (IQR 26-47.25years); male n=37.
There was a significant correlation between endoscopic activity, defined using the Mayo Endoscopic Subscore and FC (r= 0.359; p<0.01) and a significant correlation between extent of disease and FC. (r=0.286;p=0.016).A somewhat stronger correlation was observed between DUBLIN inflammatory burden score and FC (r= 0.394; p<0.01). ROC curves demonstrated an AUC = 0.79 for the endoscopic Mayo score in predicting FC and AUC=0.753 for the extent of disease in predicting FC. A greater area under the curse was observed when ROC was constructed for the DUBLIN score. (AUC=0.87).

Conclusions
The results suggest potential utility for the DUBLIN score, a simple composite score of endoscopic extent and severity as a measure of inflammatory burden in UC.

ABSTRACT 50 (149) POSTER PRESENTATION

Comparing 2-Dimensional Shear Wave Elastography with Transient Elastography in Evaluating Liver Stiffness: A Preliminary Study

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Introduction
Non-invasive assessment of hepatic fibrosis is increasingly important in the evaluation of a patient with chronic liver disease. Transient elastography(TE) by Fibroscan® has been well validated in numerous studies as an established non-invasive method of assessing hepatic fibrosis. 2-Dimensional shear wave elastography(SWE) by GE LOGIQ E9® ultrasound system is a novel ultrasound-based elastography method of assessing liver stiffness.

Aims/Background
The aim of this study is to compare liver stiffness measurements by SWE and the more established method of TE.

Method
Patients referred for liver ultrasound examination or ultrasound-guided liver biopsies were prospectively recruited for liver elastography by SWE, as part of an on-going audit for service provision. Liver stiffness measurements by TE of these patients were used as comparisons (within 1 year). Spearman correlation coefficient was used to compare the two elastography methods.

Results
32 patients were initially recruited but 2 patients were excluded because of acute hepatitis (ALT x2 upper limit of normal) and congestive cardiac failure. In another 5 patients, invalid TE measurements were obtained due to high body mass index but SWE was possible in these patients. Of the 25 patients analysed, the aetiology of chronic liver disease include 48% (12/25) chronic viral hepatitis, 24% (6/25) autoimmune liver disease, 8% (2/25) alcohol-related, 8% (2/25) NAFLD and 12% (3/25) other miscellaneous causes. The median age was 55.0 (IQR 44.0-63.5) years and 48% (12/25) were male. The median ALT and AST were 29.0(22.5-65.5)IU/L and 24.0(21.3-57.0)IU/L respectively. No significant cholestasis was noted with a median bilirubin of 8 (7-13)µmol/L and ALP of 82 (66-102)IU/L. The median liver stiffness measurements were 7.1(5.0-9.8)kPa by TE and 7.1(6.1-9.3)kPa by SWE (p=0.37). Liver stiffness measured by SWE and TE were comparable, r=0.68 (p=0.01).

Conclusions
Both SWE and TE are comparable ultrasound-based elastography methods for assessing liver stiffness. Although further data is required, SWE appears to be a promising complementary tool in the non-invasive assessment of liver stiffness.

ABSTRACT 51 (150) POSTER PRESENTATION

Single centre experience of PEG tube insertion in a tertiary referral centre 2010 – 2015

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Introduction
Percutaneous Endoscopic Gastrostomy (PEG) tubes are an established form of long-term nutrition. Whilst there is significant evidence to support the use of enteral feeding in specific circumstances there is also considerable morbidity and mortality associated with PEG insertion. In 2004 the National Confidential Enquiry into patient outcome and Death reported 1 in 5 PEG procedures were futile or not indicated. This highlights how important appropriate patient selection is to minimize morbidity and mortality.

Aims/Background
We aimed to study the patient population in St Vincent's University Hospital who had undergone PEG tube insertion in the last 5 years to review the indications and outcomes in this cohort.

Method
• Retrospective analysis of patients undergoing PEG tube insertion in SVUH from 2010-2015.
• Study population was identified using HIPE coding for admissions related to PEGs.
• Data was collected using chart review, HIPE and hospital databases.
• Data included patient demographics, indication, diagnosis, length of hospital stay, procedure type, discharge destination and 30 day mortality.

Results
• 133 initial insertions of feeding tubes were identified.
• 37 radiologically inserted (RIG) and 96 PEGs were included.
• 34 patients (25%) were over 75 years old at the time of PEG tube insertion.
• Indications for insertion included
• Malignancy (predominantly head and neck cancer) (n=27)
• stroke (n=13)
• neurological conditions (n=28)
• aspiration pneumonia and dementia (n=16)
• other (n=29)
• malnutrition/CF (n=15)
• GI (n=5).
30-day mortality = 7.3% (n=7), across a variety of indications.
30-day mortality in the >75years group was 18%, compared to 1.6% in the <75years group (p=0.003)
4 patients required ≥3 PEG insertions

Conclusions
The challenges around PEG insertion are highlighted by the 30-day mortality rate observed in the > 75 cohort who account for over 1/3 of patients undergoing PEG insertions. We acknowledge that guidelines will never be able to encompass every clinical situation. However this data suggests that careful review of indications and patient status is critical to optimizing outcomes following PEG insertion and that GI services should be involved in this discussion from the outset.

ABSTRACT 52 (151) POSTER PRESENTATION

Patient Comfort Scores at Colonoscopy: What is a reasonable target in a pubic hospital?

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Introduction
Patient comfort is a recognised component of quality assurance for colonoscopy. RCPI guidelines recommend that patient comfort should be assessed for every colonoscopy. They recommend the use of the Gloucester Comfort Scale as an objective measure of patient comfort(scores of 4 or 5 on this scale indicate significant patient discomfort). Although comfort is a key auditable outcome for colonoscopy, there are currently no defined standards for comfort during colonoscopy.

Aims/Background
In 2013 Ekkelenkamp et al. assessed performance indicators in 17,027 colonoscopies, and found that the average percentage of patients experiencing significant discomfort during colonoscopy (defined as score of 4 or 5) was 7.7%. Based on the findings of this article, we aimed to review practice in Naas General Hospital to see if patient comfort scores were in line with Ekkelenkamps findings. We proposed a goal of patient comfort scores of 4 or 5 in <10% of patients and we aimed to assess if this is a realistic target for a busy public hospital where endoscopists include medical and surgical consultants and NCHDs.

Method
We recorded comfort scores for all colonoscopies performed over a 3 month period in 2014. All comfort scores were agreed on by the endoscopist and endoscopy nurse. Average comfort scores were recorded for each endoscopist, for colonoscopies completed by Medics and Surgeons, and for the Unit as a whole. Additionally we recorded comfort scores for all patients who underwent colonoscopy performed by a medical endoscopist over an 8 month period in 2016. Data was extracted manually from the Endoscopy Patient Register Book and evaluated using Excel.

Results
A total of 764 colonoscopies were reviewed. We reviewed 502 colonoscopies performed in 2014 and found the overall percentage of patients who experienced significant discomfort (score of 4 or 5) during colonoscopy was 9.3% (ranging from 0% to 25% depending on the endoscopist). We reviewed 262 colonoscopies performed in 2016 and found the overall percentage of patients who experienced significant discomfort was 4%.

Conclusions
Our findings were in keeping with those of Ekkelenkamp et al. and suggest that a target of <10% of patients with a comfort score of 4 or 5 should be achievable in Irish hospitals.

ABSTRACT 53 (152) POSTER PRESENTATION

Streamlining efficiencies: How a virtual biologic clinic can improve patient care

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Introduction
A virtual clinic is an example of a relatively cost neutral intervention that may improve standards of care without putting further strain on overburdened healthcare budgets and resources. Biologic drugs are commonly used to treat IBD patients and require specialist input with regular review and so may provide an opportunity for utilization of this strategy.

Aims/Background
Our aim was to examine if our new Virtual Biologics Clinic (VBC) was an effective way of managing IBD patients on biologics.

Method
Our VBC takes place on a fortnightly basis and involves a multidisciplinary team including two Consultant Gastroenterologists and a Clinical Nurse Specialist. The clinic examines patients with IBD who are receiving biologic medications in our infusion unit (i.e. Infliximab, and Vedolizumab). As part of this study we reviewed the productivity from the clinic from June 1st 2016 to August 24th 2016.

Results
231 patients in total were reviewed at the VBC. Of the 231 patients, only 10 new outpatient appointments were made and 7 had their appointment brought forward. Ten patients were contacted by phone from the clinic.
On review of medication, a total of 26 patients had biologic dose alterations made (16 had their doses deescalated, 10 had dose escalated). Changes were made to oral prescriptions on 8 occasions (including alterations of immune-modulators). The biologic drug was switched on one occasion.
Referrals to other disciplines were sent in five cases (including surgery, dermatology, dietetics). Further investigations were ordered in 27 patients. Including, 3 booked for endoscopy, 16 for radiological scans, 6 for blood tests and 2 letters were sent to GP's for further blood tests.
Six patients were prescribed iron for iron deficiency and three more patients were treated for other vitamin/mineral deficiencies.

Conclusions
The VBC ensured regular review of patients on biologics whilst avoiding the need for unnecessary appointments in the outpatient department. Interestingly, 11% of patients had changes to their dosing strategy of their biologic drug, with the majority (61.5%) of these being dose reductions. A VBC has the potential to have significant impact on overall quality of care; prevent crisis admissions by proactive care and may simultaneously help reduce costs.

ABSTRACT 54 (153) POSTER PRESENTATION

Is low serum albumin a potentially useful surrogate of sub-therapeutic infliximab trough levels?

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Introduction
Low serum albumin has been suggested to be a predictive factor for altered infliximab (IFX) pharmacokinetics and as a consequence sub-therapeutic trough levels. IFX levels are increasingly becoming part of standard clinical practice. However, access to levels in this healthcare system may be limited or where available time delayed.

Aims/Background
Our aim was to examine if low serum albumin, high CRP or raised platelets was associated with low IFX trough levels in our cohort such that any or all may be used as a surrogate marker for sub-therapeutic levels where access to levels may be sub-optimal.

Method
As part of a newly established Virtual Biologic Clinic in our institution we have initiated a protocol for scheduled assessment of IFX trough and antibody levels on the day of infusion; irrespective of clinical activity of disease. Routine haematological and biochemical indices are also assessed

Results
We assessed IFX levels in 90 consecutive inflammatory bowel disease patients attending our infusion unit for infliximab. 61 patients had levels considered therapeutic (i.e. >2mg/L); of which 14 patients had levels greater than 10mg/L implying supra-therapeutic dosing. 15 patients had indeterminate infliximab trough levels. The remaining 18 patients had sub-therapeutic trough levels (i.e. <1.0mg/L).
There was no significant correlation seen in our cohort with IFX trough level and low serum albumin (r2=0.047), high CRP (r2= -0.16) or raised platelet count (r2=0.016).
In patients with sub-therapeutic IFX levels the median serum albumin level was 42, median CRP was 2.6 and median platelet count was 282.

Conclusions
In our cohort of patients, sub-therapeutic trough IFX levels were not uncommon (20%) and were found in patients with both active and inactive disease. In contrast to previous reports, low albumin was not associated with sub-therapeutic IFX trough levels in our group. No other surrogate markers could be identified from our cohort. IFX trough levels are undoubtedly an important component in the delivery of care to IBD patients, however access to timely levels and interpretation of results remains a challenge.

ABSTRACT 55 (154) POSTER PRESENTATION

A Comparison of Urgent and Non-Urgent Endoscopy Referrals to Medical endoscopy in UCHG.

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Department(s)/Institutions

Introduction
Gastrointestinal endoscopy is an integral part of GI medicine. It has not only got a diagnostic role but also therapeutic role in a wide range of gastrointestinal disorders.Over the decade an increasing demand in GI endoscopy requests has been oberved in this country. In UCHG we compared endoscopy referrals(Urgtent Vs non urgent) in terms of abnormality detection.

Aims/Background
To determine and compare urgent with non urgent endoscopy referrals in terms of abnormality detection rate. Such kind of study has not been done/ published in Republic of Ireland.

Method
This was an observational retrospective study which was completed in the medical endoscopy unit in UCHG. Total 699 mixed upper and lower GI endoscopy reports from September 2015 to April 2016 29 were included. 29 did not meet the inclusion criteria and were excluded. Inclusion criteria was all new presentations and those whos previous endoscopy was normal. We made use of PAS and EndoRaad system in the hospital computers. Urgent request were defined as those requests that are completed in 3-4 weeks and non-urgentt requests were those that are completed in 8-10 weeks. Straight percentages were obtained and comparsions were made between the two catagories.

Results
In Total of 670 endoscopies there were 334 OGDs and 336 colonoscopies. There were 117(69%) normal and 52(30%) abnormal scopes result in total 169 urgent OGD requests. On the contrary the non-urgent OGDs(165) showed that there were 49(29%) normal and 116(70%) abnormalities. This was a very astonishing and striking result. The remaining 336 colonoscopies showed similar results in the non urgent requests but with a less difference. It showed that 78(47%) were normal and 86(52%) were abnormal in urgent group and 74(43%) normal with 98(56%) abnormal in the non-urgent requests.

Conclusions
The study clearly shows that more abnormalities were picked up on non urgent request as compared to urgent request. This was more evident in the case of upper as compared to lower GI endoscopies. It need more research with large sample size and multi study centres to change the practice of rushing non urgent clinical case for urgent endoscopies.

ABSTRACT 56 (155) POSTER PRESENTATION

Neither IBD Phenotype nor CRP / Albumin Ratio are Associated with Time to Discontinuation of Subcutaneous Anti-TNF Therapy

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Introduction
Subcutaneous anti-tumour necrosis factor alpha (TNF) therapies appear to have greater efficacy in Crohn's disease (CD) compared with ulcerative colitis (UC).

Aims/Background
We aimed to evaluate, in real-world clinical practice, whether there was difference in the outcome of subcutaneous anti-TNF therapy comparing UC and CD. We also assessed the association between blood inflammatory markers and therapy outcome.

Method
Consecutive patients commencing anti-TNF therapy for UC and CD between 2011 and 2016 were identified. Demographic and baseline biochemical data were collected. CRP / Albumin ratio was calculated. Date of initiation and discontinuation of anti-TNF therapy were determined. Time to discontinuation of anti-TNF therapy was used to define therapy outcome. Primary analysis compared time to discontinuation of anti-TNF therapy between UC and CD cohorts. Secondary analyses evaluated the associations between CRP/Albumin ratio, CRP, Albumin and Week 8 CRP and time to discontinuation of subcutaneous anti-TNF therapy. P values < 0.05 were considered statistically significant.

Results
The study cohort comprised 144 IBD patients [n=70 CD /n=74 UC; Age (median, range) 43 years (17 – 81); 49% Male; 87% Adalimumab (ADA) / 13% Golimumab (GLB)]. Baseline CRP and Albumin (median [range]) were: 5 mg / L [1 – 87], and 44 [35 – 50] respectively. There was a non-significant trend toward a higher CRP in CD compared with UC cohorts (p=0.09). The median time to discontinuation of anti-TNF therapy comparing CD and UC cohorts was similar, 96.3 weeks (95% CI 51.4 – 141.2) versus 119.3 weeks (32.8 – 205.8) respectively p=0.86. Neither baseline CRP, Albumin, CRP/Albumin ratio nor Week 8 CRP were associated with time to discontinuation of anti-TNF therapy p=0.62, p=0.56 and p=0.60 and p=0.73 respectively.

Conclusions
In real world clinical practice, the success of subcutaneous anti-TNF therapy measured by time to discontinuation of drug, is similar comparing CD and UC cohorts. This finding may reflect improved understanding of subcutaneous anti-TNF dosing requirements in UC along with proactive dose optimisation. Non-invasive biomarkers of inflammatory burden did not demonstrate a clear association with therapy outcome and may be more important in patient subgroups with severe disease.

ABSTRACT 57 (156) POSTER PRESENTATION

The use of good quality cecal and terminal ileal images as an evidence of complete colonoscopy.

Author(s)
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Introduction
High cecal intubation rate is an important performance indicator and quality measure for colonoscopies. The purpose of documenting cecal intubation is to provide objective evidence of complete colonoscopy, convincing for independent reviewers. As self - recorded documentation alone is insufficient objective evidence, both American Society for Gastrointestinal Endoscopy (ASGE) and the European Society of Gastrointestinal Endoscopy (ESGE) recommend still images of caecum as a preferred evidence of documenting cecal intubation.

Aims/Background
We analysed documentation of complete colonoscopies based on endoscopic images of caecum or terminal ileum taken at the time of examination. Images of caecum or ileum may be difficult to capture despite relative ease of identifying caecum on real time endoscopy. Studies therefore done at other centres showed definite photographic documentation of cecum in almost half of procedures whereas in rest of the cases pictures were either suggestive or doubtful of cecal intubation.

Method
Our retrospective study include retrieval of EndoRAAD data for the month of May 2016. All written documented complete colonoscopies were initially included but colonoscopies without

images due to technical problems were excluded from study. Also patients who had ileocecal resection were excluded from the study. Images were distributed among 3 experienced endoscopists who were blinded about details of procedures. The reports were scored under one of the following category,
Definitely cecum or terminal ileum,
Likely cecum or terminal ileum,
Not sure of location or unlikely cecum,
No pictures recorded
The data obtained after scoring was also analysed for surgeons and gastroenterologists.

Results
A total of 170 colonoscopies were analysed. No pictures were recorded on 7 reports (4.11 %). In 86 reports (50.5%), the pictures recorded were confirmatory of cecal or ileal intubation. Among the remaining reports, 43 had pictures likely of cecum / ileum (25.2 %) whereas 34 reports had pictures not sure of their location (20%).

Conclusions
Our audit showed absolute surety of cecal intubation in 50.5% examinations which increased to 75.5% if we relax our criteria to reasonable surety of cecal or terminal ileal pictures. This higher percentage of positivity about complete examination as compared to other similar studies is perhaps due to our preference of recording multiple digital images during colonoscopy.

ABSTRACT 58 (157) POSTER PRESENTATION

Helicobacter Pylori resistance pattern in patients cohort at St. James`s Hospital Dublin.

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Introduction
At least half of the world's population is colonised by Helicobacter Pylori and developing world has much higher prevalence than west. It is a very well recognised cause for gastritis, peptic ulcer disease, gastric adenocarcinoma and MALT lymphoma. The standard first-line therapy is a one-week triple therapy consisting of proton pump inhibitors such as omeprazole and the antibiotics clarithromycin and amoxicillin. Overall, eradication rates for H. pylori are falling and the prevalence of antibiotic-resistant infection is rising.

Aims/Background
To find out the H Pylori resistance patterns in patients presenting to St. James's hospital Dublin over last 5 years.

Method
We retrospectively collected patient's data who underwent upper GI endoscopy for H Pylori culture and sensitivity over last five years. Patients with positive culture were included in the study. Their resistance patterns were recorded and analysed.

Results
Total 152 patients were included in our study. Average age was 50.79 years. Out of 152, 64(42%) were males and 88 (58%) were females. None of them had resistance to Amoxicillin and there was only one patient with resistance to Tetracycline. The resistance to Clarithromycin and Metronidazole was found in 114 (75%) and 98 (64 %) respectively. Eighty six (56%) were resistant to both Clarithromycin and Metronidazole. Twenty three out of 69 (33%) were resistant to Levofloxacin as well.

Conclusions
We can conclude that H Pylori resistance to Clarithromycin and Metronidazole is very common resulting in lower rates of successful eradication following first line triple therapy. Resistance to the Levofloxacin is slowly rising as well. In order to successfully eradicate H Pylori, there is a need to tailor the first line triple therapy according to the local resistance patterns.

ABSTRACT 59 (159) POSTER PRESENTATION

Source of Referral and Outcome in Patients with Hepatocellular Carcinoma in Ireland

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Introduction
Hepatocellular carcinoma (HCC) is the 3rd most common cause of cancer-related deaths and is the 6th most common cancer in Europe. Patients who have a history of cirrhosis are at a higher risk of developing hepatocellular carcinoma therefore regular surveillance is required. Those patients who are identified at an early stage (BCLC stage 0 or A) can be offered curative treatment.

Aims/Background
The aim of this study was to establish whether proximity to the national treatment centre affected stage at which patients are referred and their outcome.

Method
Data was extracted from the hepatocellular carcinoma database in St. Vincent's University Hospital identifying patients referred between January 2014 and September 2016. The database was analysed for source of referral and BCLC staging at referral. Those patients who did not have a referral source identified were removed from the analysis.

Results
194 patients were identified with 72.2% referred from Dublin and 27.8% outside Dublin. The majority of patients diagnosed were male (85.1%). From the Dublin referral group, the BCLC stage was as follows: Stage O or A 54.3%, Stage B 23.6%, Stage C 12.9% and Stage D 8.6%. From the outside Dublin referral group, the BCLC stage was as follows: Stage A 37.0%, Stage B 33.3%, Stage C 24.1% and Stage D 5.6%.

Conclusions
Our study shows that the National Cancer Registry grossly underestimates the true incidence of HCC in Ireland. The large numbers of Dublin based referrals suggest that effective screening of patients with cirrhosis for HCC is commonly not happening elsewhere. Additionally, Dublin based referrals were more likely to be referred at a stage where they can be offered curative therapy. HCC needs to be recognised immediately by NCCP and resources allocated to ensure effective screening of patients with cirrhosis for HCC.

ABSTRACT 60 (160) POSTER PRESENTATION

Inpatient Colonoscopy: Futile or Worthwhile?

Author(s)
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Introduction
Inpatient colonoscopy is less effective than outpatient colonoscopy, with reduced rates of caecal intubation and poorer bowel preparation. Guidelines recommend patients should have outpatient colonoscopy where possible.

Aims/Background
To compare inpatient versus outpatient colonoscopies from 2010-2011 with 2014-2015 with respect to volume and outcomes.

Method
We performed a retrospective audit of the EndoRADD database of colonoscopies from 2010/2011 compared to 2014/2015 with regards to the following outcomes: numbers of procedures, patient classification, quality markers including bowel preparation, caecal intubation, polyp detection and tumour detection. Bowel preparation for inpatients and outpatients changed from Picolax in 2010/2011 to Kleanprep in 2014/2015.

Results
Overall 4839 colonoscopies were performed in 2010/2011 compared to 5730 in 2014/2015.

Significantly more inpatient procedures were performed in 2010/2011 (821(17.0%)) compared to 2014/2015 (311(5.4%)). (P Value < 0.001)
Poor bowel preparation rates increased significantly in inpatients from 15.6% (128(2010/2011)) to 30.9% (96(2014/2015)). (P Value< 0.001). Poor bowel preparation rates significantly decreased in outpatients from 17.0% (679(2010/2011)) to 8.7% (473(2014/2015)). (P Value < 0.001)
Caecal intubation rates remained poor in both inpatient groups, 81.3% (668(2010/2011)) versus 74.6% (232 (2014/2015)). Caecal intubation rates significantly improved between outpatients, 83.2% (3344(2010/2011)) versus 93.9% (5089(2014/2015)). (P Value < 0.001).
There was no significant difference in polyp detection rates between inpatients from 23.1% (190 (2010/2011)) to 20.6% (64(2014/2015)). Polyp detection rates increased in outpatients significantly from 22.6 % (910(2010/2011)) to 33.4% (1810(2014/2015)). (P Value < 0.001). Polyp detection was significantly more likely in outpatients compared to inpatients in 2014/2015. (P Value <0.001).
Tumor detection rates were 5.6% (2010/2011) and 7.4% (2014/2015). Outpatient tumour detection rates were 2.2% (2010/2011) and 2.0% (2014/2015). Comparing tumour detection rates between inpatients and outpatients in both groups showed tumour detection was more likely in both if you were an inpatient. (P Value < 0.001 in both groups).

Conclusions
In line with guidelines inpatient colonoscopy in our unit is decreasing. Inpatient colonoscopy still has high rates of poor preparation, failed caecal intubation and low polyp detection compared to outpatient colonoscopy. Inpatient colonoscopy should be reserved for a minority of select patients.

ABSTRACT 61 (161) POSTER PRESENTATION

Review of renal function post orthotopic liver transplantation: an experience of The National Liver Transplant Unit in St. Vincent's University Hospital

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Introduction
Development of chronic kidney disease (CKD) has become increasingly prevalent post liver transplantation and is associated with an enhanced morbidity and mortality. Post-transplant patients are normally started on medications including calcineurin-inhibitor (CNI) that can predispose to developing CKD.

Aims/Background
The aim of this study was to evaluate patient's renal status within one week post-transplant and compare with renal parameters at 1-year in the national liver transplant unit in the year 2014.

Method
Data was obtained from our transplant database. We reviewed patient's peak creatinine within week 1 and tacrolimus level at day-7 post-transplant. We collected data at 1-year follow-up in terms of EGFR, presence of diabetes or hypertension, immunosuppressive drugs and their levels. In patients with an EGFR<60, additional data was collected, including blood pressure (BP), use of ACE inhibitors and whether patients were seen by nephrology.

Results
A total of 38 patients were transplanted in 2014. 2 patients passed away within 1-year. Mean peak creatinine within first 7 days is 128.9µmol/L(51-299). Mean tacrolimus level at day-7 is 7.38µg/L(<1.5–17.3). 4 patients had known kidney disease pre-transplant. At 1-year post-transplant, mean EGFR is 69.85 (19.9–109.8). 32 patients were on tacrolimus (mean level 2.6µg/L[1.9-13.2]), 3on CNI-free-regiments, and 1 on cyclosporine. 8 patients had EGFR <60mL/min/1.73 m2(22.2%), but only one was on CNI-free-regiment. In these patients, 3 had diabetes and hypertension, one had only diabetes, and two had only hypertension. Only 3 patients had a BP <140/90. 4 patients were on ACE inhibitor. One patient had EGFR <30mL/min/1.73 m2 and has been seen by nephrologist. None of these patients had a urinalysis, urinary electrolyte measurement, or renal ultrasound.

Conclusions
In our centre, renal impairment post-transplant is common. Despite CNI being associated with CKD post-transplantation, only a small portion of patients was on CNI-free-regiment. This is likely due to balancing the risk of rejection with development of CKD. In patients with EGFR <60mL/min/1.73 m2, BP control was not adequately achieved and only half was on an ACE inhibitor which could be a potential intervention. A more holistic approach to investigate patients including urinalysis, measurement of urine ACR and renal imaging is needed.

ABSTRACT 62 (162) POSTER PRESENTATION

Does MRE represent a suitable non-invasive alternative to ileocolonoscopy with Rutgeert's scores for grading post-operative recurrence in Crohn's disease?

Author(s)
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Introduction
The Rutgeert's score is the standard measure used for endoscopic quantification of post-operative recurrence in Crohn's disease, providing valuable prognostic information used to guide prophylactic treatment decisions. Magnetic resonance imaging of the small intestine or enterography (MRE) is increasing used to assess disease burden, phenotype and activity in small bowel Crohn's disease. There are very limited data on whether MRE to assess the presence/degree on recurrent Crohn's in the pre-anastomotic ileum correlates well enough with the Rutgeert's score to offer a non-invasive alternative.

Aims/Background
To compare Rutgeert's scores from ileocolonoscopy with measures of inflammatory activity in the pre-anastomotic ileum on MRE (based on T2 hyperintensities and contrast enhancement) performed at a single high volume centre.

Method
Patients who had a diagnosis of Crohn's disease and history of ileal resection who underwent colonoscopy with prospective Rutgeerts score evaluation were identified from an endoscopy electronic reporting system and cross-referenced with the hospital radiology system to identify those who had an MRI small bowel study within 6 months of ileocolonoscopy.

Results
64 patients were identified who met the criteria. Mean age was 41.4 years (SD 13) with 52% female. 29 patients (43%) were classified as having active inflammatory disease in the pre-anastomotic ileum by MRI standards. 18, 13, 11, 15 and 7 patients had a Rutgeert's score of 0, 1, 2,3 and 4, respectively. The median time between MRI scan and colonoscopy was 1.2 months (3.2 IQR).

There was no significant association between inflammatory activity as measured by the Rutgeert's score and MRE evidence of activity. The mean Rutgeert's score for patients classed as active by MRE was 1.86 (SD 1.48) while, for inactive disease was 1.54 (SD 1.3) (P 0.37). A subset of 17 patients had colonoscopy and MRE on the same day and again there was no association between Rutgeert's score and inflammatory activity on MRI (active 1.14 (SD 1.1) versus inactive 1.6 (SD 1.4), P 0.5). Negative predictive value 51% of MRI.

Conclusions
Our data suggest that endoscopic evaluation remains essential for accurate prognosis in this group.

ABSTRACT 63 (163) POSTER PRESENTATION

Use of an integrated care pathway for Acute Severe Ulcerative Colitis improves quality

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Introduction
The UK National IBD Audit identified important gaps in the care of hospitalised patients with Acute Severe Ulcerative Colitis (ASUC). A range of indicators of the quality of this care have thus emerged.

Aims/Background
To assess whether the introduction of a structured care pathway for acute colitis improves quality of patient care.

Method
A baseline review of all acute hospital admissions with ASUC from January 2010-November 2011 highlighted gaps in inpatient care. As a result, a structured pathway was introduced to be used for all admissions with ASUC. A further review of admissions with ASUC was conducted following the introduction of the care pathway from July 2015-September 2016. A comparison was made of key outcomes and quality measures at baseline and following introduction of the care pathway. Comparison was also made with the UK National IBD Audit, 2014. Key outcomes measured included length of stay, time till seen by GI team, stool C&S and C Difficile being sent, endoscopy during admission, steroids prescribed, bone protection, VTE prophylaxis, seen by dietician, seen by IBD nurse, weight recorded, stool chart recorded, PFA on admission and investigation of anaemia.

Results
67 patients were identified by HIPE coding with primary discharge diagnosis of colitis. 41 patients with ASUC were eligible for further study (patients admitted electively for endoscopy or surgery were excluded). Results are listed as current study/2010-2011 study/UK IBD Audit. Prescription of bone protection improved significantly (98%/73%/74%). Stool for C&S and C Difficile was sent in more patients (85%/77%/81%). A greater proportion of the patients were seen by an IBD specialist nurse during admission(63%/10%/44%). Anaemia was adequately evaluated in 71% of patients vs 29% in the previous study. Median length of stay was reduced following introduction of the care pathway (4 days vs 8days/7days)

Conclusions
The introduction of a structured integrated care pathway for ASUC has resulted in improvements in patient care and adherence to the UK IBD Audit guidelines, particularly with regards to IBD nurse involvement, stool sample collection, bone protection and investigation of anaemia. Use of a care pathway may also help reduce length of hospital stay.

ABSTRACT 64 (16W165) POSTER PRESENTATION

Development of a patient information leaflet on" Steroid treatment for Inflammatory Bowel Disease" (IBD)

Author
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Background
Inflammatory Bowel Disease is a chronic, relapsing, unpredictable inflammatory condition of the gastrointestinal tract for which there is no cure.
Corticosteroids (known as steroids) are a widely used medication in the management of IBD during moderate to severe episodes because of their anti-inflammatory property. Steroids are extremely effective. However they are potent agents with potentially severe side-effects in both short and long term. A review of the literature available in Rep of Ireland for patients revealed no specific information leaflet was available for patients on steroids and IBD.

The aims/objectives are:
1. To provide patients who are diagnosed with IBD adequate information on all aspects of steroids used in IBD.
2. To provide a tool for health care professionals which will be used to inform and educate patients.
3. To raise awareness about steroids used in IBD for patients and health care professionals.

Project Development
A questionnaire was developed for IBD patients who attended at Gastroenterology out-patients over a one month period. 42 patients completed the questionnaire. The questionnaire was designed to assess:
• if patients had received information either written or verbal when prescribed a course of steroids
• the degree of side-effects experienced by patients.
• if patients wanted more detailed information on steroids.
Results:
1. 79% said yes they had been given verbal explanation and 21% said they not given verbal explanation.
2. 43% said yes and 57% said they had not been given written information when prescribed a course of steroids
3. Side-effects: Only 2 patients said they did not experince any side-effects.
65% of patients experenced 3 or more of the side-effects during a course of steroids.
4. 74% agreed that they would like more written information and 26% said no.

Outcomes
A draft patient information leaflet was developed and reviewed with Consultant Gastroenterologist, pharmacist and Health Promotion officer. The final document was referred to the Editorial committee at Letterkenny University Hospital and finalised. Tillotts Pharma Limited who produce patient information leaflets on IBD nationally were approached to publish the leaflet. National distribution commenced in April 2015.

ABSTRACT 65 (16W167) POSTER PRESENTATION

Audit of hepatomas- diagnosis and management

Authors
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Introduction
Hepatocellular carcinoma (HCC) is a primary malignancy of the liver. It is the third leading cause of cancer death worldwide. The incidence of HCC in Western society has risen and this correlates with a rise in liver cirrhosis cases. This study examines the risk factors, diagnosis, management and outcome of patients with HCC in a single centre.

Aims
This study aims to highlight the incidence of HCC in a single hospital from 2004 - 2016. The commonest risk factors for HCC as well as the diagnosis, management and survival times of the study group are examined.

Method
This is a retrospective study of 47 cases of HCC from 2004 - 2016. Patients were stratified according to risk factors, imaging used to detect tumours and treatment received. Survival analysis was done by stratifying patients into transplant and non transplant group.

Results
47 patients were included in this study, 42 male: 5 female. These patients were diagnosed from 2004 – 2016. 19 (40%) had HCV, 25 (53%) had excess alcohol intake. 45 (95%) were cirrhotic at the time of diagnosis. Over 50% had 3 or more risk factors. Risk factors studied include hep B, hep C, alcohol excess, raised BMI, haemochromatosis, diabetes meillitus. Ultrasound was used for surveillance imaging and detected 85% of HCC. The majority of patients received TACE (n=18, 38%) or sorafenib (n=8, 17%) or both TACE and later sorabenib (n=6, 13%). Patients who received TACE had longer survival times than those who did not but this was not statistically significant (p=0.233). None of the patients underwent tumour resection. Eight patients (17%) from the study population received liver transplant. All transplant patients are still alive. The average survival time in the transplant group from diagnosis of HCC to present was 58 months. The average survival time of non transplant patients was 19 months, but ranged from 1 to 56 months with a median survival of 17 months.

Conclusion
The commonest risk factor for HCC was cirrhosis. Over half of the patients had over 3 risk factors for developing HCC. Ultrasound was a good initial screening investigation. Survival time was highest in the transplant group.

ABSTRACT 66 (16W 168) POSTER PRESENTATION

A 39 year old man with a fishy complaint

Authors
Thong, D, Buckley M

Introduction
A 39-year-old gentleman was referred to the Gastroenterology clinic by his GP for on-going complaints of nausea, vomiting, bloating and tenesmus. History was suggestive of a functional bowel disorder, examination was normal.

Clinical course
He complained of symptoms as above for 6 months. An OGD and colonoscopy were performed showing severe duodenitis. CLOt est was positive, triple therapy given, but despite multiple courses he remains CUBT positive.
Colonoscopy was normal to TI, and colonic histology was also normal.

At subsequent clinic review the patient complained of social isolation and exclusion at work due to a perceived malodour. He

said that both he and his colleagues complained he had a 'fishy smell' from his breath and his body. At no stage during multiple clinic visits was any unusual odour detected by the medical team. This, along with loose bowel motions and abdominal bloating were his most distressing symptoms.
These symptoms improved significantly when on antibiotics, both triple and quadruple therapy and Rifaximin. Interestingly he noted that his perceived 'fishy odour' was less apparent when he was on antibiotics and Probiotics.
The working diagnosis was of Functional Bowel disorder and the patient was referred for Cognitive Behavioural Therapy.

Subsequent Trimethylaminuria genetic testing was positive.

Discussion
Trimethylaminuria is a disorder in which the volatile, fish-smelling compound, trimethylamine (TMA) accumulates and is excreted in the urine. It is also found in sweat and breath of these patients.1 The first clear clinical case report is attributed to Humbert in 1970.3 Like our patient, individuals presents complaining of body odour and/or halitosis. The odour is intermittent, worse when stressed or sweating. The patient may have difficulty convincing the medical team of the veracity of his symptoms, as in this case!
In subjects with trimethylaminuria, there is a disparity between the quantity of TMA acquired from the diet requiring oxygenation, and the ability of the hepatic microsomal enzyme system to oxidise this load.1,4 The excess TMA accumulates and is excreted in the urine, sweat as well as other bodily secretions, and is detectable in exhaled breath.

Conclusion
Unfortunately, there is no known cure or treatment for the disorder. Exclusion of the major source of TMA from the diet, namely marine fish, is the primary dietary modality.1 Brief courses of neomycin and metronidazole have been used to suppress gut microflora and are said to be useful in some but not all cases.2

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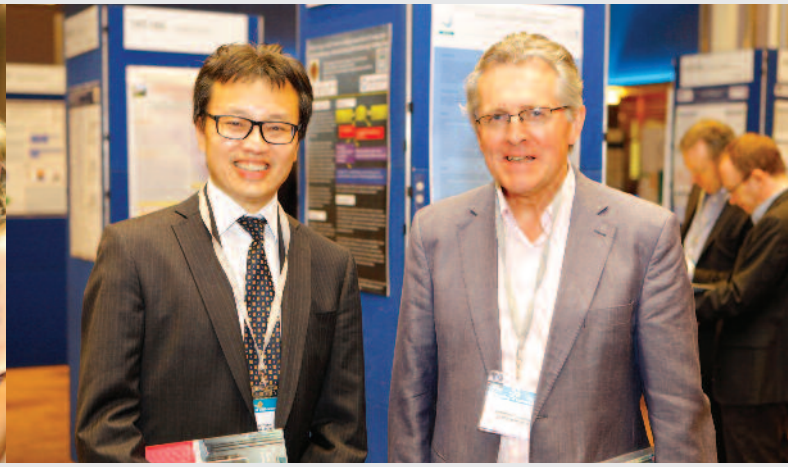

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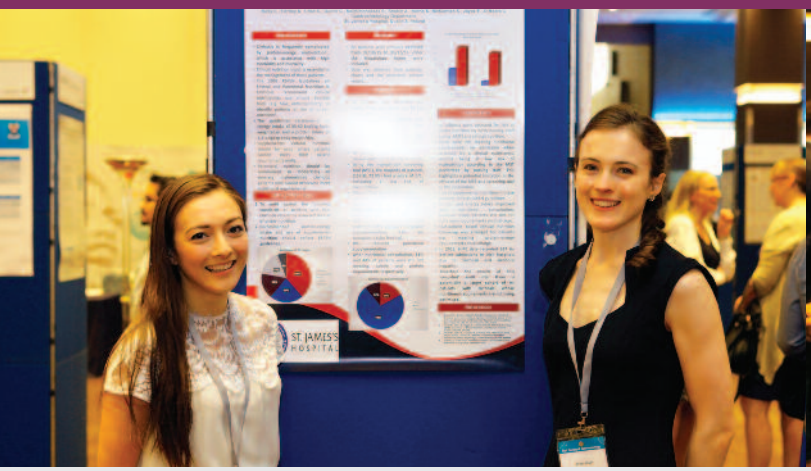

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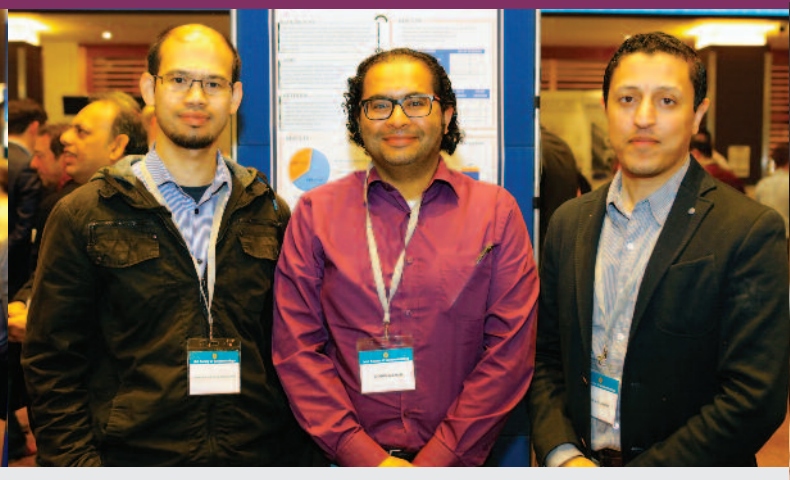

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Summer Meeting 2016

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Shane Ryan, Brian Egan, Donogh Norton

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Summer Meeting 2016

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

ASACOLON® 400mg and 800mg GR Tablets: Reddish brown, oblong, coated tablets each containing 400mg or 800mg mesalazine.

INDICATIONS: For the treatment of mild to moderate 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) with liquid 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 or hepatic function is impaired. Children: Limited data are available. Children aged 6 years 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. Consider liver function testing prior to therapy. 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 of allergic background, and in the elderly. Not for use in patients with a history of mesalazine-induced cardiac hypersensitivity. Monitor closely in patients sensitive to 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, haematoma, purpura, anaemia, persistent fever or sore throat. Data in children (aged 6 to 18 years) are limited. Tablets contain lactose (76mg/152mg); not for lactose-intolerant patients. Intact tablets in stool may be empty tablet coating. INTERACTIONS: Sulfasalazine decreases absorption of digoxin, but no data on interaction of digoxin with mesalazine. Mesalazine can increase the myelosuppressive effects of azathioprine, 6-mercaptopurine, or thioguanine; concomitant use may precipitate 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. Concurrent use of nephrotoxic 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; more frequent pre-term births cannot be excluded. 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 ineffective. Rare: 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 exanthema, 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, cholestatic hepatitis, blood bilirubin increased, alopecia, myalgia, arthralgia, impairment of renal function, nephrotic syndrome, renal failure (possibly reversible), oligospermia (reversible), chest pain. Frequency not known: exacerbation of colitis, lupus-like syndrome with pericarditis, pleuropericarditis, rash and arthralgia.

LEGAL CATEGORY: POM.
MARKETING AUTHORISATION NUMBER: Asacolon® 400 mg GR Tablets PA 2018/1/1, Asacolon® 800 mg GR Tablets PA 2018/1/2
MA HOLDER: TILLOTTS PHARMA GMBH, Warmbacher Strasse 80, DE-79618 Rheinfelden, Germany
DATE OF PREPARATION: February 2016. CODE: 2016/8.
FULL PRESCRIBING INFORMATION AVAILABLE ON REQUEST FROM THE MARKETING AUTHORISATION HOLDER OR FROM TILLOTTS PHARMA LIMITED, 25 SANDYFORD OFFICE PARK, DUBLIN 18, IRELAND, TEL: (00 353 1) 294 2015.
Asacolon® is a trademark.

1. Sandborn, WJ et al. Once-daily dosing of delayed-release oral mesalamine (400-mg tablet) is as effective as twice-daily dosing for maintenance of remission of ulcerative colitis. Gastroenterology. 2010 Apr;138(4):1286-96.

The referenced study relates to Allergan's Eudragit S-coated mesalazine. Allergan markets mesalazine products in the USA, Canada and the UK. Tillotts Pharma markets its own Eudragit S-coated mesalazine products under the trademark Asacolon® in Ireland, and under other trademarks in continental Europe (other than Switzerland, Italy, Belgium, the Netherlands and Luxembourg) and other countries. Allergan and Tillotts Pharma are not related companies.

ZERIA GROUP

TILLOTTS PHARMA

GI-health is our passion™

viekirax®
ombitasvir/ paritaprevir/
ritonavir film-coated tablets

exviera®
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Because Every Patient Matters

100%
SVR_{12}
(n=361/361)

FOR GT1b PATIENTS

WITH AND WITHOUT COMPENSATED CIRRHOSIS‡1,2

96%
SVR_{12}
(n=684/714)

FOR GT1a PATIENTS

WITH AND WITHOUT COMPENSATED CIRRHOSIS + RBV‡1,2

0.2%
(n=5/2,632)

HIGH TOLERABILITY§

DISCONTINUATION DUE TO ADVERSE REACTIONS WITH VIEKIRAX® + EXVIERA® +/- RBV1,2

When selecting a treatment, optimise the opportunity for cure*

RBV=ribavirin. *SVR was the primary endpoint to determine the HCV cure rate in the Phase 3 studies and was defined as unquantifiable or undetectable HCV RNA 12 weeks after the end of treatment (SVR_{12}).[1,2]
‡In patients who received the recommended regimen. §In Phase 2 and 3 clinical trials.

VIEKIRAX® ▼ 12.5 mg/75 mg/50 mg film-coated tablets & EXVIERA® ▼ 250 mg film-coated tablets PRESCRIBING INFORMATION PRESENTATION: Each Viekirax film-coated tablet contains 12.5 mg of ombitasvir, 75 mg of paritaprevir and 50 mg of ritonavir. Each Exviera tablet contains 250 mg of dasabuvir. Please refer to the respective Summary of Product Characteristics' (SmPC) before prescribing. **INDICATION:** For treatment of Chronic Hepatitis C (CHC) in combination with other medicinal products in adults. **DOSAGE AND ADMINISTRATION:** Oral. Treatment to be initiated and monitored by physician experienced in CHC management. See SmPC for full posology. **Dosage:** The recommended dose of Viekirax is two 12.5 mg/75 mg/ 50 mg tablets once daily with food. The recommended dose of Exviera is one 250 mg tablet twice daily (morning and evening) with food. **Recommended Co-administered medicinal product(s) and Treatment Duration:** Genotype 1b without cirrhosis or with compensated cirrhosis: Viekirax + Exviera for 12 weeks. Genotype 1a without cirrhosis: Viekirax + Exviera + ribavirin for 12 weeks. Genotype 1a with compensated cirrhosis: Viekirax + Exviera + ribavirin for 24 weeks. See SmPC for details. Genotype 4 without cirrhosis: Viekirax + ribavirin for 12 weeks. Genotype 4 with compensated cirrhosis: Viekirax + ribavirin for 24 weeks. See ribavirin SmPC for dosing instructions. **Special Populations:** HIV-1 Co-infection: No dose adjustment required. For dosing with HIV antiviral agents refer to SmPC for additional information. Liver Transplant recipients: Viekirax + Exviera + ribavirin for 24 weeks in liver transplant recipients with genotype 1 HCV infection. Viekirax + ribavirin in genotype 4 infected recipients. Elderly: No dose adjustment required. Renal impairment: No dose adjustment required. Hepatic impairment: No dose adjustment recommended in patients with mild hepatic impairment (Child-Pugh A). Viekirax is not recommended in patients with moderate hepatic impairment (Child-Pugh B). Viekirax is contraindicated and Exviera should not be used in patients with severe hepatic impairment (Child-Pugh C). Paediatric Population: No data available. **CONTRAINDICATIONS:** Hypersensitivity to any of the active substances or excipients. Ethinylestradiol-containing medicinal products such as those in most combined oral contraceptives or contraceptive vaginal rings. **Viekirax** is contraindicated in patients with severe hepatic impairment (Child-Pugh C). **Viekirax** in combination with CYP3A4 substrates: examples include; alfuzosin hydrochloride, amiodarone, astemizole, terfenadine, cisapride, colchicine in patients with renal or hepatic impairment, ergotamine, dihydroergotamine, ergonovine, methylergometrine, fusidic acid, lovastatin, simvastatin, atorvastatin, oral midazolam, triazolam, pimozide, quetiapine, quinidine, salmeterol, sildenafil (when used for the treatment of pulmonary arterial hypertension) and ticagrelor. **Viekirax with or without Exviera** in combination with enzyme inducers: examples include; carbamazepine, phenytoin, phenobarbital, efavirenz, nevirapine, etravirine, enzalutamide, mitotane, rifampicin, St. John's Wort *(Hypericum perforatum)*. **Viekirax with or without Exviera** in combination with CYP3A4 inhibitors: examples include; cobicistat, indinavir, lopinavir/ritonavir, saquinavir, tipranavir, itraconazole, ketoconazole, posaconazole, voriconazole, clarithromycin, telithromycin and conivaptan. **Exviera** is contraindicated in combination with CYP2C8 inhibitors: example includes; gemfibrozil. **SPECIAL WARNINGS AND PRECAUTIONS:** Viekirax and Exviera are not recommended as monotherapies. Hepatic decompensation and hepatic failure, including liver transplantation or fatal outcomes, have been reported postmarketing in patients treated with Viekirax with and without Exviera and with and without ribavirin. Most patients with these severe outcomes had evidence of advanced or decompensated cirrhosis prior to initiating therapy. Although causality is difficult to establish due to background advanced liver disease, a potential risk cannot be excluded. The efficacy of Viekirax has only been established in patients with Hepatitis C Virus (HCV) genotypes 1 and 4. The efficacy of Exviera has only been established in patients with HCV genotype 1 only. There are no data on the use of Viekirax and ribavirin in patients with genotype 4 infection with compensated cirrhosis, therefore optimal treatment duration has not been established. Co-administration of Viekirax with other antivirals other than Exviera and/or ribavirin has not been evaluated. For patients with cirrhosis: Monitor for clinical signs and symptoms of hepatic decompensation (such as ascites, hepatic encephalopathy, variceal haemorrhage).Hepatic laboratory testing including direct bilirubin levels should be performed at baseline, during the first 4 weeks of starting treatment and as clinically indicated thereafter. Discontinue treatment in patients who develop evidence of hepatic decompensation. When used in combination with ribavirin, women of childbearing potential or their male partners must use an effective form of contraception during the treatment and for 6 months after the treatment as recommended in the SmPC for ribavirin. Refer to the SmPC for ribavirin for additional information. Although ALT elevations associated with Viekirax and Exviera have been asymptomatic, patients should be instructed to watch for early warning signs of liver inflammation, such as fatigue, weakness, lack of appetite, nausea and vomiting, as well as later signs such as jaundice and discoloured faeces, and to consult a doctor without delay if such symptoms occur. Routine monitoring of liver enzymes is not necessary in patients that do not have cirrhosis. Early discontinuation may result in drug resistance, but implications for future therapy are not known. Use caution when administering Viekirax with fluticasone or other glucocorticoids that are metabolised by CYP3A4. Concomitant use of inhaled glucocorticoids metabolised with CYP3A can increase systemic exposures of the glucocorticoids, and cases of Cushing's syndrome and subsequent adrenal suppression have been reported with ritonavir-containing regimens. The safety and efficacy of Viekirax and Exviera have not been established in Hepatitis C/Hepatitis B co-infection patients. **INTERACTIONS:** See SmPCs for full details. **Viekirax in combination with Exviera:** Not Recommended: darunavir in patients with extensive PI resistance, fluvastatin and pitavastatin not recommended. Use caution and dose decrease may be needed for repaglinide. Use Caution: sulfasalazine, erythromycin, trazodone (lower dose of trazodone may be considered), fexofenadine, diltiazem, verapamil, rilpivirine once daily should only be used in patients without known QT prolongation, and without other QT prolongation co-medications. Monitor Levels: digoxin, warfarin (INR), Adjust Dose: Monitoring and dose reduction recommended for valsartan, losartan, candesartan and imatinib. Monitoring and dose adjustment may be needed for s-mephenytoin and levothyroxine. Reduction in colchicine dose or interruption of colchicine treatment is recommended in patients with normal renal or hepatic function. Decrease amlodipine dose by 50% and monitor. Decrease nifedipine dose and monitor. Furosemide decrease of up to 50% may be required upon monitoring. 300 mg dose of atazanavir recommended to be administered at the same time as Viekirax with Exviera, 800 mg darunavir once-daily without ritonavir recommended to be administered at the same time as Viekirax with Exviera in the absence of extensive PI resistance. Do not exceed 5 mg/day rosuvastatin. Reduce pravastatin dose by 50%. When starting co-administration, give one fifth of the total daily dose of ciclosporin once daily, monitor ciclosporin levels and adjust dose and/or dosing frequency as needed. When starting co-dosing, administer 0.5 mg tacrolimus once every week, monitor and adjust dose and/or dosing frequency as needed. Use higher doses of omeprazole if clinically indicated. Higher doses of esomeprazole/lansoprazole may be needed if clinically indicated. A decrease in alprazolam dose can be considered based on clinical monitoring. Carisoprodol, cyclobenzaprine, diazepam; no dose adjustment required, increase dose if clinically indicated. Reduction of hydrocodone dose by 50% and/or clinical monitoring should be considered. **Viekirax without Exviera:** As per combination with Exviera with following exceptions. Use Caution: dabigatran etexilate Not Recommended: Atazanavir and darunavir are not recommended with Viekirax without Exviera. Adjust Dose: Decrease digoxin dose by 30 – 50% and monitor. Do not exceed 10 mg/day rosuvastatin. **PREGNANCY AND LACTATION:** Extreme caution must be taken to avoid pregnancy in female patients and female partners of male patients when co-administered with ribavirin. See the ribavirin SmPC for information. There is only limited data on the use of Viekirax and Exviera in pregnant women. The potential risk to humans is unknown. Viekirax and Exviera should not be used in pregnancy. It is not known whether Viekirax, Exviera and their metabolites are excreted in human breast milk. **SIDE EFFECTS:** See SmPC for full details on side effects. Side-effects identified with Viekirax in combination with Exviera *Common side effects (≥1/100 to <1/10)*: pruritus Side-effects identified with Viekirax in combination with Exviera and ribavirin *Very common side effects (≥1/10)*: insomnia, nausea, pruritus, asthenia and fatigue. *Common side effects (≥1/100 to <1/10)*: anaemia. **HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Suspected adverse events should also be reported to AbbVie Limited on 01-4287900. LEGAL CATEGORY:** POM. **MARKETING AUTHORISATION NUMBERS/PRESENTATIONS:** EU/1/14/982/001 - Viekirax 12.5mg/75 mg/50 mg film-coated tablets; daily blister packs containing 2 film-coated tablets, inner cartons containing 14 film-coated tablets in multipack presentation containing 56 (4 packs of 14) film-coated tablets. EU/1/14/983/001 - Exviera 250 mg film-coated tablets; daily blister packs containing 2 film-coated tablets, inner cartons containing 14 film-coated tablets in multipack presentation containing 56 (4 packs of 14) film-coated tablets. **MARKETING AUTHORISATION HOLDER:** AbbVie Ltd, Maidenhead, SL6 4UB, UK. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. **DATE OF REVISION:** April 2016. PI/982+983/004.

References: 1. viekirax® Summary of Product Characteristics, available on www.medicines.ie **2.** exviera® Summary of Product Characteristics, available on www.medicines.ie

Date of Preparation: July 2016
IREVIEX160387

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