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Welcome Message

Dear Colleagues and Friends,

It is my great pleasure to welcome you to the 2018 Summer Meeting of the Irish Society of Gastroenterology. I would also like to extend a very warm welcome to the members of the Irish Society of Endoscopy Nurses, HepC and IBD Nurses Association of Ireland who also hold their meetings today and tomorrow alongside the ISG.

The programme for this meeting addresses several key areas in our specialty, and links medical and surgical management of common gastroenterological diseases. In the field of inflammatory bowel diseases, we will have lectures on new surgical approaches to Crohn’s disease as well as a description of the use of mesenchymal stromal cells to treat refractory perianal fistulas. This novel surgical technique looks quite promising for a difficult-to-treat subpopulation of Crohn’s patients and it will be very interesting to see how this works out in real life in Ireland, after the mesenchymal stromal cell product is launched here in 2019. For the patients who are doing well, did you ever wonder when and how to stop therapy? We will get insights in that particular dilemma as well.

Pancreatic cancer remains one of the most stubborn and deadly gastroenterological diseases. A hot topics session will link medical and surgical approaches to its management. Another lecture will focus on novel surgical approaches to pelvis floor dysfunction, a common problem seen in all of our clinics.

Quality colonoscopy is a key issue in our specialty and that is why we decided to highlight the Irish Gastrointestinal Endoscopy National Quality Improvement Programme data. We will also have an invited lecture on state of the art polyp detection and removal techniques.

The meeting will finish with a look at the Irish National Hepatitis C programme and where the current and future challenges lie with this now mostly curable infection.

In keeping with a longstanding tradition of ISG meetings, we are delighted to provide trainees the opportunity to present their research findings in the oral free papers sessions. This year we also offer trainees the opportunity to present some interesting cases for discussion which is sure to be a highlight of the meeting with plenty of audience participation. I encourage you to visit the poster presentations at 13.00 Thursday and sample the exciting results on offer.

Yours sincerely,

Prof. Laurence Egan
President ISG
SIMPONI delivers long-term disease control, maintaining efficacy over 4 years

**Aisle-itis?**

Continuous clinical response: Injecting confidence monthly

SIMPONI (golimumab) is indicated for adult patients with moderately to severely active UC who have had an inadequate response to conventional therapy including corticosteroids and 6-MP or AZA, or who are intolerant of or have medical contraindications for such therapies. 6-MP = 6-mercaptopurine, AZA = azathioprine, UC = ulcerative colitis.
# Programme for the ISG Summer Meeting

**24 - 25 May 2018, Great Southern Hotel, Killarney**

## Thursday 24th May

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>9.25</td>
<td>Opening Address</td>
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<tr>
<td></td>
<td>Prof. Laurence Egan, President ISG</td>
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<tr>
<td>9.30</td>
<td>Oral Free Papers (1-6)</td>
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<tr>
<td>10.30</td>
<td>Advances in Gastrointestinal Surgery</td>
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<td>Pelvic Floor Dysfunction</td>
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<td>Ms Aisling Hogan</td>
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<td>Consultant Surgeon</td>
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<td>University Hospital Galway</td>
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<td></td>
<td>Mesenteric Resection in Crohn’s Disease</td>
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<td>Prof. Calvin Coffey</td>
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<td>Professor of Surgery</td>
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<td>University Hospital Limerick</td>
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<tr>
<td>11.30</td>
<td>Tea/Coffee, Posters, Visit Pharma Stands</td>
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<tr>
<td>12.00</td>
<td>Clinical Cases (1-5)</td>
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<tr>
<td>13.05</td>
<td>Lunch, Visit Posters, Visit Pharma Stands</td>
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<tr>
<td>14.30</td>
<td>Oral Free Papers (7-12)</td>
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<td>15.30</td>
<td>Coffee/Ice Cream Break, Visit Pharma Stands</td>
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<tr>
<td>16.00</td>
<td>Endoscopy &amp; Colon Cancer</td>
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<td>NQIP Endoscopic Update</td>
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<td>Prof. Steve Patchett</td>
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<td>Consultant Gastroenterologist</td>
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<td>Beaumont Hospital, Dublin</td>
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<td>Enhanced Adenoma Detection Techniques</td>
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<td>Prof. Ralph Kiesllich</td>
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<td>Professor of Internal Medicine/Gastroenterology</td>
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<td>Johannes Gutenberg University of Mainz Germany</td>
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<tr>
<td>17.10</td>
<td>Close of Business</td>
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<tr>
<td>17.15</td>
<td>ISG AGM</td>
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<td>20.00</td>
<td>ISG Gala Dinner</td>
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<td>featuring Lifetime Achievement Award</td>
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<td>to Dr John Lennon</td>
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## Friday 25th May

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8.00</td>
<td>AbbVie Satellite Meeting</td>
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<td></td>
<td>“Calm Approach to IBD Management”</td>
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<td></td>
<td>Prof. Subrata Ghosh</td>
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<td>9.30</td>
<td>What’s New in IBD</td>
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<td>Mesenchymal Stromal Cells for the Treatment of Fistulizing Crohn’s Disease</td>
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<td>Prof. Julian Panes</td>
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<td>Chief of Gastroenterology Department</td>
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<td>Clinic de Barcelona, Spain</td>
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<td>Stopping IBD Treatment - can we do it?</td>
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<td>Prof. Glen Doherty</td>
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<td>Consultant Gastroenterologist</td>
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<td>St Vincent's University Hospital, Dublin</td>
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<tr>
<td>10.30</td>
<td>Tea/Coffee, Visit Pharma Stands</td>
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<tr>
<td>11.00</td>
<td>Hot Topics in Pancreatic Cancer</td>
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<td>Pancreatic Cancer Trends and Staging</td>
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<td>Prof. Dermot O'Toole</td>
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<td>Consultant Gastroenterologist</td>
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<td>St James’s Hospital, Dublin</td>
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<td>Liquid Biopsies on the Pancreas - Potential for Cancer Diagnosis and Management</td>
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<td>Prof. Anne Marie Lennon</td>
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<td>Associate Professor of Gastroenterology</td>
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<td>Johns Hopkins Hospital</td>
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<td>Baltimore, MD</td>
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<td>Outstanding Controversies in Pancreatic Cancer Endoscopic Stenting</td>
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<td>Dr Finbar McCarthy</td>
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<td>Consultant Gastroenterologist</td>
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<td>St James’s Hospital, Dublin</td>
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<td>vs Trans-Hepatic Stenting</td>
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<td>Dr Ronan Ryan</td>
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<td>Consultant Radiologist</td>
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<td>St Vincent's University Hospital, Dublin</td>
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<td>Modern Surgical Approaches</td>
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<td>Prof. Justin Geoghegan</td>
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<td>Consultant Surgeon</td>
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<td>St Vincent's University Hospital, Dublin</td>
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<tr>
<td>12.20</td>
<td>Liver Session</td>
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<td>HCV in Ireland - where to next?</td>
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<td></td>
<td>Prof. Aiden McCormick</td>
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<td>Consultant Hepatologist</td>
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<td>St Vincent’s University Hospital, Dublin</td>
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<tr>
<td>13.15</td>
<td>Presentation of Prizes/End of Meeting</td>
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</table>
90% of patients with mild to moderate UC maintain remission at 6 months at doses of 1.6g-2.4g/day1

ASACOLON® 400mg & 800mg GR Tablets are indicated in adults, adolescents and children aged 6 years and over: for the treatment of mild to moderate acute ulcerative colitis (UC), for the maintenance of remission of ulcerative colitis, and for the maintenance of surgically-induced remission of Crohn’s Disease (CD).

INTERACTIONS: Mesalazine can increase the myelosuppressive effects of azathioprine, 6-mercaptopurine, and thio-uricaric. Life-threatening infection can occur. Monitor closely for signs of infection and myelosuppression. Hematological parameters, especially the leucocyte, thrombocyte and lymphocyte cell counts should be monitored weekly, especially at initiation of combination therapy. May decrease the anti-tuberculotic effect of warfarin. USE DURING PREGNANCY AND LACTATION: Limited data on use in pregnancy. One case of neonatal renal failure was reported. Mesalazine crosses the placental barrier; use only if benefit outweighs risk. Limited data on lactation are available. N-acetyl-d-glucosamidase and mesalazine are excreted in breast milk. The clinical significance has not been determined. Hypersensitivity reactions such as Stevens-Johnson in the infant cannot be excluded. Use only if the benefit outweighs the risk. If the infant develops diarrhoea, discontinue breast feeding.

LEGAL CATEGORY: POM. MARKETING AUTHORISATION NUMBER: Asacol® 400mg GR Tablets PA 2016/171; Asacol® 800mg GR Tablets PA 2016/170; MA HOLDER: TILLOTTS PHARMA GMBH, Warmbrucher Strasse 80, DE- 78913 Kehl, Germany. DATE OF PREPARATION: April 2016. CODE: 2016/5/2. FULL PRESCRIBING INFORMATION AVAILABLE ON REQUEST FROM THE MARKETING AUTHORIZATION HOLDER OR FROM TILLOTTS PHARMA LIMITED, 25 SANDYFORD OFFICE PARK, DUBLIN 18, IRELAND, TEL: (00 353) 1 294 2005. Asacol® is a trademark.

## Irish Society of Endoscopy Nurses Agenda

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<tr>
<th>Time</th>
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<tr>
<td>08.30</td>
<td>Registration</td>
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<tr>
<td>09.00</td>
<td>Deirdre Clune, Chair Niamh Dalton ACNM 2 Kerry General Hospital Welcome to Kerry</td>
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<tr>
<td>09.15</td>
<td>Mary Hackett Brennan, Chair Hugh O Connor Msc Bsc C Eng. Medical Physics St. James Hospital JAG Requirements for Decontamination Units.</td>
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<tr>
<td>10.15</td>
<td>Glenda Hahn, Chair Aine Keogh IBD ANP Role of the IBD RANP</td>
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<tr>
<td>10.45</td>
<td>COFFEE</td>
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<tr>
<td>11.15</td>
<td>Margaret O’ Donnell, Chair Professor O’ Regan Consultant Gastroenterologist at South Tipperary General Hospital Barrett’s oesophagus &amp; Eosinophilic oesophagitis.</td>
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<tr>
<td>12.00</td>
<td>Bridget Cafferty, Chair Marichu Almazan cANP Gastroenterology UL Hospital Group, Ennis Hospital Telephone Based Education on Bowel Preparation for non- Screening Patients</td>
</tr>
<tr>
<td>12.45</td>
<td>Mary Hackett Brennan, Chair Endoscopy Committee Introduction to New Committee Members</td>
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<tr>
<td>13.00</td>
<td>LUNCH</td>
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<tr>
<td>14.00</td>
<td>Devika Ghosh, Chair Dr Danny Cheriyan Consultant Gastroenterologist Beaumont Hospital Management of Complications in Endoscopy.</td>
</tr>
<tr>
<td>15.00</td>
<td>Mary Hackett Brennan, Chair Open Forum The Role of the Endoscopy Nurse Endoscopy Unit Audit Report Findings.</td>
</tr>
<tr>
<td>15.50</td>
<td>Fiona Spleeman, Chair Deirdre Clune Education Opportunities within Endoscopy.</td>
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</table>
ADENOMA Study: Significant improvement in ADR* vs standard colonoscopy (40.9% vs 36.2%, p = 0.02)¹

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*Adenoma detection rate
†Please refer to the Compatibility Schedule available from Norgine.

Reference:

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Date of preparation: April 2016. UK/ECV/0418/0118.
Biographical Sketches

Ms Aisling Hogan
Consultant Surgeon
University Hospital Galway

Aisling Hogan graduated from University College Dublin in 2004 with an honours degree in medicine. She completed her Basic Surgical Training in St. Vincent’s University Hospital and was subsequently awarded an MD under the tutelage of Professors Des Winter and Alan Baird for a thesis entitled “Pharmacological effects of oestrogens on the gastrointestinal tract”. She was awarded a place on the Higher Surgical Training programme and developed a subspecialty interest in pelvic floor dysfunction. Following completion of surgical training in Ireland, she undertook a Colorectal/Pelvic floor fellowship at Oxford University Hospital. She is currently working as a consultant colorectal surgeon in University Hospital Galway.

Prof. Calvin Coffey
Foundation Chair
Consultant General and Colorectal Surgeon Surgery,
Graduate Entry Medical School
University Hospital Limerick

Recently appointed as Foundation Chair of Surgery at the Graduate Entry Medical School, University of Limerick and University Hospitals Limerick. Professor Coffey is a general and colorectal surgeon with a special interest in minimally invasive (keyhole) surgery. His clinical focus is in colorectal cancer, inflammatory bowel disease (ulcerative colitis and Crohn’s disease), pelvic floor abnormalities.

He is the recipient of the international James IV Travelling Fellowship Award which is arguably one of the most prestigious international surgical awards. This was for his work in colorectal cancer surgery and his scientific research in the field. In 2012 he was recipient of the Cleveland Clinic Distinguished Alumnus award for which he delivered an invited lecture. He is also the recipient of over 45 national and international awards, has over 180 publications and has delivered several named national and international lectures (Millin lecture, 2012, Sir Thomas Myles Lecture 2011, inaugural Young Investigator Lecture at the Surgical Infection Society of Europe).

After initially training in Cork University Hospital, where he received a PhD for work on cancer growth, he then trained in The Mater Misericordiae Hospital, St. Vincent’s University Hospital and finally completed a fellowship in colorectal surgery at the Cleveland Clinic. He has delivered invited lectures in The Johns Hopkins, Memorial Sloan Kettering, The Cleveland Clinic and The European Institute of Oncology.

Prof. Steve Patchett
Consultant Gastroenterologist
Beaumont 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 in Ireland. 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 therapeutic interventions in 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.

Areas of Interest
Interventional Endoscopy, Quality Assurance in Endoscopy, Inflammatory Bowel Disease.

Prof. Ralph Kiesslich
Professor of Internal Medicine/
Gastroenterology
Johannes Gutenberg University of Mainz
Germany

Prof. Dr. Ralf Kiesslich participated in residency and fellowship training in Internal Medicine at St. Hildegardis Hospital and University of Mainz. He was board certified in Internal Medicine in 2003, and board certified in Gastroenterology in 2005. Dr. Kiesslich was an Assistant Professor of Internal Medicine (Gastroenterology), University of Mainz and a Visiting Professor at Massachusetts General Hospital, Boston. He was the Head of Endoscopy Unit at University of Mainz and gained Full Professorship at Johannes Gutenberg University of Mainz (founded by Pentax Europe). Dr. Kiesslich served as Head of the Department of Internal Medicine, Gastroenterology and Oncology, St. Mary’s Hospital Frankfurt, Teaching hospital of the University of Frankfurt, Germany, and Head of the Department of Internal Medicine, Helios Dr. Horst Schmidt Kliniken Wiesbaden, Teaching Hospital of the University of Mainz, Germany. Since 2016, he served as Medical Director of Helios Dr. Horst Schmidt Kliniken Wiesbaden, Teaching Hospital of the University of Mainz, Germany. Dr.

ISG MEETING, Summer 2018
Kiesslich has received the Ludwig Demling Award, German Society for Endoscopy Clinical Research Award from the Association “Gastroenterologischen Arbeitsgemeinschaft Rheinland Pfalz”, Award for Best Lecture German Society for Gastroenterology (DGVS) Don Wilson Award, American Society for Gastrointestinal Endoscopy Martin Guelzow Award, Award for Clinical Science in Gastroenterology (DGVS; German Society for Gastroenterology), and the Bruce Lecturer Award in Therapeutic Endoscopy, founded by Dr. Herbert A. Bruce, Toronto, Canada.

Prof. Julian Panes
Chief of Gastroenterology Department
Clinic de Barcelona, Spain

Prof. Julián Panés is President of the European Crohn’s and Colitis Organization (ECCO). Resident in Gastroenterology and Hepatology, Hospital Clinic Barcelona (1981 – 1984). Research Fellow in the Hepatology Department, Hospital Clinic Barcelona (1985). Staff member at the Department of Digestive Diseases, at Hospital Mutua in Terrassa (1985-1990). Staff member at the Gastroenterology Department, at the Hospital Clinic in Barcelona (1990-1996). Senior Specialist, Hospital Clinic Barcelona (1996-2001). Consulting Gastroenterologist, Hospital Clinic Barcelona (2001-present). Chief of the Inflammatory Bowel Diseases Unit, Hospital Clinic Barcelona (1996-present). Chief of Gastroenterology Department, Hospital Clinic Barcelona (2010-present). Associate Professor of Medicine, University of Barcelona (2001-present). Global Adviser for the development of studies in inflammatory bowel disease for: Abbott, MSD, Novartis, Pfizer, UCB.

Prof. Dermot O’Toole
Consultant Gastroenterologist
St James’s Hospital, Dublin

Dermot O’Toole is Professor in Gastroenterology and Clinical Medicine at Trinity College Dublin (The University of Dublin) and is Consultant Gastroenterologist in St James’s Hospital Dublin and the Neuroendocrine Tumour specialist in the ENETS accredited European Centre of Excellence in St Vincent’s University Hospitals Dublin. He graduated from Trinity College Dublin and has postgraduate degrees from Trinity College Dublin, University of Paris and University of Angers. His major research interest is in gastrointestinal cancer biology especially focussing in neuroendocrine-related diseases and early neoplasia in the gastrointestinal tract (Barrett’s oesophagus, gastric and colorectal cancers; current H-index is 50).

Professor O’Toole leads the national endoscopic interventional program for early digestive cancers and is also national clinical lead for the neuroendocrine tumour group. He also serves on the executive committee of the European Neuroendocrine Tumours Society (ENETS) and has helped develop many guidelines papers and standards of care initiatives in the field of NET as well as chairing the ENETS-driven European Centre of Excellence program. He has been principal investigator and/or coordinator in many national and international research activities in GI oncology.

Professor O’Toole is a member of several professional bodies in Europe and North America and has served as advisor on several national health care projects/initiatives and on patient advocacy groups.

Prof. Anne Marie Lennon
Associate Professor of Gastroenterology
Johns Hopkins Hospital
Baltimore, MD

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

Dr Finbar McCarthy
Consultant Gastroenterologist, St James’s Hospital, Dublin
University College Dublin

Dr Ronan Ryan
Consultant Radiologist
St Vincent’s University Hospital, Dublin
Assistant Professor, UCD
Assistant Professor
Weill Cornell Medicine 2011 – 2012
UCD MB BCH BAO 1993 -1999

Prof. Justin Geoghegan
Consultant Surgeon
St Vincent’s University Hospital, Dublin
Prof. Aiden McCormick
Consultant Hepatologist
St Vincent’s University Hospital, Dublin

Prof Aiden McCormick graduated from UCD in 1979, and then trained in Hepatology in the Royal Free Hospital School of Medicine with Prof Dame Sheila Sherlock, Prof Neil McIntyre and Prof Andy Burroughs. Currently Hepatologist and Newman Clinical Research Professor in the National Liver Transplant Unit, St Vincent’s University Hospital and University College Dublin.

His research interests are: portal hypertension, complications of chronic liver disease and liver transplantation.

Prof McCormick is a Past President of Irish Society of Gastroenterology

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

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

Prof. 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 Crohn’s Disease) and in the importance of the host immune response in gastro-intestinal neoplasia, particularly colorectal cancer and Barrett’s oesophagus. With his colleagues at the Centre for Colorectal Disease at SVUH/UCD he has an established track record in clinical research on a range of digestive disorders and is actively involved in clinical trials in IBD.

Professor Laurence Egan,
President ISG
NUI Galway

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

ISG Board Members

USG Autumn Meeting
12th October 2018
Park Avenue Hotel, Belfast
Dr Tony C.K. Tham  
Consultant Gastroenterologist  
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 is a Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast. He has more than 70 publications in peer reviewed journals. He is the first author of a book entitled “Gastrointestinal Emergencies” which has been published as a 3rd edition and translated into Polish and Chinese. He has contributed to several other book chapters. He has been co-author of guidelines on ERCP, Barretts oesophagus, perianal Crohns, non medical endoscopy workforce and UK gastroenterology services. He was the Guidelines Editor for Gut. He is on the International Editorial Board of the journal Gastrointestinal Endoscopy; Associate Editor of the World Journal of Gastrointestinal Endoscopy; Diagnostic and Therapeutic Endoscopy. He has received several awards for being a top reviewer for Gastrointestinal Endoscopy.

He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency (deanery). He is the Training Program Director in General Internal Medicine and Vice Chair of the Specialist Advisory Committee for general internal medicine at the Joint Royal Colleges of Physicians Training Board. He is the Deputy Chair of the British Society of Gastroenterology (BSG) Clinical Services and Standards Committee and Quality Improvement lead of the BSG. He was Secretary of the BSG committee on clinical services and standards. He is an examiner for the Royal College of Physicians of Edinburgh and also Queen’s University. He has led service improvements for patients in Northern Ireland including those with gastrointestinal consequences in pelvic radiation disease, and inflammatory bowel disease.

Mr Jürgen Mulsow  
Consultant General and Colorectal Surgery  
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Jürgen Mulsow is a Consultant Surgeon in the Department of Colorectal Surgery at the Mater Misericordiae University Hospital and Clinical Lecturer in Surgery at University College Dublin. He undertook specialist training in Ireland before completing a Fellowship in Colorectal Oncology at the University Clinic in Erlangen, Germany. His specialist interests include the treatment of colorectal and peritoneal malignancy, inflammatory bowel disease, pelvic floor disorders, and surgical education and training. He was awarded the Association of Surgeons of Great Britain and Ireland Medal for first place in the Intercollegiate Exit examination (FRCS) in 2010 and was the 2012 Association of Coloproctology of Great Britain and Ireland Travelling Fellow to the United States.

Dr Paul Lynch  
Consultant Gastroenterologist  
Antrim Area Hospital

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

Professor Deirdre McNamara  
Consultant Gastroenterologist  
Tallaght Hospital, Dublin

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

Dr Susanne O'Reilly
Gastroenterology SpR
St. Vincents Hospital, Dublin

Susanne is a Gastroenterology SpR, currently undertaking her MD entitled ‘endoscopic, histological and psychosocial factors associated with a national colorectal cancer screening programme’ at the Centre for Colorectal Disease, St Vincent's University Hospital. Her interests include IBD, interventional endoscopy and cystic fibrosis-related GI disease.

Dr Manus Moloney
Consultant Gastroenterologist
University of Limerick Hospital

Dr Manus Moloney graduated in 1987 from Trinity College Dublin, trained in gastroenterology at the Mater and St James Hospital Dublin before moving to the Liver unit at King’s College Hospital in London, training in hepatology and completing an MD thesis on Immunogenetics of Primary Sclerosing Cholangitis. Completed training at Ashford Hospital in Kent and Guy’s Hospital. Dr Moloney returned to Ireland in 2000 to take up a Consultant post at Nenagh Hospital and Limerick Regional Hospital, now the University of Limerick Hospital Group. Dr Moloney is currently serving as endoscopy lead for the group, main interests include management of Inflammatory Bowel Disease and interventional endoscopy.

Irish Society of Gastroenterology

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## Oral Presentations - ISG Summer Meeting
### 24 May 2018

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**ORAL PRESENTATIONS**

(ISG S’2018 106)

**Acceptance and Commitment Therapy Improves Body Image in Inflammatory Bowel Disease Patients**

**Author(s)**
Fennessy AM (1), McHugh L (2), Rowan C (1), Wynne B (2), Keegan D (1), Byrne K (1), Hartery K (1), Dooley B (2), Mulcahy H (1)

**Department(s)/Institutions**
1. Centre for Colorectal Disease, St. Vincent’s University Hospital, Elm Park, Dublin 4 2. School of Psychology, University College Dublin, Belfield, Dublin 4

**Introduction**
Body image dissatisfaction is common in Inflammatory Bowel Disease (IBD). Acceptance and Commitment Therapy (ACT) involves exercises which promote psychological flexibility. ACT positively impacts stress in IBD patients and has also been utilised for other psychological disorders, including body image dissatisfaction in the general population. ACT has not previously been assessed as a treatment for body image dissatisfaction in IBD.

**Aims/Background**
To identify the effect of ACT on body image in IBD subjects.

**Method**
122 subjects were randomised to an eight-week ACT course (n=61) or standard care (n=61) with the original trial outcome being stress (ClinicalTrials.gov RegNo: NCT02350920). Body image was a secondary outcome in the original trial. Baseline data were available for 122 patients, while the follow-up study included 77 who attended five or more ACT sessions and had a baseline body image score of three or more. The Hopwood Body Image Scale was completed at baseline and after 8 and 20 weeks.

**Results**
Baseline body image dissatisfaction was greater in females (p=0.007), younger subjects (p=0.006) and those who had undergone previous surgery (p=0.03). Body image dissatisfaction decreased by 14% and 37% in the ACT group from baseline to 8 and 20 weeks and by 10% and 9% in the control group with a significant treatment x group interaction (p=0.001). ACT also impacted favourably on a range of other psychological variables including stress (p<0.001), anxiety (p=0.02) and depression (p=0.002).

**Conclusions**
An eight-week ACT therapy course improves body image in IBD subjects with body image dissatisfaction.

(ISG S’2018 101)

**The Impact of the Gut Microbiota on Hepatic Drug-Metabolising Enzymes: Potential Implications for Clinical Practise of Neurogastroenterology**

**Author(s)**
Walsh, J 1,2; Van de Wouw, M 2,3; Moloney Cryan, JF 2,5; Dinan, TG 3,5; Griffin, BT 4,5; Hyland, NP 1,3; Clarke, G 3,5

**Department(s)/Institutions**
1 Department of Pharmacology and Therapeutics 2 Department of Anatomy and Neuroscience 3 Department of Psychiatry and Neurobehavioural Science 4 School of Pharmacy 5 APC Microbiome Ireland, University College Cork.

**Introduction**
Although the direct microbial metabolism of xenobiotics is increasingly appreciated as an important factor for drug activity and toxicity, indirect microbial modulation of drug metabolism remains a neglected topic of research. The cytochrome P450 (CYPs) enzyme superfamily is implicated in the metabolism of 70-80% of all drugs in clinical use. Microbial regulation of hepatic CYP expression could be an important and modifiable source of the inter-individual variation in pharmacotherapy.

**Aims/Background**
Using germ-free (GF) mice, we sought to investigate whether supplementation with butyrate, a microbial metabolite, and histone deacetylase inhibitor, could normalise microbiologically-regulated hepatic CYP gene expression.

**Method**
Sodium butyrate or sodium-matched saline was administered for 21 days via the drinking water (3g/L) to conventional and GF male C57BL/6 mice (n=15/group). Mice were euthanised by decapitation and total RNA was isolated from harvested liver tissue. Reverse-transcriptase PCR was employed to compare the mRNA expression of 12 drug-metabolising CYP1-3 family isoenzymes.

**Results**
Expression of CYP2a4 (7.81 fold; P<0.001), CYP2b10 (7.3 fold; P<0.001) and CYP 3a11 (36.9 fold; P<0.001) were all significantly increased in the livers of GF mice. These enzymes are important for the metabolism of psychostimulants, anaesthetics and analgesics, and antipsychotics respectively. Notably, butyrate supplementation further potentiated the induction of these particular enzymes in GF mice but had no significant impact on the CYP expression in conventional animals.

**Conclusions**
These results may thus have important implications for clinical neurogastroenterology and may provide the impetus to consider the gut microbiota as an additional source of variation in patient response to neuroactive and gastrointestinal therapies.
**Aims/Background**
We evaluated the appointment of a GI nurse specialist to triage DAC referrals in our endoscopy unit in a tertiary referral hospital.

**Method**
We carried out a prospective study evaluating adjustments to colonoscopy rates following telephone triage. DAC referrals from July 2017-January 2018 were reviewed and patients were contacted regarding indications and suitability for colonoscopy. Available clinical information, NICE and hospital guidelines were used to identify inappropriate referrals. These were declined or re-directed to either OPD, GP follow-up or an alternative procedure.

**Results**
1166 DAC referrals were received over 7 months (mean=167/mo). 86% were GP referrals (n=1006). Following triage, 521 patients (44.7%) did not proceed to DAC. Of 1166 referrals, 20% were re-directed to sigmoidoscopy and 2.7% to gastroscopy. 9.9% were re-directed to OPD (105 GI, 10 other). 6% were declined and directed to their GP. Based on local colonoscopy pricing, we estimated cost savings of €651,250 over 7 months, offset by €217,890 for alternative procedures.

**Conclusions**
Our initial data highlights that nearly half of DAC referrals were inappropriate. Many patients required more limited or alternative examinations or clinical review. We demonstrated the successful appointment of a GI nurse specialist reducing costs and unnecessary procedures, which will clearly have a significant impact on our waiting lists.

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**An Inflammation Targeted Nano-Drug Delivery System In Inflammatory Bowel Disease**

**Author(s)**
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**Department(s)/Institutions**
Centre for Research in Medical Devices (CÚRAM), National University of Ireland Galway, Newcastle, Galway, Ireland

**Introduction**
There is a pressing clinical need for inflammation targeted drug delivery systems for inflammatory bowel disease (IBD) including Crohn’s and ulcerative colitis. Targeting drugs selectively to the local inflamed intestine may improve therapeutic outcomes and minimize associated systemic toxicity.

**Aims/Background**
Inflammation of the colonic mucosa is accompanied by depletion of the mucus layer and in situ accumulation of positively charged proteins (transferrin, BPIs, AMPs, eosinophil cationic proteins) resulting in the buildup of positive charges at the damaged epithelial surface. Hyaluronic acid functionalized anionic nano drug particles selectively target to positive inflamed colon mucosa in colitis via electrostatic and receptor interactions.

**Method**
In the current investigation, hydrophobic model drug (curcumin) loaded HA nanoparticles were fabricated for inflammation-specific colon targeting. Nanoparticles were characterized for size, surface charge, stability, encapsulation/loading efficiencies, drug release studies, uptake studies in HT-29 cells and adhesion studies on simulated positive inflammatory surfaces in vitro, ex vivo.

**Results**
Drug-HA nanoparticles were found to be spherical in shape and of 200-400 nm in size, with high negative surface charge (-51.3 mV) and 56.0% drug released after 72 hrs. HA functionalization increased cellular uptake in HT-29 cells over that of uncoated nanoparticles. Further, nanoparticles were preferentially adhered (30 folds high) to transferrin, polyallylamine, amine-coated positive surfaces than those of mucin (negative) coated surfaces.

**Conclusions**
By understanding the pharmacological colitis tissue surface characteristics, we successfully fabricated drug-HA nanoparticles with negative surface charge and showed preferential adhesion on simulated positive surfaces, in vitro. Further in vivo (DSS/TNBS mice) studies are to be conducted to prove the hypothesis in terms of targetability, local drug delivery and biodistribution and kinetics.

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**MLH1 preservation in a cohort of Dysplastic Sessile Serrated Polyps**

**Author(s)**
SM O’Reilly, AJ McCarthy, K Hughes, P Molony, M Tosetto, E Ryan, G Cullen, K Sheahan

**Department(s)/Institutions**
Centre for Colorectal Disease, St Vincent’s University Hospital, Elm Park, Dublin 4

**Introduction**
Sessile serrated polyps (SSPs) were first described histologically in 1990 by Longacre et al. Between 5 and 10% are dysplastic, with malignant potential. MLH1 loss and BRAF mutation are seen in >80% of dysplastic SSPs.

**Aims/Background**
We sought to describe the pattern of MLH1 loss in our dysplastic SSPs.

**Method**
The histology database was searched using the key words ‘serrated adenoma’. All specimens identified (n=520) between 2004 and 2016 were reviewed by one or two pathologists. Immunohistochemical analysis of MLH1 protein was performed.

**Results**
35 dysplastic SSPs were identified (6.7%), of which 24 cases had adequate staining and were included. 50% were male, with a median age of 70 years old. Adenomatous dysplasia was present in 15/24 (62.5%), serrated dysplasia in 14/24 (58.3%), minimal deviation dysplasia in 2/28 (7.1%) and dysplasia of not-otherwise-specified (NOS) type in 12/24 (50%). 13/24 (54.2%) exhibited more than one type of dysplasia. MLH1 was preserved in 13/15 (86.6%) SSPs with adenomatous dysplasia, 12/14 (85.7%) with serrated type dysplasia, 1/2 (50%) exhibiting minimal deviation dysplasia, and 8/12 (66.6%) exhibiting NOS dysplasia. Overall, loss of MLH1 was only seen in 5/24 (20.8%). 4/5 of these were in the right colon (80%), and 2/5 (40%) were >1cm in size. There was no difference in location or size when compared to the 19 specimens showing MLH1 preservation.

**Conclusions**
Contrary to published literature, our analysis has demonstrated preservation of MLH1 in the majority of dysplastic SSPs studied. A study of a larger population would be required in order to explore this further.
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**INDICATION(S):**

- Plaque psoriasis adults:
  - Active psoriatic arthritis:
  - Psoriatic arthritis: Paediatrics
  - Ulcerative colitis:

**CONTRAINDICATIONS:**

- Neutropenia
- Clinical signs suggestive of infection

**SIDE EFFECTS:**

- Common:
  - Upper respiratory tract infection
  - Nasopharyngitis
  - Headache

**INTERACTIONS:**

- Refer to SmPC for details of interactions.

**RECOMMENDATIONS:**

- Discontinue if no response at 16 weeks.

**PREGNANCY:**

- Use effective contraception during treatment and for at least 15 weeks post-treatment.

**LACTATION:**

- Not recommended for psoriasis.

**PHYSICIANS:**

- Refer to SmPC for full details of interactions.

**LEGAL CATEGORY:** Prescription Only Medicine.

**PRESENTATIONS, PACK SIZES:**


**PHRI/STEL/0417/0009(2) | Date of Preparation:** May 2018

**References:**

- Vienna, Austria. 4. Sanders BE et al. ECCO 2017. OP010. Presentation OP005, United European Gastroenterology Week (UEGW): 15-19 October 2016; Vienna, Austria.

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**PHRI/STEL/0002(0) | Date of Preparation:** May 2018
(ISG S'2018 108)

Gastrointestinal Serotonergic Responses to an Acute Stressor are Altered in the Absence of the Microbiota

**Author(s)**
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**Department(s)/Institutions**
APC Microbiome Ireland, University College Cork, Cork, Ireland. 711th Human Performance Wing, Air Force Research Laboratory, Wright-Patterson Air Force Base, Dayton, Ohio, USA. Department of Psychiatry and Neurobehavioural Science, University College Cork, Cork, Ireland. Department of Anatomy and Neuroscience, University College Cork, Cork, Ireland.

**Introduction**
Gut-derived serotonin (5-HT) produced following stress can exert physiologically and clinically-important local and systemic effects. We have previously demonstrated a murine strain-dependent temporal response of the gastrointestinal serotonergic system following acute stress, but the role of the gut microbiome in modulating this profile is unknown.

**Aims/Background**
We therefore sought to define the role of the gut microbiome in the gastrointestinal serotonergic system response to acute stress.

**Method**
Adult male and female C57/BL6 conventional and germ-free, mice were randomly allocated to the unstressed control or stress group. Stressed animals were subjected to 15min of restraint stress and sacrificed immediately or 45min post-stressor. Plasma corticosterone was assayed using ELISA. Gastrointestinal 5-HT and 5-HIAA concentrations were determined using HPLC. Results were analyzed by student’s t-test or ANOVA, where applicable, and statistical significance was set at p<0.05.

**Results**
In the control group, germ-free corticosterone levels were significantly greater than in conventional mice. However, corticosterone levels were significantly elevated in all mice immediately after restraint stress. Germ-free ileal 5-HIAA was significantly greater compared to conventional animals at baseline and 45min post-stress. Plasma corticosterone was assayed using ELISA. Gastrointestinal 5-HT and 5-HIAA concentrations were determined using HPLC. Results were analyzed by student’s t-test or ANOVA, where applicable, and statistical significance was set at p<0.05.

**Conclusions**
The gut microbiome defines the set point of the gastrointestinal serotonergic system and its response to acute stress in a region-dependent manner. Further studies are required to understand the impact of colonization and the implications of these findings for the control of stress-induced 5-HT-mediated gastrointestinal symptoms.

(28x72) (ISG S’2018 149)

Specificity of Ultrasound in Characterising Polypoid Lesions of the Gallbladder

**Author(s)**
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**Department(s)/Institutions**
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**Introduction**
Current guidelines recommend cholecystectomy for polyps exceeding 8mm on ultrasound, due to the risk of malignant change above this threshold.

**Aims/Background**
This study sought to assess the impact of this policy on the yield of true polypoid lesions of the gallbladder.

**Method**
Patients undergoing cholecystectomy from January 2015 to March 2018 were eligible for inclusion. Clinico-pathological features were retrospectively reviewed from a prospectively maintained database. Histological analysis of patient gallbladders in whom gallbladder polyps were the primary indication for surgery were further assessed. Patients in whom incidental polyps were identified only on histology were not included.

**Results**
815 patients underwent cholecystectomy in the study time period. Of these, 70 (8.8%) were identified pre-operatively as having polypoid gallbladder lesions on ultrasound. Histological analysis confirmed the presence of polyps in 32 (46%) of patients, 38 (54%) did not have identifiable polyps. Of the 32 patients in whom polypoid lesions were histologically identified, 29 (91%) were shown to have benign ‘pseudopolyps’ (polypoid cholesterolosis, papillary hyperplasia, adenoxyomatosis). Three patients were diagnosed with neoplastic polyps. Of the 32 patients in whom polypoid lesions were identified, 41 (41%) had gallstones, and 8 (25%) had evidence of chronic cholecystitis. The remainder had no identifiable pathology. Polyp size on US was not predictive of finding a polypoid lesion on histology (p=0.2113). However, all malignant polyps were larger than 8mm on imaging.

**Conclusions**
Ultrasound overestimates the prevalence of gallbladder polyps. This study calls into question the rationale of current guidelines in the management of gallbladder polyps detected with ultrasonography.

(ISG S’2018 113)

It’s worse than you think: rates of missed upper GI cancer

**Author(s)**
S.Kelly, P Maheshwari, R.Stack, M.Farman, A O’Toole, G C Harewood, F Murray, S Patchett, D Cheriyan

**Department(s)/Institutions**
Beaumont Hospital

**Introduction**
Missed upper GI cancer is defined as a new diagnosis of upper GI cancer in an individual with a normal upper endoscopy in the preceding 3 years. The literature suggest the rate of missed upper GI cancer ranges from 4-14%. The BSG position statement (2017) has included missed upper GI cancer as a key performance indicator, recommending that the rates should not exceed 10%. It also stipulates that each unit should audit upper GI cancer miss rates every 3 years.
Conclusions

Our high volume, tertiary referral centre had a missed upper GI cancer rate in line with published data; however, it does not meet the relevant KPI as outlined by the BSG. Miss rates can be lowered further by appropriate training and strict adherence to quality measures.

(ISG S’2018 117)

Implementation of a minimally invasive oesophagectomy programme: Results of 108 consecutive cases

Author(s)
JA Elliott, L Buckley, A Griffin, TJ Murphy

Department(s)/Institutions
Department of Surgery, Mercy University Hospital, Cork, Ireland

Introduction

Open Ivor-Lewis oesophagectomy has traditionally been the standard treatment for resectable oesophageal cancer, but is associated with significant postoperative morbidity. Minimally invasive oesophagectomy (MIO) is increasingly adopted, with reduced pulmonary morbidity and improved quality of life in survivorship as demonstrated in two recent European randomised controlled trials.

Aims/Background

To describe short term outcomes with implementation of an MIO programme in Ireland.

Method

Consecutive patients undergoing minimally invasive Ivor-Lewis oesophagectomy for oesophageal cancer from 2011 – 2017 were prospectively studied. Neoadjuvant therapy was utilised for ≥T2 and/or ≥N1 disease. All patients underwent radical abdominothoracic en bloc oesophagectomy with two-field lymphadenectomy and high intrathoracic end-to-side circular stapled oesophagogastric anastomosis, and a postoperative ERAS protocol was utilised.

Aims/Background

To describe short term outcomes with implementation of an MIO programme in Ireland.

Method

Data from all upper GI cancers diagnosed over a three year periods in Beaumont hospital were evaluated. Recurrent and metastatic cancers were excluded.

Results

164 cases of upper GI cancers were assessed, of which 34 had an OGD in the preceding three years. 11 patients were excluded. 19 (11.5%) were missed cancers (11 oesophageal and 8 gastric). 7/19 (37%) missed cancers were metastatic at diagnosis. Appropriate, high quality photo documentation was absent in all missed cancers.

Conclusions

The implementation of a minimally invasive oesophagectomy programme was successful, feasible and safe. Perioperative and oncologic outcomes compared favourably with published benchmarks. Minimally invasive oesophagectomy should be considered the standard of care for resectable oesophageal cancer.

(ISG S’2018 126)

Medium-term outcomes from the Irish Early Access Programme of Direct Acting Antiviral (DAA) Therapy for HCV in patients with decompensated cirrhosis: High risk but high reward

Author(s)

Department(s)/Institutions
St. Vincent’s Hospital, Dublin; St. James’s Hospital, Dublin; Cork University Hospital, Cork; Galway University Hospital, Galway; Mater Misericordiae Hospital, Dublin; Irish Hepatitis C Outcomes Research Network

Introduction

DAA therapy can improve liver function in some patients with decompensated HCV cirrhosis. However, treatment benefit must be balanced against the risks of adverse events such as death or liver transplantation.

Aims/Background

There are limited data on medium term outcomes following DAA therapy for decompensated HCV.

Method

Patients with decompensated cirrhosis or a history of decompensation were treated for 12 weeks with ledipasvir/sofosbuvir + ribavirin as part of the Irish Early Access Programme for DAA therapy. The primary outcome was survival following therapy. Secondary outcomes were death, improvement to CP class A cirrhosis or liver transplantation.

Results

In all, 101 patients underwent treatment (Baseline CP B/C – 66.3%/18.8%). The rate of sustained virological response (SVR12) was 74.3%. Two patients were lost to follow-up following SVR. The overall survival rate in our cohort was 70.7% (median follow-up 3 years). Survival rates at 1, 2 and 3 years from the start of treatment were 86.8%, 79.7% and 70.7% respectively. During the follow-up period, 7 patients were transplanted (3 year transplant free survival 63.6%). Failure to achieve SVR was associated with a significant increased risk of death (OR 3.35, 95% CI 1.903 – 5.891, p < 0.0005). At the end of follow-up, 75% (47/63) of surviving non-transplanted patients had CP class A compensated cirrhosis.

Conclusions

SVR is associated with medium-term survival in patients with
decompensated HCV cirrhosis treated with DAA. Despite the previously reported high mortality rate in CP B and C patients undergoing DAA therapy, a high proportion of the total cohort improved to CP class A cirrhosis.

(ISG S’2018 146)

Increasing age and survival after orthotopic liver transplantation. Should age be a contraindication?

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Introduction
The mean age of patients receiving liver transplantation is increasing worldwide. There is increasing demand for liver transplantation among the elderly, however despite the shortage of organs, the outcome for this population is not well defined.

Aims/Background
Our aim was to evaluate the short and long term survival rates of patients over 65 who underwent orthotopic liver transplantation (OLT) and to compare them to a younger cohort aged 15-64 in a single national transplant center.

Method
Data from 1070 patients who underwent OLT between January 1993 and December 2017 was obtained from national liver transplant database. Patients under and over 65 years of age were compared with respect to 1 year, 5 year and 10 year survival. Baseline characteristics, length of ICU stay, length of hospital admission and cause of death were also compared.

Results
Of the 1070 patients who received a liver transplantation, 90 patients (8.4%) were over 65 years of age. The one year, five year and ten year survival were 81% (n=69), 71.9% (n=41) and 51% (n=19) respectively. This was not significantly different to the younger under 65 cohort with 86% (n=814) one year survival (p=2306), 76.2% (n=562) five years survival (p=3971) and 63% (n=307) 10 years survival (p=1472). There was no significant difference in the length of ICU stay or length of hospital admission post transplant. Patients over 65 were more frequently transplanted for HCC (p=<0.001) and NASH (p=<0.001). There was no significant difference in the causes of death between the older and younger cohort.

Conclusions
Carefully selected patients over 65 have similar survival rates after OLT compared to younger counterparts. Age over 65 alone should not be considered a contraindication for OLT.

(ISG S’2018 142)

A Multicentre Study on Response Rates to Ursodeoxycholic Acid in Primary Biliary Cholangitis

Author(s)
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Introduction
Primary biliary cholangitis (PBC) is a chronic, destructive cholangiopathy. Failure of response to treatment can result in progression to cirrhosis, liver transplantation or death. Until recently, ursodeoxycholic acid (UDCA) was the only approved therapy. Obeticholic acid (OCA) has now been licensed but not reimbursed as a potential second-line therapy for PBC patients with an inadequate response to UDCA.

Aims/Background
To assess the numbers of non-responders who may benefit from OCA.

Method
Patients attending any of three Irish hepatology centres with a confirmed diagnosis of PBC over the age of 16 were included. Patients were excluded if there was insufficient data, if they were transplanted or if they were deceased. Data was analysed using SPSS. The modified Toronto criteria (ALP>1.67x ULN after 6 months of UDCA) was used to determine non-response.

Results
201 patients were included for analysis. 90% were female. The mean age was 61.4 years. 93.2% of patients were receiving UDCA. The median UDCA dose was 750mg/day (0-1500mg/day). 69.3% of patients were responders. Weights were available for 55 out of 201 patients. Of these, 56.4% were on the correct weight-based dosing of UDCA. 34.2% of the non-responders who had data for their weight recorded were receiving sub-therapeutic dosing of UDCA.

Conclusions
In 201 adults with PBC we saw UDCA response rates of 69.3%. Of the patients with weight recorded, 43.6% were under-dosed. UDCA dose should be optimised in all non-responders, but up to 30% of patients may benefit from a second line therapy.

POSTER PRESENTATIONS

(ISG S’2018 102)

Host and environmental factors influencing the expression of bacterial-derived metabolic enzymes in faeces: Potential implications for microbiota-mediated drug metabolism

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**Introduction**

The gastrointestinal tract houses a reservoir of bacterial-derived enzymes, including β-glucuronidase and β-glucosidase, which can directly catalyse the metabolism of drugs. It is important to investigate the host and environmental factors, which may influence the expression and activity of these enzymes, to explore novel mechanisms driving inter-individual variation in drug metabolism.

**Aims/Background**

Our aim was to investigate the effects of age, sex, genetic background, germ-free (GF) status, antibiotic treatment, and species on enzymatic activity.

**Method**

Fecalase, a cell-free extract of faeces, was prepared from mouse, rat and human faeces, according to a modified method previously described by Lee et al. To quantify the enzymatic activity in fecalase, we utilised a colorimetric-based assay. Enzyme activity was indicated as the amount required to catalyse the formation of 1nmole of p-nitrophenol per minute and expressed as U/mg protein. Two different antibiotic cocktails, previously found to ablate the gut microbiota, were administered via the drinking water for 21 days to adolescent and adult C57/BL6 male mice (n=8-12/group).

**Results**

The absence of enzyme activity in GF animals confirmed these enzymes are microbial-derived. Our data show that the activity of β-glucuronidase and β-glucosidase depends on the sex, host genetics, age, and species of the experimental animal. The antibiotic-cocktails depleted enzymatic activity during treatment, which recovered one week after stopping antibiotic administration.

**Conclusions**

Antibiotic-treated animals may thus serve as a possible alternative to the GF model in pharmacokinetic studies. The implications of these findings for drug metabolism and pharmacokinetics warrant further investigation.

(ISG S’2018 103)

**Comparison of biopsy sites for diagnostic accuracy of Helicobacter pylori infection: a retrospective study.**

**Author(s)**

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**Introduction**

Helicobacter pylori infection is very common worldwide, occurring in 40% to 50% of the population in developed countries. The infection causes chronic gastritis which significantly increases the risk of developing gastric or duodenal ulcer, gastric adenocarcinoma, and mucosa-associated lymphoid tissue (MALT) lymphoma. Eradication of H. pylori infection has been shown to improve the outcome of peptic ulcer disease in terms of recurrence and complications. Hence, accurate diagnosis of H. pylori infection is of clinical importance.

**Aims/Background**

To assess the optimal site for biopsy for detection of H.pylori infection and whether different sites provide different accuracy.

**Method**

We did a retrospective study on 943 patient who underwent upper GI endoscopy for dyspepsia at Monaghan General Hospital between March 2009 and July 2013. Biopsies were obtained from two sites in antrum and corpus respectively during upper endoscopy. The biopsy specimen were taken immediately for the CLO rapid urease test. Two biopsies were sent for histology and the results were followed to compare the CLO test result and biopsy results.

**Results**

Sensitivity of RUT in the body vs antrum was 73% vs 68% respectively specificity of RUT in the body vs antrum was 96% vs 97% respectively

**Conclusions**

Both biopsy sites had an almost similar results in the detection of H.pylori infection. The RUT should be combined with other endoscopic or nonendoscopic modalities to establish the presence or absence of this infection. Increasing the number of biopsies and the number of sites will increase accuracy. However, this prolongs endoscopy time and adds to the discomfort of the patient.

(ISG S’2018 104)

**The prevalence of alcohol use disorders in medical admissions to the Mater Misericordiae University Hospital**

**Author(s)**

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**Department(s)/Institutions**

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**Introduction**

Alcohol consumption can contribute directly or indirectly to the need for medical admission to hospital. The impact of alcohol consumption and the drinking patterns of medical admissions to the Mater hospital are not known.

**Aims/Background**

We sought to quantify alcohol consumption and determine the prevalence of alcohol use disorders in patients admitted to our hospital. We also aimed to determine whether the admission was alcohol attributable, alcohol associated or unrelated.

**Method**

We determined the alcohol consumption for every patient admitted medically over one whole week and then classified them as abstinent, low risk, hazardous, harmful or dependent. Every patient that was not medically admitted to the Mater Misericordiae University Hospital. We also aimed to determine whether the admission was alcohol attributable, alcohol associated or unrelated.

**Results**

We collected data on 199 patients. Alcohol use disorders were uncommon in patients ≤40 or ≥66. 40% (19/48) of patients in the 41-65 year old group had an alcohol use disorder (mean AUDIT score = 32). There were more dependent women than men. In this age group 10% had low risk was asked to complete an AUDIT (Alcohol Use Disorders Identification Test) questionnaire. Patients were divided into three age groups; ≤40, 41-65, ≥66 years old.

**Conclusions**

Alcohol use disorders are common in patients aged between 41 and 65 admitted medically to the Mater Hospital. It is important to screen this population and deliver targeted interventions.
**The diagnostic yield of EUS guided FNA in a tertiary referral center.**

**Author(s)**
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**Introduction**
Endoscopic ultrasound-guided fine needle aspiration cytology (EUS-FNAC) is a minimally invasive technique widely used for the evaluation of deep-seated benign and malignant lesions. The advantages of EUS include real-time puncture, reduced risk of complications due to the proximity of the needle to the lesion, and the ability to sample small lesions that might be hard to sample using other methods.

**Aims/Background**
Compare the diagnostic yield of EUS guided FNA in our unit with international standards.

**Method**
The histological reports of the list of the patients who had EUS guided FNA in 1 year reviewed and results were recorded.

**Results**
Of total 553 total EUS done in 1 year, 74 patients had EUS guided FNA, the diagnosis of malignancy was made in 53%, and the sample size was enough to exclude malignancy in 28%

**Conclusions**
EUS guided FNA has relatively high diagnostic yields compared to other imaging-guided biopsies. Our diagnostic yield is compatible with international standards. The presence of cytopathologist in the procedure room may increase the diagnostic yield.

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**“GAL-SWITCH: A Prospective Observational study of planned switch from bio-originator Infliximab to biosimilar Inflectra.”**

**Author(s)**
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**Introduction**
Recent studies have shown that the efficacy of Infliximab (IFX) biosimilars appears similar to Remicade when patients were switched without significant increase in adverse drug reactions and immunogenicity.

**Aims/Background**
To prospectively assess the efficacy, safety and patient satisfaction (using patient reported outcome measures) when switching patients from Remicade to biosimilar Inflectra in our Inflammatory Bowel Disease Cohort.

**Method**
In this open-label prospective cohort study all patients with IBD receiving Remicade were switched to biosimilar Inflectra in October 2017. Data was collected 6 months and 3 months prior to the switch, at the time of the switch and 3 months after. Data collected includes CRP, fecal calprotectin, Infliximab trough levels, antibodies to infliximab and patient symptom scores (IBD-control, Visual Analogue scale, Harvey-Bradshaw Index and partial Mayo score).

**Results**
53 patients are included in the study. 55% of patients are male and 75% are Crohn’s patients. 98% of patients were still receiving Inflectra at 3 months. There were no crisis admissions for IBD flares and no serious ADRs reported. On average, there was a cost reduction of 56% annually per patient. There was no significant difference in PROMs or mean CRP pre-switch and at 3 months after. Pre-switch median IFX trough level was 4.6mg/L compared to a median of 5.2mg/L 3 months post switch. None of our patients have developed antibodies to IFX to date.

**Conclusions**
From our preliminary data, there is no concern regarding safety, efficacy, immunogenicity or patient satisfaction having switch from Remicade to Inflectra. Longer term post switch data is currently being collected.
Empower Crohn’s patients to live life their way¹

Conor Byrne


Date of Preparation: September 2017 [US/CA/IN/JP/IN/BR/BR/BR/BR/BR]
Only 9% reported they have knowledge about the vaccination and 10% reported they were educated about the vaccinations. Forty percent reported they have up-to-date influenza vaccine and only 15% have their Pneumococcal vaccine. Fifteen percent have their vaccine against the hep B. Sixty percent of the women were having their regular cervical smear checked.

**Conclusions**
Despite all efforts uptake is low and we advocate that vaccination should now be proactively administered by the IBD physicians.

(ISG S’2018 111)

**EUS guided gallbladder drainage with the hot AXIOS stent: The first Irish experience**

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**Introduction**
The management of gallbladder disease is particularly challenging in patients who are elderly or poor surgical candidates. Current standard of care for acute cholecystitis in this cohort involves antibiotics and possible percutaneous drainage via interventional radiology. External drains are uncomfortable, may dislodge, and can result in delayed hospital discharge.

**Aims/Background**
We report the first six cases in Ireland of EUS guided placement of a lumen apposing metal stent between the gallbladder and stomach or duodenum using the hot AXIOS system

**Method**
6 patients with acute or recurrent cholecystitis were prospectively selected as appropriate candidates. Each patient was deemed unsuitable for surgical intervention given advanced age or co-morbidities. Under conscious sedation in the endoscopy unit, EUS guided gallbladder drainage (EUS-GBD) was performed.

**Results**
EUS- GBD was performed in 6 patients (4 male, 2 female, mean age 78, range 65-95).3 patients had recurrent cholecystitis requiring multiple admissions. 1 patient, with a history of recurrent cholecystitis, presented with a gallbladder perforation. 2 patient with hilar cholangiocarcinoma developed acute cholecystitis following percutaneous transheptatic biliary stenting. Stent placement was successful in 100% of patients, with no immediate complications. All patients were discharged well. At mean follow up of 5 months, no patient has re-presented to hospital with cholecystitis.

**Conclusions**
EUS-GBD in carefully selected patients is safe, and may reduce the morbidity and long term care issues associated with percutaneous drains

(ISG S’2018 112)

**Measures of predicting inflammatory and fibrotic strictures in Crohn’s disease patients using magnetic resonance**

**Author(s)**
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**Introduction**
Small bowel (SB) Crohn’s disease (CD) strictures can comprise of both inflammation and fibrosis. Dense fibrotic matrix exhibits delayed gadolinium enhancement on MRI. Relative contrast enhancement (REC) of >24% on delayed MRI sequences may accurately detect fibrosis.

**Aims/Background**
To determine the feasibility of Magnetic Resonance Enterography, MRE, SB stricture assessment with early (70s) and late (7mins) phase post gadolinium imaging.

**Method**
A retrospective study on 208 MREs for patient with suspected and known CD. Disease status, demographics and biochemical markers were recorded. MREs assessed by 2 radiologist for evidence of RCE, T2 signal intensity(SI), MaRIA score and evidence of stenosis.

**Results**
Median age 40.5 years; male n= 83(39.9%). 117, 72 and 19 patients had known CD, suspected CD and indeterminate IBD, respectively. 119(57%) MREs were normal. Ileitis, strictures and fistulas were found in 40(19%), 49(24%) and 1(0.5%), respectively. 69 MREs were further assessed on patients with strictureing and inflammatory ileal CD. Median age = 42 years. Male n= 26(38%). RCE >24% and high T2SI occurred in 26(38%) and 35/69 (51%) respectively. MaRIA score comprised of: Mild<7; 5(7%), moderate 7-11; 11(16%), severe>11; 53(77%). No significant change in MaRIA score between 70sec and 7mins. 36(52%) had stenosis on MRE. RCE, T2SI and MaRIA scores for patients with stenosis versus no stenosis were: RCE>24%; 13v13. High T2 SI: 30v5. MaRIA <7; 2v3. MaRIA 7-11; 6v5. MaRIA >11; 28v25. RCE<24% and high T2SI; 23(33.3%). 20(30.3%) had neither High T2 SI nor RCE>24%. 12(17%) had both RCE>24% and high T2SI while 14(20%) had RCE>24% without high T2SI.

**Conclusions**
MaRIA scores do not differentiate between inflammatory and stenotic disease. T2SI may be a useful marker of stenosis. RCE>24% was comparable in groups with both stenosis and without, further analysis is required into patients who have isolated RCE>24% and where this may be a marker of fibrotic versus inflammatory disease.
**Minimally invasive surgical management of spontaneous oesophageal perforation (Boerhaave’s syndrome)**

**Author(s)**
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**Introduction**
Spontaneous oesophageal perforation (Boerhaave’s syndrome) is a highly morbid condition traditionally associated with poor outcomes.

**Aims/Background**
The Pittsburgh perforation severity score (PSS) accurately predicts risk of morbidity, length of stay (LOS) and mortality. Operative management is indicated among patients with intermediate (3 – 5) or high (>5) PSS, however the role of minimally invasive surgery remains uncertain.

**Method**
Consecutive patients presenting with Boerhaave’s syndrome with intermediate or high PSS to a single oesophagogastric unit from 2012-2017 were reviewed. Demographic, clinical presentation, management and outcomes were analysed.

**Results**
Ten patients (80% male) with a mean age of 61.2 years (range: 37–81) were included. Three patients had intermediate and seven patients had high PSS (7.3±2.9, range: 4–12). The mean time from onset of symptoms to diagnosis was 25±15 hours and APACHE II score was 12.4±6.7. Nine patients were managed operatively and one conservatively. Thoracoscopic debridement and primary repair was performed in seven patients, with two perforations repaired primarily conservatively. Thoracoscopic debridement and primary repair was performed in seven patients, with two perforations repaired primarily over a T-tube. Laparoscopic feeding jejunostomy was performed in all cases, and decompressing gastrostomy in five patients. Critical care LOS was 8.1±7.5 days (range: 0–26), while inpatient LOS was 22.1±12.3 days (range: 8–46), significantly associated with PSS (P<0.01, R2 =0.63). Median comprehensive complications index was 34.6 (range: 0 – 69.6), with grade IIIa and IV morbidity in 50% and 10%, respectively. One patient developed dehiscence at the primary repair, which was managed non-operatively. In-hospital and 90-day mortality was 10%.

**Conclusions**
Minimally invasive surgical management of spontaneous oesophageal perforation with high perforation severity scores is feasible and safe, with outcomes which compare favourably to the published literature.

**Lymph node yield from pancreaticoduodenectomy (Whipple) specimens; a three year audit from 2015-2017**

**Author(s)**

**Department(s)/Institutions**
National Surgical Centre for Pancreatic Cancer, St. Vincent’s University Hospital.

**Introduction**
The surgical management of neoplasms of the pancreas, ampulla and distal bile duct is pancreaticoduodenectomy (Whipple procedure). Identification and histological examination of the lymph nodes is a key staging and prognostic element of the pathological evaluation of these specimens in cases of malignancy.

**Aims/Background**
A LND yield of ≥10 in pancreaticoduodenectomy specimens is a key performance indicators (KPI) set by the National Cancer Control Program. Our primary aim was to determine if lymph node dissection in these specimens in our laboratory has met this KPI.

**Method**
Details of all pancreaticoduodenectomy specimens reported in St Vincent’s University Hospital from 2015-2017 were retrieved via a search of the laboratory information system. Pathology reports of cases of invasive malignancy were reviewed to obtain the lymph node yield and the mean, median and percentage of cases that met the KPI were calculated. Data was stratified yearly to obtain a trend and was also compared to a previous similar audit from 2012-2014.

**Results**
A total of 189 cases were reviewed. The mean number of lymph nodes retrieved was 17.15(range 2-55) and the median was 16. There was a yearly improvement in the mean lymph node yield and an improvement since the previous audit of 2012-2014 (mean 13.45). 89.4% (n=169) cases had a lymph node yield of ≥10.

**Conclusions**
This audit confirmed that lymph node retrieval in pancreaticoduodenectomy specimens for invasive malignancy met the key performance indicators set by the National Cancer Control Program of ≥10 in 89.4% of cases (mean 17.15), with a yearly improvement in lymph node yield since 2012.

**Microbial Regulation of Hepatic Gene Expression: Implications for Tryptophan Metabolism**

**Author(s)**
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**Introduction**
Communication along the microbiome-gut-brain axis exerts a marked impact on brain function and behaviour. Microbial regulation of tryptophan metabolism, an essential amino acid and precursor to serotonin and neuroactive kynurenine pathway metabolites, represents a potential mechanism underpinning this influence.

**Aims/Background**
The liver is a major site of tryptophan metabolism to kynurenine by tryptophan 2,3-dioxygenase (TDO2) and other enzymes. The gut microbiome influences hepatic gene expression but the contribution of this crosstalk to the circulating availability of tryptophan and its metabolites is currently unknown.
Introducing Entyvio: the first and only gut-selective biologic for patients with moderately to severely active ulcerative colitis (UC) or Crohn’s disease (CD)

The first and only gut-selective biologic

- 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 different from anti-TNFα therapies

- No weight-based dosing: 300-mg IV infusion

References:

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Entyvio vedolizumab

Your Gut-SELECTIVE Biologic

Pharmacist: Multiple administrations (PMA). In rare cases, may be observed in patients treated with Entyvio. In the event of a serious adverse reaction, please contact the Takeda Pharmacovigilance department at 1-877-878-1818. For more information, please visit www.takedapharm.com/

Your gut-SELECTIVE Biologic

Entyvio (vedolizumab) is a monoclonal antibody that selectively binds to the GI mucosal sites in adults with ulcerative colitis (UC) or Crohn’s disease (CD). It is indicated for adults with moderately to severely active ulcerative colitis or Crohn’s disease who have responded to or have tolerated a course of corticosteroids. Entyvio is a gut-selective biologic that prevents the binding of lymphocytes to the gut wall, which can help reduce inflammation.

Entyvio is approved for use in adults with ulcerative colitis or Crohn’s disease who have responded to or have tolerated a course of corticosteroids. Entyvio is a gut-selective biologic that prevents the binding of lymphocytes to the gut wall, which can help reduce inflammation.

- 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 different from anti-TNFα therapies

- No weight-based dosing: 300-mg IV infusion

References:

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Entyvio vedolizumab

Your gut-SELECTIVE Biologic

Pharmacist: Multiple administrations (PMA). In rare cases, may be observed in patients treated with Entyvio. In the event of a serious adverse reaction, please contact the Takeda Pharmacovigilance department at 1-877-878-1818. For more information, please visit www.takedapharm.com/
Method
Butyrate or saline was administered via the drinking water (3g/L) for 21 days to conventional and germ-free male C57BL/6 mice (n=15/group). Mice were euthanised by decapitation and total RNA was isolated from harvested liver tissue. Quantitative reverse-transcription polymerase chain reaction (qRT-PCR) was used to examine the expression of relevant hepatic tryptophan-metabolising enzymes.

Results
The expression of TDO2 was reduced in germ-free mice compared to conventionally colonised animals (p<0.05). Butyrate supplementation was unable to normalise the expression of this enzyme in germ-free animals nor did it have an effect in conventional controls. A similar pattern of hepatic gene expression was also observed for indoleamine 2,3-dioxygenase 1 (IDO1).

Conclusions
Microbial regulation of hepatic gene expression may represent an important mechanism though which the gut microbiome regulates the availability of tryptophan and its metabolites. Further studies are required to understand the microbial mediators involved in this cross talk between the gut microbiome and the liver and to determine if is possible to manipulate this relationship to control gut-brain axis signalling.

(ISG S'2018 127)

To evaluate Photographic confirmation of complete colonoscopy

Author(s)
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Introduction
Colonoscopy is the gold standard investigation for examining the lower GI tract. Colonoscopy must be of high quality in order to maximise its benefit. BSG and ESGE guidelines recommend photographic and written documentation of caecal intubation. Such photo-documentation includes images of both the ileocecal valve and the cecum with views of the appendiceal orifice.

Aims/Background
Establishing reliability of photo-documentation of caecum as evidence of caecal intubation in our hospital.

Method
A retrospective study of consecutive colonoscopies in endoscopy unit from 29/01/2018 to 07/02/2018 by gastroenterology registrars, surgical registrars and consultants. Data was collected from endoraad. Total of 112 colonoscopies were performed in above period. 18 colonoscopies were excluded from audit (no photograph due to technical reason, failed colonoscopies and previous surgery). 94 included in the audit. 5 endoscopists then independently scored the photographs ranging from 1-4. Score 1 is definitely caecum, 2 likely caecum, 3 maybe caecum and 4 not caecum.

Results
Inter observer variability (number of caecal picture with the difference of more than 1 point) was 4 of 94 (4.2%) . Photographs assessed as either definitely caecum or likely caecum was 63 (72.3%) and 22 (23.4%) was assessed as may be caecum or not caecum.

Conclusions
Photographic documentation of caecum is well establish KPI of colonoscopy. As evident from this audit 23.4% caecal photo documentation by experienced endoscopist was not established. This audit evaluate the need for adherence with established KPI’s. A further alternative to the above is video-documentation of the cecal landmarks if available.

(ISG S'2018 128)

Barrett’s Oesophagus Surveillance in a Tertiary Centre

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Introduction
Guidelines regarding interval surveillance endoscopy for Barrett’s oesophagus (BO) are well established. Novel techniques including narrow band imaging (NBI), ascetic acid chromoendoscopy (AACE) and transparent cap (TC) use have shown better accuracy in detecting dysplasia. These techniques remain outside international guidelines, potentially leading to a wide variation in assessment.

Aims/Background
To review BO assessment techniques and variation in practice within a tertiary endoscopy centre.

Method
A retrospective review of 180 OGDs identified 21 OGDs with BO. Techniques including NBI, AACE and TC use were documented. Use of Prague Criteria, Seattle Protocol or targeted biopsies were noted.

Results
Median age 61 years (Male n=14). Indication for endoscopy: previous dysplasia (5); BO follow-up (6); other (10). There was no significant difference in use of lidocaine spray and midazolam. Fentanyl use by registrars was 66% (8) and consultants 44% (4). Prague Criteria was documented in 19 (90%) cases, registrar = 12 (100%) and consultant = 7 (77%). Short BO (<3cm) = 10 (47%). Long BO = 11 (53%). NBI was performed in 15 (21%) cases: previous dysplasia 5/5 (100%), known BO 6/6 (100%); new BO 4/4 (100%); short BO 7/10 (70%); long BO 8/11 (73%). AACE was performed in 5/21 (24%); short BO 0/10 (0%); long BO 5/11 (45%); previous dysplasia 2/5 (40%); known BO 3/6 (50%); new BO 0/10 (0%). TC was performed in 5/21 (24%) short BO 2/10 (20%); long BO 3/11 (27%); previous dysplasia 3/5 (60%); known BO 2/6 (33%); new BO 0/10 (0%). There was no significant difference between registrar and consultant endoscopists. Quadrantic biopsies were taken in 100%, with no targeted biopsies.

Conclusions
We found wide variation in BO assessment techniques in a single unit. Local and international guidelines are required to standardise BO assessment and improve dysplasia detection.
Endoscopic Colonic Polyps Reporting. Are we doing it right?

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Introduction
Approximately 3-6% of colorectal adenomas detected at colonoscopy are large sessile polyps and up to 20% of all polyps are flat or minimally elevated. The detection of these lesions is likely to increase with the introduction of population screening for colorectal cancer. Polyp description (size, location), procedure performed (excision and methodology) and the use of internationally recognized Paris or NICE (NBI-Narrow Band Imaging International Colorectal Endoscopic) classifications ideally should be documented in a standard endoscopy report.

Aims/Background
The aim of this retrospective observational study is to assess endoscopists’ approach on colonic polyps reporting in our institution.

Method
Endoscopy reporting is performed using the Unisoft Software. A total of 100 colonoscopy reports generated from mid-January to February 2018 involving detection and management of colonic polyps were reviewed.

Results
There were 93 (93%) reports documenting measurements of polyps’ size with 7 describing polyps as small without measurement. 99% reports documenting colonic segments of polyps encountered. 99% reports documented method of excision (forceps biopsy/snare/endoscopic mucosal resection (EMR). There was one case documented only biopsy performed with the other 99 cases managed with polypectomy. 4 reports commented on the polyps having hyperplastic appearance. Of the 100 colonoscopies, 63% were performed by non-consultant hospital doctors (43 medical, 20 surgical) with 37% performed by consultants (30 medical, 7 surgical). 18% endoscopists applied Paris classification in their reports (all medical endoscopists).

Conclusions
This single centre observational study has shown good reporting manner with high percentage amongst endoscopists including details on polyps’ size, site and methodology of polypectomy in reports. However, there was a low utilization of internationally recognized polyp classifications. A number of variables may account for this.

Hepatitis C success rates and improvement in liver enzymes at St Luke’s Hospital Kilkenny

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Introduction
Historical treatment of Hepatitis C with interferon had high drop out rates and high recurrence rates. The novel direct acting antiviral agents (DAAs) are now widely available in Ireland and are easier and more successful than interferon based treatment. They are however expensive and real world data is needed to ensure efficiency and efficacy.

Aims/Background
To retrospectively analyse all hepatitis C patients treated at our institute with novel direct acting antiviral agents to assess success rates

Method
All patients with hepatitis C at our institute are followed up at a specialised nurse led clinic. Patients who have been treated at our institute since February 2017 with DAAs were entered into a specific database and analysed. Our primary measure was the number of patients pcR negative 3 months post treatment. We also measured changes in liver enzymes during and after treatment.

Results
Thirty eight patients were treated at our institute since February 2017. 26(68%) males and 12 females. Mean age 47.3 (28-68). Genotype 1a (14). Genotype 1b (12). Genotype 2 (2). Genotype 3 (10). 30 non-cirrhotic, 8 cirrhotic. Mean treatment duration was 12.2 weeks (8-24) with 32 patients prescribed the 12 week programme. One patient was not fully compliant with treatment and has since stopped attending. Only one patient was pcR positive at 3 months. Therefore in intention to treat we had a 95% success rate. Mean ALT pre-treatment was 81 (16-307) and the mean at end of treatment was 21(2-51). Mean GGT pre-treatment was 84 (7-687) and the mean at end of treatment was 33(12-449).

Conclusions
Our data shows that treatment with the new DAAs at our institute is effective and safe resulting in 95% viral clearance and significant improvement in liver enzymes.
Individualised Prescribing for H. pylori Eradication, Proven Efficacy in Practice

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**Introduction**
Current best practice guidelines state that 14-day triple therapy or Bismuth quadruple therapy should be adopted as first line treatment of H. pylori.

**Aims/Background**
This study aims to evaluate the effectiveness of switching from a 7-day triple therapy regimen to 14-day triple or quadruple therapy in terms of H pylori eradication rates.

**Method**
From September 2016 to December 2017 patients undergoing OGD at the Bon Secours Hospital, Cork had H. pylori status determined by CLO test (BioHIT). All patients undergoing OGD also had biopsies sent for H. pylori culture. H. pylori positive patients were treated with 7-day triple therapy, 14-day triple therapy or 14-day quadruple therapy. Patients were offered urea breath test (Diabact UBT) 3-4 months after completing treatment. Patients were excluded if they did not attend follow-up breath testing or if data was unavailable. Eradication rates in the different treatment groups were compared.

**Results**
Of 1891 patients undergoing OGD, 146 (7.7%) had positive CLO tests. 28 patients had negative CLO tests on OGD but went on to have positive H. pylori biopsies. Of the total 174 patients identified as H pylori positive, 112 went on to have urea breath testing: 5 patients were excluded due to incomplete prescription details. 42 received triple therapy for 7 days, 54 received triple therapy for 14 days and 11 received quadruple therapy for 14 days. The overall eradication rate was 89/107 (83.2%). The eradication rates per group were 36/42 (85.7%) in the 7-day triple therapy group, 46/54 (85.2%) in the 14-day triple therapy group and 7/11 (63.6%) in the quadruple therapy group.

**Conclusions**
Implementation of the new guidelines and individualised prescribing has lead to an improvement in H. pylori eradication rates from 71.4% in a previous audit (Bon Secours, 2017) to 83.2%.

**Proven Efficacy in Practice**

Forced Diuresis In Patients With Decompensated Liver Disease – Is There Significant Benefit To Be Gained?

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**Introduction**
Human albumin solution (HAS) has traditionally been used in patients with liver disease to prevent renal failure in spontaneous bacterial peritonitis, circulatory collapse following paracentesis and in the treatment of hepatorenal syndrome. The ANSWER trial recently suggested that administration of HAS alongside diuretics infers significant survival benefit in decompensated liver cirrhosis as well as improving quality of life.

**Aims/Background**
We evaluated the effectiveness of forced diuresis in the management of cirrhotic patients with peripheral oedema aiming to show improvement in functional status.

**Method**
Prospective assessment of patients admitted to the Regional Liver Unit from August 2017 until January 2018. Inclusion criteria comprised confirmed cirrhosis (Fibroscan, radiology or histology), peripheral oedema restricting mobility, failure of oral diuretics and absence of tense ascites or hepatorenal syndrome. All received
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treatment with 20g HAS daily alongside IV furosemide (40mg to 80mg daily) or IV bumetanide 1-2mg. Inpatient days, weight, renal function and ECOG score were assessed.

Results
22 patients were assessed. With the exception of two palliative patients all showed significant improvement in ECOG scores from 1-3 to 0-1. Mean inpatient stay was 13.9 days. Renal function was maintained in all cases. Only 14 patients had accurate weights throughout treatment. Of this cohort the mean total weight loss was 9kg (range 3.5kg–17.1kg).

Conclusions
For a subset of patients with liver cirrhosis, forced diuresis offers significant symptomatic relief and optimisation of functional status whilst preserving renal function. In light of inpatient days required, consideration should be given to development of an ambulatory pathway.

(ISG S’2018 139)
Attitudes towards Treatment Withdrawal in IBD

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Introduction
A recently published ECCO topical review on exit strategies in IBD has underlined the role of treatment withdrawal in selected cohorts with stable disease. Select patients may no longer require immunosuppression once disease remission is achieved and maintained.

Aims/Background
To assess patients’ attitudes towards immunosuppressive therapy and to potential treatment withdrawal.

Method
We invited patients undergoing immunosuppressive therapy, attending out-patients or the infusion suite during a 4-week period, to participate in this prospective observational study. Participants were asked a series of questions regarding their disease and treatment history, compliance with treatment, awareness of risks of immunosuppression, concerns regarding long term treatment, concerns regarding treatment withdrawal and willingness to switch to generic medication.

Results
In total, 88 (female = 48%) patients participated. Mean age 42.6 years (16 - 72). Crohn’s 77%. Treatment – 28% Infliximab, 13% Combination therapy, 17% Adalimumab, 10% Imuran, 4% Ustekinumab, 2% Vedolizumab, 1% Golimumab. Mean duration of therapy 5 years (0.5-18). 35% required steroids in the past 12 months. 16% smokers. 29% ex-smokers. Missed dose reported in 80% Imuran, 35% Infusions, 78% Subcutaneous. Mean HBI = 6.3. Mean partial Mayo = 1. 97% aware therapy affected immune system. 70% concerned regarding same. 84% agreeable to life-long therapy. 54% happy to stop treatment if advised by their Physician, rising to 87% if decision based on drug levels. 68% happy to switch to biosimilar. Main concerns regarding treatment withdrawal include relapse (68%), loss of response (16%) none (16%).

Conclusions
Patients are aware of the risks of long term immunosuppression and are interested in treatment withdrawal if advised by their Physician.

(ISG S’2018 140)
PBC Management in a Regional Liver Unit – Establishing the Role for a PBC MDM

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Introduction
Primary Biliary Cholangitis (PBC) is a progressive autoimmune disease that destroys the small interlobular bile ducts leading to cirrhosis. The goals of treatment are to delay/avoid the need for transplantation. The current mainstay of treatment is ursodeoxycholic acid (UDCA). New medications have recently received NICE approval for second line treatment of PBC.

Aims/Background
To identify PBC patients under follow up with the Liver Unit of the Royal Victoria Hospital (RVH), who are not on appropriate weight-based treatment of UDCA or are non-responders to UDCA who may be eligible for second line agents.

Method
A retrospective, cross-sectional evaluation of consecutive PBC patients attending the RVH liver clinic between September 2016 and June 2017. Written consent was obtained during outpatient clinic consultations and anonymized data was collected from hospital databases and medical notes including patient demographics, management and outcomes i.e. biochemical response.

Results
103 patients were included. 85% of patients were female; mean age 51.2 years at diagnosis; 93% (96/103) were on UDCA. Of 96 patients (93%) on UDCA, 13 (14%) were on the recommended dose (13 – 15 mg/kg), 65 (68%) were on the incorrect dose and 18 (19%) had no weight recorded. 60% (58/96) were deemed to be UDCA responders (ALP ≤1.67 upper limit of normal (ULN) and bilirubin≤0.8 mg/dL). 51.2 years at diagnosis; 93% (96/103) were on UDCA. Of 96 patients on UDCA were non-responders and therefore may be appropriate for consideration of a second line medication such as bezafibrate or obeticholic acid. This suggests a regional PBC MDM would be beneficial to identify patients suitable for escalation of treatment.

(ISG S’2018 143)
Measuring Compliance with Adalimumab using Smart Sharps Bin Technology

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**Introduction**

Adalimumab is a patient-administered subcutaneous anti-TNF agent used in both Crohn’s Disease and Ulcerative Colitis. It has previously been shown that there is significant non-compliance with patient-administered subcutaneous therapies.

**Aims/Background**

To evaluate compliance with Adalimumab among our patient cohort enrolled in the Health Beacon programme.

**Method**

We collated data supplied by Health Beacon on a monthly basis to determine rates of non-compliance with Adalimumab therapy including, early, late and missed dosing. A drop is counted as administration of Adalimumab and placement of the pre-filled pen or syringe into the smart sharps bin.

**Results**

A total of 496 drops were counted among 26 patients. 15 males and 11 females are currently enrolled in the programme with an average age of 40.6 years. 17 patients have a diagnosis of Crohn’s Disease and 9 with Ulcerative Colitis. 355 drops were recorded as being on-time, giving an overall compliance rate of 71.5%. Compliance among males is 76.8% and females 63.8%. Compliance is 71.7% and 70.6 in Crohn’s Disease and Ulcerative Colitis, respectively. 46.2% of patients have missed at least two doses.

**Conclusions**

We have shown high rates of non-compliance with Adalimumab therapy in patients who have agreed to have their compliance tracked. This may be attributed to the administration of the medication by the patient at home. In this case, infusion therapy may show benefit over subcutaneous therapy. Further correlation with inflammatory markers, endoscopic findings and faecal calprotectin may aid in desescalating therapy in those patients who are non-compliant, yielding significant savings for our department.

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**Management Of Pbc Patients Pre-Obeticholic Acid Era**

**Author(s)**

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**Department(s)/Institutions**

Department of Gastroenterology, Tallaght University Hospital, Dublin and Department of Clinical Medicine, Trinity College, Dublin

**Introduction**

Primary Biliary Cholangitis is a chronic autoimmune disease characterised by progressive damage of interlobular bile ducts leading to end-stage liver disease in some cases.

**Aims/Background**

To evaluate the management of PBC patients attending Tallaght University Hospital over the last 2 decades, in comparison to 2017 EASL guidelines.

**Method**

We performed a retrospective study of 39 PBC patients attending our institution using chart review, NIMIS electronic radiology system, and our local blood/pathology electronic system.

**Results**

The mean age of our cohort was 57.92 (range 33 – 78). 87.2% (n=34) of patients were female, and 76.92% (n=30) were above age fifty. 26 (66.7%) patients were treated with Ursodeoxycholic acid (UDCA), with 18 (69.2%) on suboptimal doses (<13 -15 mg/kg/day). Of the 26, 11 (42.3%) were non-responders based on Toronto criteria with an Alkaline phosphatase (ALP) > 1.67 x upper limit of normal. 8 (72.7%) of the 11 non-responders were on suboptimal dose of UDCA. 15 patients responded to UDCA based on Toronto criteria, 7 (26.9%) of these had ALP>1.67 x ULN before commencing treatment with UDCA, with ALP remaining <1.67 x ULN over 24 - 36 months.

**Conclusions**

Most patients were on suboptimal doses of UDCA, especially non-responders. This reflects previous uncertainty about the efficacy of UDCA. The dose is being optimised for these patients. True non-responders will be considered for obeticholic acid. All patients with ALP<1.67 x ULN who were treated with UDCA had a non-progressive disease course, which may relate to early treatment.
Aims/Background
We sought to examine use of endoscopy and its findings in a large cohort at our centre.

Method
The CF patient database (n=341) was used to review all endoscopic records 2008-2018 at our centre. Date of procedure, indication, and findings were recorded. An age-matched control population of patients who underwent colonoscopy at our centre was used for comparison (1:1).

Results
169/341 were genotype ∆F508, 131 (38.4%) male, with a median age of 32. 84/341 (25%) underwent gastroscopy, and 38/341 (11.4%) underwent colonoscopy. Commonest indications were reflux symptoms (25.3%), PEG insertion (21.7%), investigation of anaemia (13.3%) and assessment/banding of varices (18.1%). 35/84 (42.2%) had a normal OGD. 18% were found to have a hiatus hernia, 8.4% Barrett's oesophagus, 13.3% oesophagitis, 27.7% gastritis, 6% a duodenal ulcer, and 24.5% oesophageal varices. ∆F508 patients were more likely to have Barrett’s (15.6% vs 0%, p=0.014). There were no differences between genders. The commonest indications for colonoscopy in CF patients were rectal bleeding (38%) and anaemia (18%). Patients with CF were more likely to have a polyp identified at colonoscopy (23.7% versus 12.4%, p=0.05).

Conclusions
CF patients are more likely to have colonic polyps than age-matched controls. Genotype may be significantly related to the presence of Barrett’s oesophagus, but further study is required.

Aims/Background
We sought to describe the relevant clinical course for adult patients with biliary atresia who underwent a Kasai operation in childhood and who have not been transplanted at the time of transition to adult services (“adult Kasai”)

Method
Retrospective audit of the adult care of patients from a single centre programme embedded in a large transplant unit (1999-2016)

Results
Of 95 patients (54 female- mean age 26.2± 0.69 years) reported with a Kasai procedure as a child, 63 had undergone liver transplantation (LT). Eight patients had LT post transition to adult care. 32 remained with their native liver –two were lost to follow-up- (19 female, mean age of 26±0.75 years) with median follow up 63.8 months. Portal hypertension was present in 22 patients: 13 (43%) with varices and splenomegaly. Variceal bleeding occurred in 4 patients; 1 patient developed ascites and 1 hepatocellular carcinoma. Pruritus and abdominal pain affected 11 patients (36.6%). Cholangitis (1-10 episodes) appeared in 12. 16 patients (53%) were admitted to hospital at least once due to their liver disease. Malabsorption appeared in 2, and 5 had underlying bone disease. MRI performed in 9 (30%) included features of sclerosing cholangitis and bile dilatation. A total of 9 patients underwent a liver biopsy, only 5 presented advanced fibrosis. 10 patients were on long term UDCA and 10 required rotating antibiotics

Conclusions
The “adult Kasai” patient has a heterogeneous course that includes: cirrhosis, portal hypertension, symptomatic cholangitis and pain. Clinical care of patients needs to account for this

Aims/Background
Use of endoscopy services by cystic fibrosis patients in a national cohort

Method
A review of consecutive patients who underwent percutaneous ultrasound and fluoroscopic guided cholecystectomy tube insertion over a 3 year period (01/01/2015-31/12/2017) was performed. Patients were identified using NIMIS and the hospital internal computer system. Outcomes assessed included; cholecystectomy, cholecystostomy reinsertion, no further interventions, and mortality.

Results
There were 63 patients in total (45 male, 19 female). Patient age range was 29 to 93, mean 70 years. Acute cholecystitis was the most
common indication. 49 were transhepatic drain insertions, 2 were direct gallbladder punctures. Route of insertion was not specified in 13 cases. 45 (69%) had a subsequent tubogram to assess patency of the cystic duct prior to catheter removal (37) or to assess position (8). 16 patients subsequently underwent cholecystectomy (12 laparoscopic, 4 open). 7 (11%) had a cholecystostomy reinserted (2 were due to recurrence of symptoms, 5 were due to inadvertent catheter dislodgement). Time to reinsertion ranged from 2 to 107 days, average 33 days. 29 (35%) had no further intervention post removal of cholecystostomy. 1 required subsequent drainage of a hepatic abscess. 9 patients (14%) died during the recruitment period.

Conclusions
Cholecystostomy remains an important treatment method of acute cholecystitis in the short term, or as an alternative treatment option in those unsuitable for surgery. 11% of those that did not proceed to cholecystectomy required reinsertion of a cholecystostomy.

(ISG '2018 152)

Cross-Specialty Analysis of Infliximab Dosing

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Introduction
Infliximab is prescribed for numerous conditions, including IBD and Rheumatoid Arthritis (RA). Numerous biologic agents are licensed for the treatment of RA. However, IFX remains a stalwart of IBD therapy as few alternatives exist.

Aim
To compare the overall use and dosing of Infliximab by relevant specialties.

Methods
The study was performed in a single academic centre between January and March 2018. Data regarding the dose(mg) and number of vials per infusion of Infliximab, and prescribing specialty for each individual infusion were retrieved from the Pharmacy database.

Results
405 Infliximab infusions were administered in the study period. 75.8% were prescribed by Gastroenterology, compared with 19.3% by Rheumatology, the second largest cohort. Dermatology and Neurology accounted for 3.7% and 1.2% respectively. The median dose/infusion was 430mg (IQR 350-620mg); median number of vials/infusion was 5 (IQR 4-7). The median dose of Infliximab prescribed by Gastroenterology was significantly higher compared with the Rheumatology service. (440mg; IQR 360-630mg vs 400mg; IQR 300-472mg; p=0.001). There was no significant difference in dose/infusion between the Gastroenterology service and Dermatology or Neurology prescribers. (p=0.29 and p=0.15 respectively).

Conclusion
Gastroenterology represent the largest proportion of Infliximab prescribers in this tertiary referral centre, administering over 3 times as many infusions as the Rheumatology service in the same study period. Gastroenterology patients were administered a significantly higher dose of Infliximab/infusion. IFX trough levels can be used to safely reduce IFX dose. The adequate resourcing of IBD specialty nurses and biologic registries could have a significant impact on hospital expenditure on Infliximab.
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Dr Nap Keeling and Prof Fergus Gleeson

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Sinead Cabben and Mai Hanlon, Tillotts

Dr Susan McKiernan

Dr Diarmuid Houlihan

Dr Christian Maaser with Audience

Prof. Glen Doherty
Winter Meeting 2017

Poster Winner - Loretta O’Brien, Winner Dr Ciaran Judge collected by Dr David Kevans and Prof Laurence Egan.

Poster Winner - Loretta O’Brien AbbVie, Dr Jane Doherty and Prof Laurence Egan.

Poster Winner - Loretta O’Brien, Dr Sara Naimimohasses and Prof Laurence Egan.

Oral Winner - Robert Felton, Norgine, Dr Paul Armstrong and Prof Laurence Egan.

Oral Winner - Robert Felton, Norgine, Dr Margaret Walshe and Prof Laurence Egan.

Oral Winner - Robert Felton, Norgine, Dr Fintan O’Hara and Prof Laurence Egan.
Winter Meeting 2017

Best Video Clip, Margaret Shaughnessy – Takeda, M. Syafie Ismail receiving award on behalf of Catriona Gallagher and Prof Laurence Egan

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Date of Preparation: March 2018