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Irish Society of Gastroenterology

Winter Meeting

23 - 24 November 2017

Killashee Hotel, Co. Kildare

The first biosimilar monoclonal antibody (mAb) for use in rheumatology, gastroenterology and dermatology

Gain a fresh perspective

INFLECTRA™ is the first biosimilar mAb. Designed with comparable efficacy and safety to reference infliximab to increase the treatment options for your rheumatology, gastroenterology and dermatology patients.[1]

Change your perspective. Choose INFLECTRA™.

INFLECTRA™ ▼
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Abbreviated Prescribing Information
INFLECTRA ▼ (Infliximab) powder for concentrate for solution for infusion.
Please refer to full Summary of Product Characteristics (SmPC) before prescribing. **Presentation:** Vial containing 100 mg of infliximab powder for concentrate for solution for infusion. **Indications:** *1) Rheumatoid arthritis (RA)* in combination with methotrexate (MTX) in adult patients with active disease with inadequate response to disease-modifying antirheumatic drugs (DMARDs) or adult patients with severe, active and progressive disease not previously treated with MTX or other DMARDs. *2) Adult Crohn's disease* (CD) a) In patients with moderately to severely active CD who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; or who are intolerant to or have medical contraindications for such therapies. b) In patients with fistulising, active CD who have not responded despite a full and adequate course of conventional treatment (including antibiotics, drainage and immunosuppressive therapy). *3) Paediatric* CD Severe, active CD in patients aged 6 to 17 years, who have not responded to conventional therapy including corticosteroid, immunomodulator and primary nutrition therapy; or who are intolerant to or have contraindications for such therapies. *4) Ulcerative colitis* (UC) In both adult patients with moderate to severely active UC, and children and adolescents aged 6 to 17 years with severely active UC and an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA), or those who are intolerant to, or have medical contraindications for such therapies. *5) Ankylosing spondylitis* (AS) In adult patients with severe active AS who have responded inadequately to conventional therapy. *6) Psoriatic arthritis* (PsA) In adult patients with active and progressive PsA when response to previous DMARD therapy has been inadequate. Infliectra should be administered in combination with MTX - or alone in patients who show intolerance to MTX, or for whom MTX is contraindicated. *7) Psoriasis (PsO)* In adult patients with moderate to severe plaque PsO who failed to respond to, or who have a contraindication to, or are intolerant to systemic therapy including cyclosporine, MTX or Psoralen ultra-violet A (PUVA.) **Dosage & Administration:** All doses to be administered as an intravenous (IV) infusion over 2 hours initially and monitor post-infusion for at least 1-2 hours for infusion- related reactions. *1) RA* 3 mg/kg repeated 2 and 6 weeks after initiation, then every 8 weeks. Infliectra must be given concomitantly with MTX. *2) Moderately to severely active CD* 5 mg/kg repeated 2 weeks after initiation. If no response after 2 doses, no additional dose should be given. In responding patients: Maintenance dose of 5 mg/kg at 6 weeks after the initial dose, followed every 8 weeks, or: Re-administration of 5 mg/kg if signs and symptoms recur. *3) Fistulising, active CD* 5 mg/kg repeated 2 and 6 weeks after initiation. If no response after 3 doses, no additional dose should be given. In responding patients: Maintenance dose of 5 mg/kg every 8 weeks or: Re-administration of 5 mg/kg if signs and symptoms recur, followed by 5 mg/kg every 8 weeks. *4) UC* 5 mg/kg repeated 2 and 6 weeks after initiation, then every 8 weeks. *5) AS* 5 mg/kg repeated 2 and 6 weeks after initiation, then every 6 to 8 weeks. If no response by 6 weeks, no additional dose should be given. *6) PsA* 5 mg/kg repeated at 2 and 6 weeks after initiation, then every 8 weeks. *7) PsO* 5 mg/kg repeated 2 and 6 weeks after initiation, then every 8 weeks. If no response after 14 weeks no additional dose should be given. *8) Paediatric CD (6 to 17 years):* 5 mg/kg repeated 2 and 6 weeks later, then every 8 weeks. Data do not support further treatment in children and adolescents not responding within the first 10 weeks. *9) Paediatric UC (6 to 17 years):* 5 mg/kg repeated at 2 and 6 weeks, then every 8 weeks. Available data do not support further treatment in in patients not responding within the first 8 weeks. *Older people (≥ 65 years):* Studies have not been conducted. No major age-related differences in clearance or volume of distribution observed in clinical studies. No dose adjustment is required. *Impaired renal and/or hepatic function:* Not studied. No dose recommendations can be made. **Contraindications:** Hypersensitivity to infliximab, to other murine proteins, or to any excipients. Tuberculosis (TB) or other severe infections such as sepsis, abscesses, and opportunistic infections. Moderate or severe heart failure (NYHA class III/IV). **Warnings and Precautions:** Caution in patients with or at risk of infusion reactions and hypersensitivity. Do not administer in patients with bacterial infections, invasive fungal, viral or other opportunistic infections. Monitor for TB, and do not use in patients with TB. Test for latent/active TB prior to initiation of therapy. Do not use Infliectra in patients with active TB. In patients with latent TB, treatment with anti-TB therapy must be started before the initiation of Infliectra, and in accordance with local recommendations. Consult a physician with expertise in the treatment of TB. Monitor closely for infections, including TB before, during and for six months post-treatment. Patients with fistulising CD with acute suppurative fistulas must not initiate therapy until source of infection, specifically abscess, is excluded. Test for HBV infection before initiating treatment. For patients who test positive, consult a physician with expertise in the treatment of hepatitis B. Closely monitor carriers of HBV for signs and symptoms of active HBV infection during and after therapy. In patients with HBV reactivation, stop Infliectra and initiate effective antiviral therapy with supportive treatment. Symptoms or signs of liver dysfunction should be evaluated for evidence of liver injury. If jaundice and/or ALT elevations ≥5 times the upper limit of normal develop(s), stop Infliectra and initiate thorough investigation. Concurrent administration of Infliectra with anakinra, abatacept or other biologic therapeutics is not recommended due to possible increased risk of infection and/or other potential pharmacological interactions. Live vaccines or therapeutic infectious agents should not be used concurrently with Infliectra. Patients should continue to be monitored while switching from one biologic to another. If a patient develops symptoms suggestive of lupus-like syndrome following treatment with Infliectra and is positive for antibodies against double stranded DNA, discontinue Infliectra treatment. In patients with pre-existing or recent onset of demyelinating disorders (including multiple sclerosis and Guillain Barré syndrome), the risk/benefit of anti-TNF treatment should be carefully considered before initiation of Infliectra. Discontinuation of Infliectra should be considered if these disorders develop. Caution should be exercised in considering treatment of patients with increased risk for malignancy or when considering treatment in patients that develop a dysplasia or a malignancy or with previous history of malignancy. Caution should also be exercised in patients with psoriasis and a medical history of extensive immunosuppressant therapy or prolonged PUVA treatment. Potential risk of development of hepatosplenic T-cell lymphoma (HSTCL) when used in combination with AZA or 6-MP, especially in adolescents and young adult males with CD or UC. Periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. Patients with UC who are at increased risk or prior history of dysplasia for dysplasia or colon carcinoma should be screened for dysplasia (including colonoscopy and biopsies) at regular intervals before therapy and throughout their disease course. Use with caution and monitor closely in mild heart failure (NYHA class I/II). Discontinue Infliectra treatment in patients who develop new or worsening symptoms of heart failure. Patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation of Infliectra should be considered in patients with confirmed significant haematologic abnormalities. For patients that require surgery, Infliectra long half-life should be taken into account and should be monitored for infections. *Special populations:* Risk of infections should be considered when treating elderly and paediatric patients. If possible, comply with vaccination program for paediatric patients prior initiating treatment with Infliectra. *Women of childbearing potential:* Use adequate contraception to prevent pregnancy and continue its use for at least 6 months after the last Infliectra treatment. *Pregnancy:* Administration of infliximab is not recommended during pregnancy. *Breast feeding:* Unknown whether infliximab is excreted in human milk or absorbed systemically after ingestion. As human immunoglobulins are excreted in milk, women must not breast feed for at least 6 months after Infliectra treatment. **Undesirable effects:** Viral infection (e.g. influenza, herpes virus infection), bacterial infection (e.g. sepsis, cellulitis, abscess), TB, fungal infection (e.g. candidiasis), meningitis, opportunistic infection, parasitic infection, hepatitis B reactivation, vaccine breakthrough infection, lymphoma, non-Hodgkin's lymphoma, Hodgkin's disease, leukaemia, melanoma, cervical cancer, hepatosplenic T-cell lymphoma, Merkel cell carcinoma, neutropenia, leucopenia, anaemia, lymphadenopathy, thrombocytopenia, lymphopenia, lymphocytosis, agranulocytosis, thrombotic thrombocytopenic purpura, pancytopenia, haemolytic anaemia, idiopathic thrombocytopenic purpura, allergic respiratory symptom, anaphylactic reaction/shock, lupus-like syndrome, serum sickness like reaction, vasculitis, sarcoid-like reaction, depression, insomnia, amnesia, agitation, confusion, somnolence, nervousness, apathy, headache, vertigo, dizziness, hypoaesthesia, paraesthesia, seizure, neuropathy, transverse myelitis, demyelinating disorders, conjunctivitis, keratitis, periorbital oedema, hordeolum, endophthalmitis, transient visual loss, tachycardia, palpitation, cardiac failure, arrhythmia, syncope, bradycardia, cyanosis, pericardial effusion, myocardial ischaemia/ infarction, hypotension, hypertension, ecchymosis, hot flush, flushing, peripheral ischaemia, thrombophlebitis, haematoma, circulatory failure, petechia, vasospasm, upper respiratory tract infection, sinusitis, lower respiratory tract infection, dyspnoea, epistaxis, pulmonary oedema, bronchospasm, pleurisy, pleural effusion, interstitial lung disease, abdominal pain, nausea, gastrointestinal haemorrhage, diarrhoea, dyspepsia, gastroesophageal reflux, constipation, intestinal perforation/stenosis, diverticulitis, pancreatitis, cheilitis, hepatic function abnormal, transaminases increased, hepatitis, hepatocellular damage, cholecystitis, jaundice, liver failure, psoriasis (new onset or worsening), urticaria, rash, pruritus, hyperhidrosis, dry skin, fungal dermatitis, eczema, alopecia, bullous eruption, onychomycosis, seborrhoea, rosacea, skin papilloma, hyperkeratosis, abnormal skin pigmentation, Toxic Epidermal Necrolysis, Stevens Johnson syndrome, erythema multiforme, furunculosis, worsening of symptoms of dermatomyositis, arthralgia, myalgia, back pain, urinary tract infection, pyelonephritis, vaginitis, infusion related reaction, pain, chest pain, fatigue, fever, injection site reaction, chills, oedema, impaired healing, granulomatous lesion, autoantibody positive; complement factor abnormal. **Legal category:** POM; S1A **Marketing Authorisation Number:** EU/1/13/854/001, EU/1/13/854/002, EU/1/13/854/003, EU/1/13/854/004, EU/1/13/854/005. **Marketing Authorisation Holder:** Hospira UK Limited, Queensway, Royal Leamington Spa, CV31 3RW, UK. **Last Revised:** August 2016.
Ref: IF 1_0 1E.

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 of the SmPC for how to report adverse reactions.

For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at EUMEDINFO@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

References:
1. INFLECTRA™. European Public Assessment Report (EPAR). June 2013. Available at: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Summary_for_the_public/human/002778/WC500151491.pdf. [Accessed June 2016]

PP-IFA-IRL-0018 October 2016

Welcome Message

Dear Colleagues and Friends,

It is my great pleasure to welcome you to the 2017 Winter 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, IBD Nurses Association of Ireland and Irish Hepatology Nurses Association who also hold their meetings today and tomorrow alongside the ISG. As a firm believer in multidisciplinary patient care and inter-disciplinary learning, I am sure that the co-hosting of these meetings is advantageous for all. How we organize the delivery of care to our patients around the country represents a key challenge to us all. For this reason it gives me particular pleasure to welcome a special guest, Dr. Colm Henry, National Clinical Advisor and Group Lead, Acute Hospital Division, Health Service Executive. Dr. Henry will address us on moves afoot to establish a National Clinical Programme in Gastroenterology and Hepatology.

In 2017, the care of patients suffering from gastroenterological and liver diseases has been transformed in many specific examples, most notably that of hepatitis C. But more incremental advances have also been made in the management of many chronic diseases such as IBD, Barrett's Oesophagus, cholestatic liver disease, and liver cancer. We have decided to highlight in the scientific programme of this meeting advances that have been made in several of those disease areas with speakers from Ireland and overseas.

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. I am sure you will be as impressed as I am with the quality and originality of the research to be presented which is a testament to the vitality of our training programmes and the attractiveness of our specialty to the brightest young doctors in the country. Also being presented at this meeting are a very nice selection of research poster presentations. I encourage you to visit the poster presentations at 13.00 Thursday and sample the exciting results on offer. Remember that the poster presenters represent the future of our specialty in Ireland and they deserve our every encouragement.

Yours sincerely,

Prof. Laurence Egan
President ISG

Entyvio® ▽
vedolizumab

Entyvio: the first and only gut-selective biologic for adult patients with moderately to severely active UC and CD[1]

TREAT WITH PRECISION

PRESCRIBE WITH CONFIDENCE:
Gut-selective Entyvio targets only the site of inflammation[1]

Entyvio® ▽ (vedolizumab) PRESCRIBING INFORMATION

Refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: 300 mg powder for concentrate for solution for infusion. **Indication:** Adult patients with moderately to severely active ulcerative colitis(UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist. **Dosage & Administration:** Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn's disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. Ulcerative colitis: Recommended dose regimen 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Reconsider treatment if no evidence of therapeutic benefit at week 10. If patients experience a decrease in response, they may benefit from increased dosage frequency to 300mg every 4 weeks. Corticosteroids may be reduced/discontinued in patients who respond to treatment with Entyvio. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Crohn's disease: Recommended dose regimen is 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Patients who have not shown evidence of therapeutic benefit may benefit from a dose at week 10. Continue therapy every 8 weeks from week 14 in responding patients. Therapy should be discontinued if no evidence of therapeutic benefit is observed at week 14. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Paediatric populations: No data available in children aged 0-17 years. Not recommended. Elderly patients: No dosage adjustment required. Renal or hepatic impairment: Entyvio has not been studied in these populations. No dose recommendation can be given. **Contraindications:** Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, cytomegalovirus, listeriosis and opportunistic infections such as Progressive Multifocal Leukoencephalopathy (PML). **Warnings and Precautions:** Patients should be observed continuously during infusions for signs/symptoms of hypersensitivity reactions. Patients should continue to be observed for two hours following infusion completion for the first two infusions and one hour for subsequent infusions. Infusion-related reactions (IRR): Hypersensitivity reactions have been reported, the majority were of mild to moderate severity. Discontinue treatment if anaphylaxis or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IRR, slow or interrupt infusion. Consideration for pre-treatment with antihistamine, hydrocortisone and/or paracetamol should be given prior to next infusion, for patients with history of mild/moderate IRR to Entyvio. Infections: Not recommended in patients with active, severe infections until infections are controlled. Consider withholding in patients who develop severe infection while on treatment with Entyvio. Before initiating treatment, patients must be screened for TB. If latent TB is diagnosed, anti-tuberculosis appropriate treatment must be initiated prior to Entyvio treatment. Progressive Multifocal Leukoencephalopathy (PML): No cases were observed in Entyvio clinical trials, but John Cunningham (JC) virus infection resulting in PML and death has occurred in patients treated with other integrin receptor antagonists and systemic immunosuppressive agents. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs/symptoms. Malignancy: Underlying increased risk of malignancy in UC and CD. Immunomodulatory products may increase risk. Prior and concurrent use of biological products: No clinical data available for Entyvio use in patients previously treated with natalizumab or rituximab. Patients previously exposed to natalizumab should wait at least 12 weeks prior to initiating Entyvio therapy. Entyvio not recommended for concomitant use with biologic immunosuppressants as no clinical data available. Live and oral vaccines: Patients may continue to receive non-live vaccines. Patients recommended to be up-to-date with all appropriate immunisations prior to initiating Entyvio. Live vaccines may be administered concurrently only if benefit clearly outweighs risk. **Interactions:** No interaction studies performed. Concomitant administration of corticosteroids, immunomodulators (azathioprine, 6-mercaptopurine, and methotrexate) and aminosalicylates did not have a clinically meaningful effect on Entyvio pharmacokinetics. **Fertility, pregnancy and lactation:** Women of child-bearing potential should use adequate contraception and continue for at least 18 weeks after last Entyvio treatment. Since maternal antibodies are excreted in breast milk, decision whether to discontinue breast-feeding or discontinue/abstain from Entyvio should be made according to relative benefit to child of breast-feeding or to mother of Entyvio. **Undesirable Effects:** Very Common (≥1/10): nasopharyngitis, headache, arthralgia. Common (≥1/100, <1/10): bronchitis, gastroenteritis, URTI, influenza, sinusitis, pharyngitis, paraesthesia, hypertension, oropharyngeal pain, nasal congestion, cough, anal abscess, anal fissure, nausea, dyspepsia, constipation, abdominal distension, flatulence, haemorrhoids, rash, pruritus, eczema, erythema, night sweats, acne, muscle spasm, back pain, muscular weakness, fatigue, pain in extremities, pyrexia. Other serious undesirable effects (≥1/1000 to <1/100): respiratory tract infection, infusion site reaction, infusion-related reaction. **Refer to the SmPC for details on full side effect profile and interactions. Basic NHS Price:** £2,050. **Legal Classification:** POM. **Marketing Authorisation:** EU/1/14/923/001 300mg powder for concentrate for solution for infusion. Takeda UK Ltd is responsible for sale and supply of Entyvio in the UK. Further information is available from Takeda UK Ltd. Building 3, Glory Park, Glory Park Avenue, Wooburn Green, Buckinghamshire, HP10 0DF. Tel: 01628 537900 Fax: 01628 526617. **PI Approval Code:** UK/EYV/1511/0240 **Date of revision:** November 2015.

Please refer to the summary of product characteristics for details on the full side-effect profile and drug interactions of Entyvio. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Takeda UK Ltd. Tel- 01628-537900

▽ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information.

References:

1. Entyvio Summary of Product Characteristics. www.medicines.org.uk March 2017.

ITEM CODE: UK/EYV/1704/0049 DATE OF PREPARATION: APRIL 2017

Takeda

Programme for the ISG Winter Meeting
23rd / 24th November 2017 Killashee Hotel

Thursday 23rd November

8.00 **Registration**

9.00 **Oral Free Papers (1-5)**

Session 1
Liver Hot Topics

10.00 ***Extracorporeal liver assist devices***
Prof. Ross MacNicholas
Consultant Hepatologist,
St. Vincent's University Hospital, Dublin

Hepatocellular carcinoma in Ireland: An update
Dr Diarmuid Houlihan
Consultant Hepatologist,
St. Vincent's University Hospital, Dublin

Novel therapies for Non-alcoholic fatty liver disease
Dr Matthew Armstrong MRCP PhD
Consultant in Hepatology and Transplant Medicine, Queen Elizabeth University Hospital, Birmingham.

11.15 **Tea/Coffee, Visit the Industry**

Session 2
Management of Barrett's Oesophagus

11.45 Endoscopic: **Dr Ken Wang**,
Mayo Clinic, Rochester, Minnesota.
Surgical: **Prof. John Reynolds**,
St. James's University Hospital, Dublin

13.00 **Lunch, Visit the Industry & Poster Presentation**

14.30 **Oral Free Papers (6-10)**

15.30 **Coffee/ice Cream Break**

Session 3
Non-anaesthetist administration of propofol in GI endoscopy

16.00 ***Safe and better for patients***
Dr Christian Maaser,
Lueneburg, Germany

16.30 ***Procedural sedation and analgesia (PSA) with or without an Anaesthetist - the ESA guidelines***
Dr Jan Steiner
Consultant Anaesthetist/Intensivist,
Galway Clinic

17.00 Panel Discussion

17.30 MSD Satellite Meeting

20.00 **ISG Conference Dinner**

Friday 24th November

8.00 AbbVie Satellite (Gastro)

9.15 Video Abstract Presentation
Presented by **Dr S. Sengupta & Dr Jan Layden**

Session 4

10.00 ***Bowel Screen Review***
Prof. Diarmuid O'Donoghue (Chair)
2 Oral Papers by:
Dr S M O'Reilly and Dr E Benz

10.40 ***Recent advances in Clostridium difficile infection***

Faecal transplantation
Dr John Keohane
Consultant Gastroenterologist,
Our Lady of Lourdes Hospital, Drogheda.

11.20 **Tea/Coffee and Visit the industry**

Session 5
Inflammatory Bowel Disease

11.45 ***A Programme for Gastroenterology; looking to the future***
Dr Colm Henry
National Clinical Advisor and
Group Lead Acute Hospitals Division, HSE.

12.20 ***The Liric study***
Prof. Wim Bemelman
Colorectal Surgeon
AMC Netherlands

13.00 **Lunch & Presentation of Prizes**

13.30 **IBD Cloud Based Solution**
presented by
Professor Glen Doherty
Consultant Gastroenterologist, SVUH
Mr Ken Curran Cancer Care, SVUH

SIMPONI delivers long-term disease control, maintaining efficacy over 4 years[1]

Aisle Seat-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 to or have medical contraindications for such therapies.[2]

6-MP = 6-mercaptopurine; AZA = azathioprine; UC = ulcerative colitis

Simponi® golimumab

SIMPONI 50 MG, 100 MG SOLUTION FOR INJECTION IN PRE-FILLED PEN
SIMPONI 50 MG SOLUTION FOR INJECTION IN PRE-FILLED SYRINGE (GOLIMUMAB)
ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing **PRESENTATION** Simponi 50 mg solution for injection in pre ftilled pen Simponi 50 mg solution for injection in pre filled syringe Simponi 100 mg solution for injection in pre filled pen **INDICATIONS** *Rheumatoid Arthritis (RA):* Simponi, in combination with methotrexate (MTX), is indicated for: the treatment of moderate to severe, active rheumatoid arthritis in adults when the response to disease-modifying anti-rheumatic drug (DMARD) therapy including MTX has been inadequate; the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with MTX. Simponi, in combination with MTX, has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function; *Psoriatic Arthritis (PsA):* Simponi, alone or in combination with MTX, is indicated for the treatment of active and progressive PsA in adults when the response to DMARD therapy has been inadequate. Simponi has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function. *Ankylosing Spondylitis (AS):* Simponi is indicated for the treatment of severe, active AS in adults who have responded inadequately to conventional therapy. *Non-radiographic axial spondyloarthritis (nr-Axial SpA):* Simponi is indicated for the treatment of severe, active nr-Axial SpA who have had an inadequate response to or are intolerant to NSAIDs. *Ulcerative colitis (UC):* Simponi is indicated for treatment of moderately to severely active UC in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6 mercaptopurine (6 MP) or azathioprine (AZA), or who are intolerant to or have medical contraindications for such therapies. *Polyarticular juvenile idiopathic arthritis (pJIA):* Simponi 50mg in combination with MTX is indicated for the treatment of polyarticular juvenile idiopathic arthritis in children with a body weight of at least 40 kg, who have responded inadequately to previous therapy with MTX. **DOSAGE AND ADMINISTRATION** Simponi should be injected subcutaneously. Treatment should be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of RA, PsA, AS, nr-Axial SpA, UC or pJIA. After proper training in subcutaneous injection technique, patients may self-inject, if their physician deems it appropriate. *RA:* Simponi 50 mg given once a month, on the same date each month, concomitantly with MTX. *PsA:* Simponi 50 mg given once a month, on the same date each month, alone or in combination with MTX. *AS and nr-Axial SpA:* Simponi 50 mg given once a month, on the same date each month. Clinical response is usually achieved within 12-14 weeks of treatment (3 or 4 doses). Continued therapy should be reconsidered in patients who show no evidence of therapeutic benefit within this time period. In patients weighing more than 100 kg who do not achieve an adequate clinical response after 3 or 4 doses, increasing the dose of golimumab to 100 mg once a month may be considered, taking into account the increased risk of certain serious adverse reactions with the 100 mg dose compared with the 50 mg dose. *UC: Patients weighing < 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks. *Patients weighing ≥ 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks. During maintenance treatment, corticosteroids may be tapered, following clinical practice guidelines. Clinical response is usually achieved within 12 14 weeks of treatment (after 4 doses). *pJIA:* Simponi 50 mg administered once a month, on the same date each month, for children with a body weight of at least 40 kg. Clinical response is usually achieved within 12 to 14 weeks of treatment (after 3 4 doses). *Missed dose:* If a patient forgets to inject Simponi on the planned date, the forgotten dose should be injected as soon as the patient remembers. The patient should be instructed not to inject a double dose. *Older patients (≥ 65 years):* no dose adjustment required. *Paediatric patients (<18 years):* For indications other than pJIA, Simponi is not recommended. *Patients with renal and hepatic impairment:* Simponi is not recommended. **CONTRAINDICATIONS** Patients with a hypersensitivity to golimumab or any of the excipients; Patients with active tuberculosis (TB) or other severe infection such as sepsis and opportunistic infections; patients with moderate or severe heart failure (NYHA class III/IV). **PRECAUTIONS AND WARNINGS** Infections: Patients must be monitored closely for infection before, during and for 5 months after cessation of treatment. Exercise caution when considering Simponi in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Simponi should not be given to patients with clinically important active infection. Patients should be advised of the potential risk factors. Bacterial infections (including sepsis and pneumonia), mycobacterial (including TB), invasive fungal and opportunistic infections, including fatalities, have been reported. The invasive fungal infection should be suspected if they develop a serious systemic illness. There was a greater incidence of serious infections, including opportunistic infections and TB, in patients receiving golimumab 100 mg compared with patients receiving golimumab 50 mg. Serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease, could predispose them to infection. There have been reports of active TB in patients receiving Simponi, including patients previously treated for latent TB. Patients should be evaluated for active or latent TB before Simponi treatment. All such tests should be recorded on the Patient Alert Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be monitored closely for signs and symptoms of active TB and advised to seek medical advice if signs and/or symptoms of TB appear. *Hepatitis B (HBV) reactivation:* Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi *Malignancies and lymphoproliferative disorders:* Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy, additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded. Rare cases, usually fatal, of hepatosplenic T-cell lymphoma (HSTCL) have been reported, the majority of cases occurred in adolescent and young males nearly all on concomitant treatment with azathioprine (AZA) or 6 mercaptopurine (6–MP). The potential risk with the combination of AZA or 6 MP and Simponi should be carefully considered. A risk for the development for HSTCL in patients treated with TNF-blockers cannot be excluded. Colon dysplasia/carcinoma - Screen for dysplasia in all patients with UC who are at increased risk or had a prior history for dysplasia or colon carcinoma. In newly diagnosed dysplasia patients the risks and benefits of continued Simponi use should be carefully assessed. Melanoma and Merkel cell carcinoma (all TNF-blocking agents including Simponi) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. *Heart Failure:* Simponi should be used with caution in patients with mild heart failure (NYHA class I/II). Patients should be closely monitored and Simponi must be discontinued in patients who develop new or worsening symptoms of heart failure. Some cases had a fatal outcome. *Neurological events:* Use of anti-TNF therapy, including Simponi, has been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and peripheral demyelinating disorders. Discontinuation of Simponi should be considered if these disorders develop. Carefully consider the benefits and risks before initiation of therapy in patients with a history of demyelinating disorders. *Surgery:* Patients requiring surgery whilst on Simponi therapy should be closely monitored for infections. *Autoimmune processes:* If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Simponi and is positive for antibodies against double-stranded DNA, treatment should be discontinued. *Haematological reactions:* There have been post-marketing reports of pancytopenia, leukopenia, neutropenia, aplastic anaemia, and thrombocytopaenia in patients receiving TNF-blockers. Cytopenias including pancytopaenia have been reported infrequently in clinical trials. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant haematologic abnormalities. *Vaccinations/therapeutic infectious agents:* It is recommended that live vaccines or any therapeutic infectious agents should not be given concurrently. *Allergic reactions:* If an anaphylactic reaction or other serious allergic reaction occurs, administration of Simponi should be discontinued immediately, and suitable treatment initiated. The needle cover of the pre-filled pen contains latex and may cause allergic reactions in those sensitive to latex. *Special populations: Older patients (≥ 65 years):* Adverse events, serious adverse events and serious infections in patients aged ≥65 were comparable to those observed in younger patients. However, caution should be exercised when treating the elderly, particular attention should be paid to infections. There were no patients age 45 and over in the nr-Axial SpA study. *Paediatric patients (<18 years):* Vaccinations: it is recommended that prior to initiating Simponi therapy, paediatric patients be brought up to date with all immunisations in agreement with current immunisation guidelines. *Excipients:* Simponi contains sorbitol (E420). Patients with rare hereditary problems of fructose intolerance should not take Simponi. **INTERACTIONS** Combination of Simponi and other biological therapeutics used to treat the same conditions as Simponi, including anakinra and abatacept is not recommended. **PREGNANCY AND LACTATION** Administration of Simponi is not recommended during pregnancy or breast-feeding. Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Simponi treatment. **SIDE EFFECTS Refer to SmPC for complete information on side effects** *Very Common (≥ 1/10):* upper respiratory tract infection; *Common (≥1/100):* bacterial infections, lower respiratory tract infections, viral infections, bronchitis, sinusitis, superficial fungal infections, abscess, anaemia, allergic reactions, autoantibody positive, depression, insomnia, dizziness, headache, paraesthesia, hypertension, asthma and related symptoms, dyspepsia, gastrointestinal and abdominal pain, nausea, gastrointestinal inflammatory disorders, stomatitis, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, rash, alopecia, dermatitis, pyrexia, asthenia, injection site reaction, chest discomfort, bone fractures were reported. Serious, including fatal adverse events have been reported including septic shock, lymphoma, leukaemia, melanoma, Merkel cell carcinoma, hepatosplenic T-cell lymphoma*, leukopenia, thrombocytopaenia, pancytopaenia, aplastic anaemia, serious systemic hypersensitivity reactions (including anaphylactic reaction), skin exfoliation, vasculitis (systemic), sarcoidosis, demyelinating disorders, congestive heart failure, arrhythmia, ischaemic coronary artery disease, thrombosis, interstitial lung disease and lupus-like syndrome. *Observed with other TNF-blocking agents. *Paediatric population: pJIA:* The safety of golimumab has been studied in a phase III study of 173 pJIA patients from 2 to 17 years of age. The average follow-up was approximately two years. In this study, the type and frequency of adverse events reported were generally similar to those seen in adult RA studies. **PACKAGE QUANTITIES** 1 x 50 mg pre-filled pen containing 50 mg of golimumab in 0.5 ml solution for injection 1 x 50 mg pre-filled syringe containing 50 mg of golimumab in 0.5 ml solution for injection 1 x 100 mg pre-filled pen containing 100 mg of golimumab in 1 ml solution for injection **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number** 50 mg Pre-filled Pen EU/1/09/546/001 50 mg Pre-filled Syringe EU/1/09/546/003 100 mg Pre-filled Pen EU/1/09/546/005 **Marketing Authorisation Holder** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands **Date of Revision of Text:** February 2017 *Simponi/PI-IRE/02-17*

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie. Adverse events should also be reported to MSD (Tel: 01-2998700)

References: 1. Reinisch W, Gibson P, Sandborn WJ, et al. Safety, efficacy, and pharmacokinetics of golimumab in patients with moderately to severely active ulcerative colitis: PURSUIT-SC long-term extension. Poster 307 presented at the 11th Congress of the European Crohn's and Colitis Organisation, March 16–19, 2016, Amsterdam, the Netherlands. **2.** Simponi SPC, available at www.medicines.ie.

Date of preparation: September 2017.

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

GAST-122848-0004

Irish Society of Endoscopy Nurses
Agenda

08.30 **Registration**

09:10 **Elaine Egan,** Chair
Mary Hackett Brennan
Chairperson ISEN
Welcome ISEN

09:20 **Deirdre Clune,** Chair
Ms Sharon Hough
RANP Gastroenterology
St. James Hospital
Inflammatory Bowel Disease

09.50 **Leah Palado Vinzons,** Chair
Dr Garret Cullen
Consultant Gastroenterologist
St Vincents University Hospital
ERCP

10:30 **COFFEE**

11:00 **Leah Palado Vinzons,** Chair
Ms Georgina Farren
Barrister-at-Law & Mediator
Nurse-Midwife
NMBI
Professional and Legal Aspect of Nursing

12:15 **Deirdre Clune,** Chair
Dr Subhasish Sengupta
Consultant Gastroenterology,
Our Lady of Lourdes Drogheda and Louth County Hospital, Dundalk
Polypectomies

13:15 **LUNCH**

14:15 **Mary Shea,** Chair
Mary Hackett Brennan
Chairperson ISEN & ISEN Committee
ISEN Discussion

14.30 **Margaret O'Donnell,** Chair
Mr John Mc Namee
Decontamination Lead
Galway University Hospital Associate Lecture IT Tallaght
Decontamination

15:30 **Margaret O'Donnell,** Chair
Ms Lyn Concepcion
Leah Palado Vinzons
St. Vincents University Hospital
Barcelona Feedback 2017

15:45 **Deirdre Clune,** Chair
Educational Updates
Educational Updates & Evaluation

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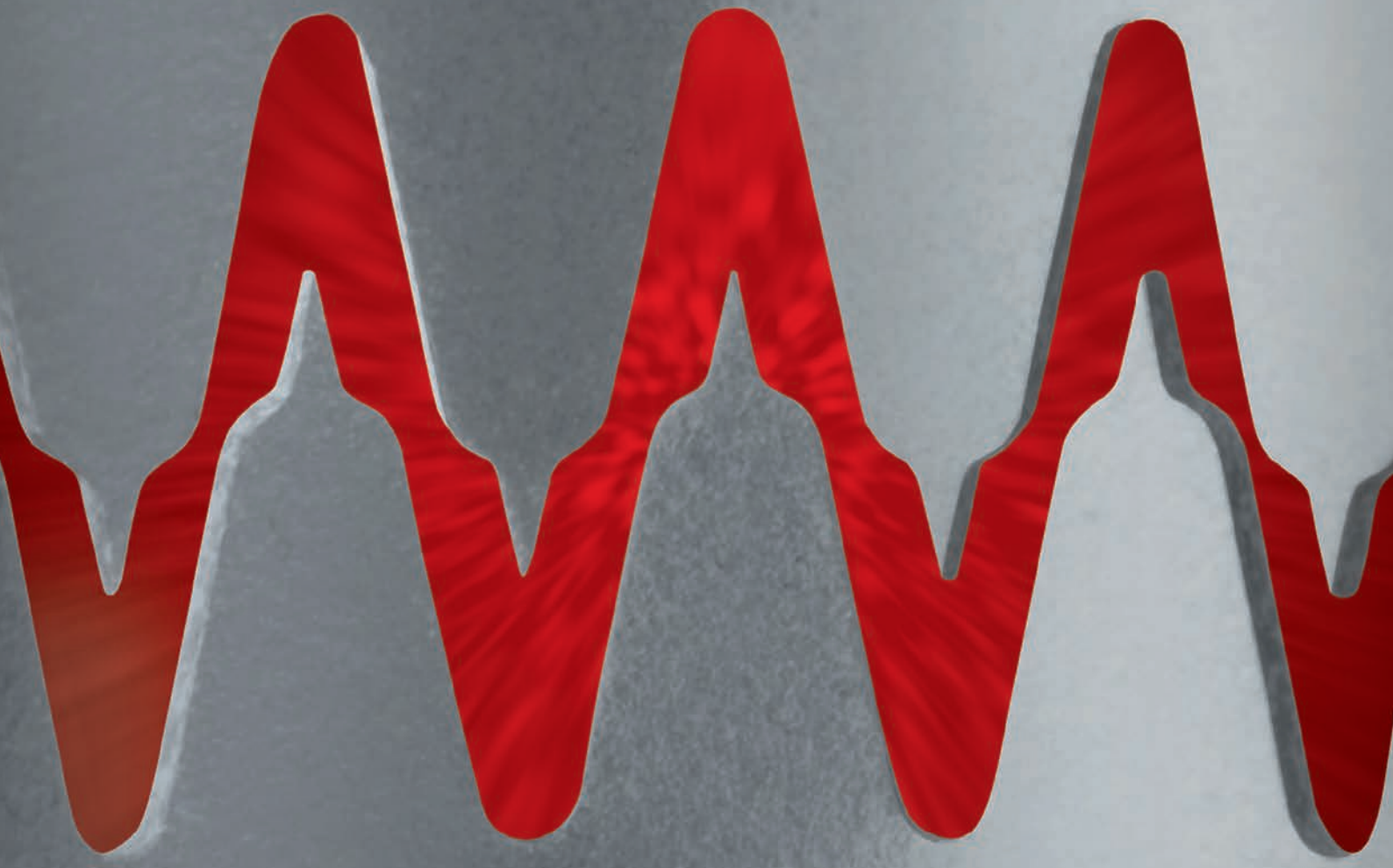

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OTSC® in first-line therapy significantly reduces re-bleeding risk and bleeding associated mortality in UGIB (FLETRock evaluation[1]).

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1 Wedi E. et al. (2017), **Multicenter evaluation of first-line endoscopic treatment with the OTSC in acute non-variceal upper gastrointestinal bleeding and comparison with the Rockall cohort: the FLETRock study.** Surgical Endoscopy, doi:10.1007/s00464-017-5678-7.

2 Schmidt A. et al. (2017), **STING trial – Randomized controlled trial shows breakthrough in treatment of recurrent bleeding.** 47th DGE-BV Congress, Berlin, Germany, April 6-8, 2017.

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Biographical Sketches

Prof. Ross MacNicholas
Consultant Hepatologist,
St. Vincent's University Hospital, Dublin

Professor MacNicholas worked as an intern, medical house officer and specialist registrar in Tallaght, St James's, Mater Misericordiae and St Vincent's University Hospitals. In 2011 Dr MacNicholas was awarded a certificate of specialist training in Gastroenterology & General Internal Medicine. On completion of his training he was appointed as a locum consultant gastroenterologist in St Vincent's.

In 2012 he commenced a one year fellowship in Advanced Hepatology and Liver Transplant in the Queen Elizabeth Hospital Birmingham (one of the largest liver transplant and general hepatology units in Europe).

In 2013 Prof. MacNicholas moved to Western Australia and was appointed as a Consultant Gastroenterologist (special interest liver disease) in the state liver transplant unit at Sir Charles Gairdner Hospital, Perth. He also worked as a Senior Lecturer in University of Western Australia and has a particular interest in teaching. He was awarded a Masters in Medical Education by Queens University Belfast in 2010.

In 2015 Prof. MacNicholas returned as a full time Consultant Gastroenterologist (special interest liver disease) to St Vincent's University Hospital.

In 2016 Prof. MacNicholas was an Associate Professor in the UCD school of medicine. He is a member of the Irish Society of Gastroenterologist, the European Association for the study of the liver. He is a fellow of the Royal College of Physicians Ireland and the European Board of Gastroenterologist and Hepatology.

Dr Matthew Armstrong
Consultant in Hepatology and Transplant Medicine, Queen Elizabeth University Hospital, Birmingham.

Dr Matthew Armstrong is a Wellcome Trust Clinical Research Fellow (commenced Oct 2009). He qualified from Leeds Medical School in 2004 with honours, during which he obtained a 1st Class BSc in clinical sciences with research in small bowel surgery. His post-graduate training was undertaken in hospitals throughout the Yorkshire region, until he started his PhD at Birmingham University in 2009.
His keen interests lie in non-alcoholic fatty liver disease (NAFLD). His translation research involves a multicentre trial looking into the efficacy and mechanisms of a new group of diabetes drugs in NAFLD patients. He is a keen teacher.

Dr Ken Wang
Mayo Clinic, Rochester, Minnesota.

Kenneth K. Wang, MD is the Russ and Kathy Van Cleve Professor of Gastroenterology Research and the director of Advanced Endoscopy at the Mayo Clinic in Rochester Minnesota. He performed his undergraduate studies at the University of Michigan in Ann Arbor, Michigan and received his medical degree from Wayne State University in Detroit, Michigan. He had his subsequent training in Internal Medicine and Gastroenterology at the Mayo Clinic where he remained on staff. His interests are in the detection, staging, and therapy of esophageal neoplasia. His research in this area has been continuously supported by the National Institutes of Health for the past 23 years during which time he has published 255 original articles. He is the past president of the American Society of Gastrointestinal Endoscopy and the International Society for Diseases of the Esophagus.

Prof. John Reynolds
St. James's University Hospital, Dublin

Professor Reynolds is Professor of Clinical Surgery at the St. James's Hospital and Trinity College Dublin. He is the National Lead for oesophageal and gastric cancer. He is Cancer Lead at St. James's Hospital and the Trinity School of Medicine, and a Principal Investigator in the Trinity Translational Medicine Institute. He has formerly held Fellowship positions with the University of Pennsylvania and Wistar Institute in Philadelphia and at the Memorial Sloan-Kettering Cancer Centre in New York. He was a Senior Lecturer at St. James's University Hospital in Leeds (1994-6).

Professor Reynolds has obtained numerous research awards and has published widely in cancer research, with over 250 publications and approximately €5m research grant

income. His clinical interest is in diseases of the oesophagus and stomach. His research interest is in four areas: (1) pathogenesis of Barrett's oesophagus and progression; (2) prediction of response and resistance to chemotherapy and radiation therapy; (3) obesity, altered metabolism, and cancer; (4) malnutrition and peri-operative nutrition.

Dr Jan Steiner
Consultant Anaesthetist/Intensivist,
Galway Clinic

Dr Jan Steiner is Consultant Anaesthetist/ Medical Director Intensive Care, Galway Clinic, Galway. Jan did his medical internship in Sligo General Hospital and has worked as a SHO in both Germany and Sligo General Hospital. From 2009-2011 he was SpR in University Hospital Limerick, St James's Hospital, Dublin and Our Lady's Children's Hospital, Crumlin, Dublin. From 2011-2012 Locum work in several Irish hospitals including Blackrock Clinic, Letterkenny General Hospital and Mid Western Regional Hospital. From 2012-2013 was Anaesthetic Specialist Registrar, Ernst von Bergmann Klinikum (EvB) Potsdam, Germany; and 2013-2015 Specialist in Anaesthesiology Ernst von Bergmann Klinikum (EvB) Potsdam, Germany.

Dr Fidelma Fitzpatrick
Consultant Microbiologist, RCSI Dublin

Year of Graduation: 1993 (MB BAO BCh, BA (Mod), DME, FRCPI, FRCPath, MD)
Medical School: University of Dublin, Trinity College
Fellowship Higher specialist training:
FRCPath, Royal College of Pathologists, London, UK.
Certificate of Completion of Specialist Training, Microbiology, Irish College of Higher Medical Training, MD, University College Dublin and Royal College of Surgeons in Ireland, FRCPI, Royal College of Physicians of Ireland, Scottish Patient Safety Fellowship, Healthcare Improvement Scotland, Diploma in Medical Education, Royal College of Surgeons in Ireland
Areas of Clinical Practice:
Clinical Microbiology, Epidemiology of healthcare-associated infection and antimicrobial resistance, Antimicrobial stewardship, Infection Prevention and Control, Medical Education. Quality Improvement.
Areas of Special Expertise:
Epidemiology, prevention and control of healthcare-associated infection and antimicrobial resistance, C. difficile infection, Antimicrobial stewardship, Sepsis, Patient safety and quality improvement, Medical education, Public engagement - healthcare-associated infection and antimicrobial resistance

Dr John Keohane
Consultant Gastroenterologist,
Our Lady of Lourdes Hospital, Drogheda.

Dr Keohane completed his undergraduate training in University College Cork and basic specialist training in Cork teaching hospitals. This was followed by Higher Specialist training in hospitals throughout Ireland when he completed his MD thesis on 'Biomarkers in IBD' in UCC. He completed an advanced endoscopy fellowship in Memorial Sloan Kettering Cancer Center, New York. He returned to take up his current post as Consultant Gastroenterologist in Our Lady of Lourdes hospital in 2011 where he is the lead clinician in the Department of Medicine.

Dr Colm Henry
National Clinical Advisor and
Group Lead Acute Hospitals Division, HSE.

Dr Colm Henry is National Clinical Advisor and Group Lead for Acute Hospitals in the HSE. Prior to taking up this post, he was National Lead for the Clinical Director Programme from 2012 to 2014. He was Clinical Director of the Mercy University Hospital in Cork from 2009 to 2012. He was appointed as Consultant Geriatrician to the same hospital in 2002.

Prof. Wim Bemelman
Colorectal Surgeon
AMC Netherlands

Willem A. Bemelman graduated as a surgeon in 1994 trained at the department of Surgery of the Academic Medical Hospital, University of Amsterdam and St. Lucas Hospital in Amsterdam. After his training as a surgeon, he worked at the department of Surgery at Leiden University Medical Center being responsible for the benign gastrointestinal disease from 1995 - 1998. In 1999 he returned to the Academic Medical Center to develop and implement the Minimal Invasive Surgery. In 2006 he was appointed as a Professor in Surgery. His field of interest in patient care and research is the (minimal invasive) treatment of IBD, colorectal cancer and complication surgery.
Bemelman is a EBSQ certified colorectal surgeon (Bologna 2005).

ISG Board Members

Professor Larry 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.

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

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

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

Glen grew up in Northern Ireland and graduated in Medicine at Trinity College Dublin in 1998. He was awarded his PhD by
NUI in 2006 and completed his gastroenterology training in Ireland followed by an advanced IBD fellowship at Beth Israel Deaconess Medical Center and Harvard Medical School, Boston. Since 2010 he has worked as a consultant gastroenterologist at St Vincent's University Hospital in Dublin and as a senior clinical lecturer in the School of Medicine and Medical Science at University College Dublin. His research interests are in the role of innate and adaptive immunity in inflammatory bowel disease (Ulcerative Colitis and Crohns Disease) and in the importance of the host immune response in gastro-intestinal neoplasia, particularly colorectal cancer and Barrett's oesophagus. With his colleagues at the Centre for Colorectal Disease at SVUH/UCD he has an established track record in clinical research on a range of digestive disorders and is actively involved in clinical trials in IBD.

Dr Tony C.K. Tham
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 has been Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast since 1997. During this time, he has developed gastroenterology services in the Ulster Hospital, especially in therapeutic endoscopy and ERCP. His other interests include inflammatory bowel disease (IBD). He has more than 70 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" and the third edition has just been published. He is the Guidelines Editor for Gut and on the international editorial board of Gastrointestinal Endoscopy.
He has contributed to several other book chapters. He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency and is currently Training Program Director in general internal medicine. He sits on the Specialist Advisory Committee for general internal medicine at the Joint Royal College of Physicians Training Board. He is the secretary of British Society of Gastroenterology (BSG) clinical services and standards committee. He is the guidelines lead for the BSG. He is an examiner for the Royal College of Physicians and also Queen's University. He has assisted in obtaining funding for IBD nurses and biological therapy in N. Ireland.

Mr Jürgen Mulsow
Consultant General and Colorectal Surgery
Mater Hospital, Dublin

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

Dr David Gibson
Specialist Registrar
St James' Hospital, Dublin

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

Professor Padraic MacMathuna,
Consultant Gastroenterologist
Mater Hospital, Dublin

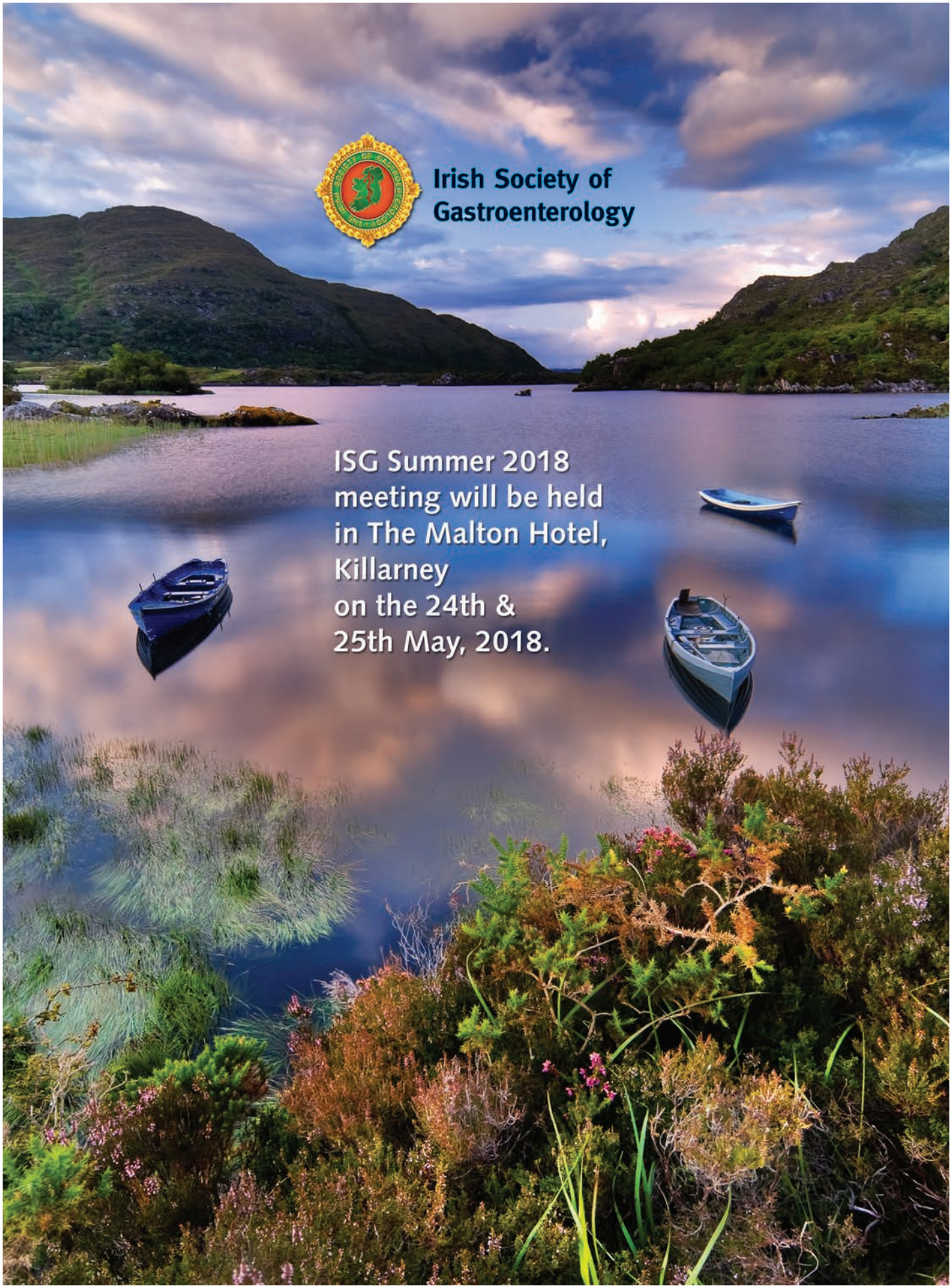
1981 UCD graduate with training in Ireland, London and Boston in Gastroenterology. Appointed Consultant Gastroenterologist to Mater University Hospital in 1995. Track record in clinical and laboratory research in areas from Colon Cancer biology, CT Colon Imaging, High Risk colorectal Cancer screening 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 Herediary Cancer Risk.

Dr Susanne O'Reilly
Gastreoenterology 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.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Consultant Gastroenterologist

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Consultant Gastroenterologist

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

Oral Presentations - ISG Winter Meeting 2017
Thursday 23rd November

Morning Session

No.	Abstract No.	Name	Title of Paper	Time
1	17W105	T. Nuzum	A smart approach to the diagnosis of minimal Hepatic Encephalopathy	09.00
2	17W175	D. Almuaili	Liver Metastic Tissue excludes Anti-Tumour Lymphoid populations despite secreting high levels of the Lymphoid Chemokines, CXCL9 and CXCL10	09.12
3	17W115	D Houlihan	Real World Evidence of the Effectivenes of ABT-450/r - Ombitasvir, ± Ribavirin in Patients with Chronic Hepatitis C - An observational study in Ireland	09.24
4	17W118	Paul Armstrong	Fibroscan Score Predicts Liver Outcome at Five Years	09.36
5	17W212	SM O'Reilly	Characteristics and Attitudes of first round invitees to BowelScreen, the national colorectal cancer screening programme	09.48

Afternoon Session

	Abstract No.	Name	Title of Paper	Time
6	17W194	N Mc Gettigan,	Monitoring IBD Activity in a Virtual Biologic Clinic: Correlation Between Patient Reported Outcomes And Biomarkers	14.30
7	17W174	YY Hong	Helicobacter Pylori Resistance Pattern over Last 14 Years In A University Teaching Hospital	14.42
8	17W203	Louise Elliott	Tumour infiltrating Monocytes Correlate with CD8 + T cells in a Subset of Colorectal Cancer (CRC) Tumours with High CCL3 and CCL5 expression and Intact aerobic respiration	14.54
9	17W195	M. Walshe	Alterations in Mucosal Associated Invariant T cells and CD5+ B cells are associated with IBD and Response to Anti-TNF	15.06
10	17W137	G. Harkin	"Prevention Is Better Than Cure": Uptake of Preventive Healthcare in Patients on Biologic therapy for Inflammatory Bowel Disease attending Galway University Hospitals.	15.18

ABSTRACT NO. 1 (17W105) ORAL PRESENTATION

A Smart Approach To The Diagnosis of Minimal Hepatic Encephalopathy

Author(s)
T. Nuzum[1], M. Hussey [1,2], T. Khanna[3], E. MacGregor[3], J. Olaniyi[3], C. Tersaruolo[2], N. Breslin[1], D. McNamara[1-3]

Department(s)/Institutions
[1] Department of Gastroenterology, The Adelaide and Meath Hospital, Dublin; [2] Trinity Academic Gastroenterology Group, Dublin; [3] Trinity College Dublin, Dublin.

Introduction
Minimal Hepatic Encephalopathy (MHE), associated with a poor prognosis, can occur in 30% of chronic liver disease (CLD) patients. MHE detection using standard neuropsychological tests (PHES) is laborious. A smartphone application (Stroop) has been suggested as a viable alternative.

Aims/Background
To compare Stroop with PHES for MHE detection in an Irish population.

Method
Known CLD patients and healthy controls were prospectively recruited. Baseline demographics, level of education and Child-Pugh score were recorded. Each patient performed both PHES and Stroop Tests. A PHES of -4 was considered positive and Stroop on+off times were recorded.

Results
96 patients (51M) were recruited, 35 CLD, age 51.7 ± 16.6 years. Child-Pugh; 30 (86%) A, 4 (11%) B and 1 (3%) C. MHE occurred in 7(7%) subjects. More CLD patients had a positive PHES, 4/35 (11%) vs. 3/61 (5%), Odds Ratio 2.49, 95% CI 0.52-11.86.
Overall Stroop times were similar, 198.4s CLD v 187.9s controls, but were significantly longer in CLD with MHE 260s vs. 190s, p=0.02. Stroop ROC gave a sensitivity and specificity of 100% and 59% for >187s cut-off. 39 (41%) patients had a Stroop >187s, 18 (51%) with CLD resulting in an overall fair correlation between the 2 tests, κ=0.240.
PHES took longer to complete 20 vs. 5 minutes and older age and limited years of education correlated with poorer Stroop tests($r=0.62$, $p<0.0001$ and $r=-0.322$, $p<0.0001$, respectively).

Conclusions
MHE occurred in 11.5% of CLD patients. Overall, test correlation was fair. Stroop is easier and quicker to perform and may be a convenient filter test for MHE.

ABSTRACT NO. 2 (17W175) ORAL PRESENTATION

Liver Metastatic Tissue Excludes Anti-tumour Lymphoid Populations Despite Secreting High Levels Of the Lymphoid Chemokines, CXCL9 and CXCL10

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Introduction
A significant proportion of colorectal cancer patients develop liver metastases (CRLM) despite its substantially potent anti-tumour properties. The healthy liver is maintained by immune populations that are recruited, regulated and controlled by local chemokines and cytokines including CXCL9 and CXCL10, important chemokines for lymphocyte populations.

Aims/Background
We propose that a dysregulation of the liver cytokine microenvironment compromises its defense and increases its metastatic susceptibility and aim to investigate changes in immune populations and levels of CXCL9 and CXCL10 in the livers of CRLM patients.

Method
Tumour and tumour adjacent liver biopsies were collected from patients undergoing resection for CRLM [N=18] and from donor livers [N=9]. Portions were paraffin embedded for immunohistochemistry and stained for CD45 (immune cells marker), and CD3 (lymphocyte marker), homogenised for total protein extraction, or incubated with ex vivo media for 72hrs for supernatants to run protein arrays.

Results
CXCL9 and CXCL10 were expressed in healthy liver and significantly raised in tumour and tumour adjacent tissue from patients with CRLM. Immunohistochemistry demonstrated T cell populations throughout liver parenchyma with aggregations around portal tracts in healthy liver. Wide spectrum of T cells was found in metastatic liver tissue. Immune populations aggregated around the edges of tumours, and were excluded from the tumour tissue.

Conclusions
We demonstrate lymphocytes exclusion from tumour tissue in CRLM patients despite high levels of the T cell attractants CXCL9 and CXCL10. Lymphoid infiltration has been linked to prognosis. Identification of the specific factor or microenvironmental signature responsible for this exclusion could provide a novel target for immune therapy.

ABSTRACT NO. 3 (17W115) ORAL PRESENTATION

Real World Evidence of the Effectiveness of ABT-450/r – Ombitasvir, ± Dasabuvir, ± Ribavirin in Patients with Chronic Hepatitis C - An Observational Study in Ireland

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Department(s)/Institutions
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Introduction
The combination of ombitasvir/paritaprevir /ritonavir + dasabuvir (3D) ± ribavirin (RBV) for the treatment of chronic HCV has demonstrated efficacy and a favourable safety profile in clinical trials.

Aims/Background
This observational cohort study aimed to evaluate the safety and efficacy of 3D± (RBV) in clinical practice in Ireland

Method
The setting was 5 Irish academic centres. Patients with genotype (GT1) HCV infection who were treatment naïve or interferon experienced with or without compensated cirrhosis received 3D± RBV as per approved label. We assessed sustained virologic response at 12 weeks post treatment (SVR12; HCV RNA ≤50 IU/mL) and adverse events (AEs) in pts who initiated treatment before 01 January 2017

Results
101 patients enrolled. Interim results on 67 patients are reported. 67 patients (76% female) mean (SD) age 58 (± 12) years were treated with 3D±RBV for 12 weeks. 84% of patients were GT1b, 16% were GT1a. 13% (9/67) had cirrhosis and 18% (12/67) were treatment experienced. 21% of patients received RBV. An SVR 12 rate of 100% (67/67) was achieved. Adherence reported to be >95% in 98.5% (66/67) patients. The most common AEs were fatigue 35%, headache 22%, and nausea 22%. 1 patient had an SAE, macular degeneration. No patients discontinued treatment prematurely. 2 patients had a RBV dose modification due to anaemia. 1 patient had a Grade 3 lab abnormality (ALT)

Conclusions
Real-world evidence confirms the effectiveness and safety profile of 3D± RBV in HCV GT1 infected patients in Ireland, irrespective of cirrhosis status, treatment experience or RBV use

ABSTRACT NO. 4 (17W118) ORAL PRESENTATION

Fibroscan Score Predicts Liver Outcome At Five Years

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Introduction
Fibroscan (FS) is a non invasive tool to assess liver stiffness (LSM measured in kPa) which correlates with hepatic fibrosis. The clinically relevant cut-offs are >12kPa, which implies a 90% risk of advanced fibrosis and >25kPa, which has a 90% positive predictive value for clinically significant portal hypertension.

Aims/Background
We performed a retrospective study across liver disease aetiologies to assess whether baseline Fibroscan score associated with liver decompensation and liver related mortality.

Method
We reviewed all Fibroscans performed in the Liver Centre of the Mater Hospital in 2012 and selected all patients with a score of >35kPa. We then randomly selected similar numbers of patients with FS scores of <21kPa and 21-35kPa to achieve a total number of 100. Finally we determined liver outcomes at five years post Fibroscan.

Results
Patients with a baseline LSM >35kPa had a five year decompensation rate of 43% (8.6%/year) and liver related mortality of 20%. This compared to 19% (3.8%/year) and 12% in those with a baseline score of 21-35kPa and 6% (1.2%/year) and 0% in those with a baseline score of <21kPa. Aetiology did not impact on outcome.

Conclusions
This retrospective study corroborates our prospective study showing that LSM can be used to determine risk of decompensation and liver mortality in liver disease regardless of aetiology. This finding can be used to prognosticate, ration therapies, and select patients for experimental therapeutic studies.

ABSTRACT NO. 5 (17W212) ORAL PRESENTATION

Characteristics and Attitudes of first round invitees to BowelScreen, the national colorectal cancer screening programme

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Introduction
BowelScreen invited 488,000 people aged 60-69 in the first round, with uptake of 40.2%. We sought to assess patient knowledge of the programme and to examine attitudes and beliefs regarding colorectal cancer (CRC) and screening.

Method
A questionnaire based on previous National Screening Service questionnaires and Champion's Health Belief Model was mailed to 3,500 invitees from the first round; SPSS was used for analysis.

Results
The response rate was 37.7% (n=1463 -349 invalid). 46% (517/1000) were FIT positive, 48% (535/1000) FIT negative and 6% (62/1500) were BowelScreen non-responders. 581 (52%) respondents were male. 25% were university educated and 54% secondary educated. 76% of respondents were aware of BowelScreen and 94% found the instructions easy to understand. 21% found the BowelScreen process stressful (36% of FIT positives and 8% of FIT negatives p<0.001). Females expressed more stress than males, regardless of FIT status).

The only licensed treatment for the reduction in recurrence of overt hepatic encephalopathy (OHE)[1]

At home they are still at risk;

...TARGAXAN® rifaximin-α reduces the risk of recurrence of overt hepatic encephalopathy.[1]

Targaxan® 550
Rifaximin-α

Long-term secondary prophylaxis in hepatic encephalopathy (HE)[2]

TARGAXAN® 550 mg film-coated tablets (rifaximin-α). REFER TO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING
Presentation: Film-coated tablet containing rifaximin 550 mg. **Uses:** Targaxan is indicated for the reduction in recurrence of episodes of overt hepatic encephalopathy in patients ≥ 18 years of age. **Dosage and administration:** Adults 18 years of age and over: 550 mg twice daily, with a glass of water, with or without food for up to 6 months. Treatment beyond 6 months should be based on risk benefit balance including those associated with the progression of the patients hepatic dysfunction. No dosage changes are necessary in the elderly or those with hepatic insufficiency. Use with caution in patients with renal impairment. **Contraindications:** Contraindicated in hypersensitivity to rifaximin, rifamycin-derivatives or to any of the excipients and in cases of intestinal obstruction. **Warnings and precautions for use:** The potential association of rifaximin treatment with *Clostridium difficile* associated diarrhoea and pseudomembranous colitis cannot be ruled out. The administration of rifaximin with other rifamycins is not recommended. Rifaximin may cause a reddish discolouration of the urine. Use with caution in patients with severe (Child-Pugh C) hepatic impairment and in patients with MELD (Model for End-Stage Liver Disease) score > 25. In hepatic impaired patients, rifaximin may decrease the exposure of concomitantly administered CYP3A4 substrates (e.g. warfarin, antiepileptics, antiarrhythmics, oral contraceptives). Both decreases and increases in international normalized ratio (in some cases with bleeding events) have been reported in patients maintained on warfarin and prescribed rifaximin. If co-administration is necessary, the international normalized ratio should be carefully monitored with the addition or withdrawal of treatment with rifaximin. Adjustments in the dose of oral anticoagulants may be necessary to maintain the desired level of anticoagulation. Ciclosporin may increase the rifaximin C_{max}. **Pregnancy and lactation:** Rifaximin is not recommended during pregnancy. The benefits of rifaximin treatment should be assessed against the need to continue breastfeeding. **Side effects:** Common effects reported in clinical trials are dizziness, headache, depression, dyspnoea, upper abdominal pain, abdominal distension, diarrhoea, nausea, vomiting, ascites, rashes, pruritus, muscle spasms, arthralgia and peripheral oedema. Other effects that have been reported include: Clostridial infections, urinary tract infections, candidiasis, pneumonia cellulitis, upper respiratory tract infection and rhinitis. Blood disorders (e.g. anaemia, thrombocytopenia). Anaphylactic reactions, angioedemas, hypersensitivity. Anorexia, hyperkalaemia and dehydration. Confusion, sleep disorders, balance disorders, convulsions, hypoesthesia, memory impairment and attention disorders. Hypotension, hypertension and fainting. Hot flushes. Breathing difficulty, pleural effusion, COPD. Gastrointestinal disorders and skin reactions. Liver function test abnormalities. Dysuria, pollakiuria and proteinuria. Oedema. Pyrexia. INR abnormalities. **Legal category:** UK - POM, Ireland-Prescription only. **Cost:** UK - Basic NHS price £259.23 for 56 tablets. Ireland - €262.41 for 56 tablets **Marketing Authorisation number:** UK - PL 20011/0020. Ireland - PA 102/29/1 **For further information contact:** Norgine Pharmaceuticals Limited, Norgine House, Moorhall Road, Harefield, Middlesex, United Kingdom UB9 6NS Telephone: +44(0)1895 826606 E-mail: medinfo@norgine.com
Ref: UK/XIF5/0116/0173(2) **Date of preparation:** August 2017

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

Ireland – Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL – Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Adverse events should also be reported to Medical Information at Norgine Pharmaceuticals on +44 1895 826606.

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UK/XIF5/0917/0350
Date of preparation: September 2017.

NORGINE

Women were more likely to find colonoscopy painful than men (11.9% vs 4.5%, p=0.002).
17% reported alteration in bowel habit in the year preceding screening. FIT positive clients were more likely to have altered bowel habit (25% vs 11%, p<0.001).
BowelScreen participants report a high rate of satisfaction with the programme (97%). Non-participants remain a difficult group to assess with less than 6% responding to this questionnaire: 92% reported faith in CRC screening, but the majority felt they had low risk of CRC.

Conclusions
Direct FIT provision and an advertising campaign have commenced to address participation. Focus groups are planned to provide more targeted information to improve participation.

	Male	Female	p
n (%)	581	533	
FIT positive	307	210	<0.001
FIT negative	244	290	<0.0001
Non-Responders	30	32	NS
Aware of BowelScreen	434 (75%)	441 (83%)	<0.001
Stressful	106 (18.3%)	126 (24%)	0.012
Altered Bowel Habit (ABH)	104 (18.8%)	89 (17.7%)	NS
Attended GP with ABH	48 (8.8%)	38 (7.6%)	NS
Family History	69 (12.6%)	91 (18.3%)	0.002
Personal Risk Belief	172 (32%)	131 (27.1%)	0.05
Effect on Personal Life	107 (20%)	76 (16.2%)	0.068
Interest in Health	516 (94.8%)	467 (93.5%)	NS
Embarrassed by Screening	66 (12.1%)	82 (16.7%)	0.021
Faith in Screening	547 (97.5%)	498 (.97.1%)	NS

ABSTRACT NO. 6 (17W194) ORAL PRESENTATION

Monitoring IBD Activity In A Virtual Biologic Clinic: Correlation Between Patient Reported Outcomes And Biomarkers

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Introduction
Virtual Biologic clinics (VBC) have recently been demonstrated as a cost-effective, low maintenance option for delivering personalised care to inflammatory bowel disease (IBD) patients. However, controversies exist about the clinical effectiveness of this approach.

Aims/Background
The aim of this study is to identify if our VBC leads to an improvement in IBD outcomes.

Method
A retrospective study was performed of our IBD patients receiving Inflectra. Data was collected at 0 and 6 months after initiation of the VBC.

Results
A total of 63 patients were included. The median IBD-Control at baseline was 80/100 vs 90/100 at 6 months follow-up (n=43). The median score at 6 months increased from 59.5/100 to 92.5/100 in the 37% who improved. IBDQ scores improved in 45.5.% (n=20), 18% (n=8) patients reported no change. The median score was 13/16 at initiation and 14/16 at 6 months. For the 45.5% who improved- the median score at 6 months was 15/16 compared to 7.5/16 at baseline. HBI and partial Mayo scores improved in 30% (n=13) with 11 patients achieving remission.16% (n=7) of patients deteriorated. The remainder remained in remission. Improvement in faecal calprotectin was observed in 62% (n=18/29), 10% (n=3) no change and 28% (n=8) of patients had an increase. Trends in the CRP vs faecal calprotectin demonstated a negative correlation (r2=-0.06). Absolute changes in CRP were less significant than faecal calprotectin levels measured over time.

Conclusions
Initiation of a VBC (and by extension personalisation of biologic) led to subjective improvements in patient symptomatology, and also importantly improvements in objective markers of disease activity.

ABSTRACT NO. 7 (17W174) ORAL PRESENTATION

Helicobacter Pylori Resistance Pattern Over Last 14 Years In A University Teaching Hospital

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Introduction
Helicobacter Pylori (H.Pylori) infection is a recognized cause for chronic gastritis, peptic ulcer disease, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue lymphoma. There has been an increase in the prevalence of antibiotic-resistant bacteria. The Irish Helicobacter Pylori Working Group Consensus has stated that standard triple therapy for 7 days' duration can no longer be recommended.

Aims/Background
To investigate H.Pylori resistance patterns in patients having gastroscopy with culture & sensitivity(C&S) at St. James's Hospital, over last 14 years.

Method
This is a retrospective study, evaluating H.Pylori C&S sent over the last 14 years. Resistance patterns were analysed for the positive C&S.

Results
Out of a total of 1228 C&S sent for H.pylori, 643 (52.36%) were positive while, 585 (47.64%) were negative for the bacteria. Within positive C&S, 402(62.52%) were female, with the mean age of 42.69 years. The sensitivity testing for amoxicillin and metronidazole were discontinued after 2010. Resistance rate for clarithromycin and metronidazole were 78.08% and 66.37% respectively. Comparing the period from 2004-2009 to 2010-2017, the resistance rate for clarithromycin was rising from 69.27% to 81.51%. Resistance rate for amoxicillin, tetracycline, and rifampicin were 3.44%, 0.31%

and 1.09% respectively. 35.87% were resistant while 3.26% were intermediate sensitivity to levofloxacin.

Conclusions
In the cohort of patients with previous H Pylori eradication failure, resistance to Clarithromycin and Metronidazole is common, with increasing resistance rate to clarithromycin over the years. Resistance pattern to levofloxacin is also on the rise. This further validates the use of H Pylori C&S to guide the antibiotic regimen in this cohort.

ABSTRACT NO. 8 (17W203) ORAL PRESENTATION

Tumour Infiltrating Monocytes Correlate with CD8+ T cells in a Subset of Colorectal Cancer (CRC) Tumours with High CCL3 and CCL5 expression and Intact aerobic respiration

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Introduction
The inflammatory state of the tumour microenvironment (TME) is now recognised as an active participant in governing all aspects of the neoplastic lesion.

Aims/Background
Here, we characterise the innate cellular mechanisms and inflammatory mediators at play in the CRC TME.

Method
Fresh tumour and uninvolved tissue were obtained from CRC patients undergoing surgical resection. We analysed the composition of tumour infiltrating myeloid cells (n=20) employing flow cytometry. Next, we compared the cytokine profile in a second cohort (n=49) and assessed the immune composition and metabolic profile by immunohistochemistry. Finally, we investigated the mechanism by which of tumour released soluble factors influence monocyte function.

Results
We show a significant increase in infiltrating CD11b+ cells unique to the tumour tissue highly enriched for granulocytes and dendritic/monocyte cells. Characterised by their CD14 expression, monocytes expressed inhibitory (ILT4 & PDL1), pro-angiogenic (TIE-2) and activation markers (CD40). In vitro studies showed that the TME promoted the stabilisation of HIF-1α gene expression and the induction of IL-1β in monocytes. This induction was associated with an accompanying increase in glycolytic enzymes (PKM2 & GAPDH) and mTOR activation.

Conclusions
We have identified a monocyte cell that correlates with the presence of CD8+ T cells in a subset of CRC tumours with a distinct chemokine signature and metabolic profile

ABSTRACT NO. 9 (17W195) ORAL PRESENTATION

Alterations in Mucosal Associated Invariant T cells and CD5+ B cells are Associated with IBD and Response to Anti-TNF

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Introduction
Our group previously reported reduced circulating regulatory T cells in IBD, and subsequent recovery with successful anti-TNF treatment. However, the role of additional immune cells important for mucosal homeostasis and self-tolerance have not been investigated in relation to anti-TNF treatment response.

Aims/Background
To explore the role of CD5+ regulatory B cells and mucosal associated invariant T (MAIT) cells in IBD patients commencing treatment with anti-TNF.

Method
IBD patients commencing infliximab or adalimumab were recruited. Blood samples were obtained from patients and matched healthy controls at week 0, 2, and 14 (approx.) of treatment. Patients were deemed responders or non-responders at week 14 based on necessity to escalate treatment. Flow cytometry was used to define and analyse B cell and T cell populations. PRISM software was used for statistical analysis.

Results
Thus far, 13 patients have been recruited. At week 14(approx.), 7 were responders, and 5 required treatment escalation (non-responders). (1 patient is awaiting assessment.) At baseline, we found a significant decrease in MAIT ($p=0.02$) and CD5+ B cells ($p=0.04$) in IBD patients compared to healthy controls. At baseline, patients later deemed responders had significantly lower MAIT cells (but not CD5+ B cells) than non-responders; $p<0.05$. Provisional follow up analysis at week 14 shows a striking recovery of CD5+ B cells in responders, though no such recovery in MAIT cells was observed.

Conclusions
Perturbations in MAIT cell and CD5+ B cell populations are associated with IBD, and anti-TNF treatment response. Additional follow up analysis will be presented at the ISG Winter Meeting.

ABSTRACT NO. 10 (17W137) ORAL PRESENTATION

"Prevention Is Better Than Cure": Uptake of Preventive Healthcare in Patients on Biologic therapy for Inflammatory Bowel Disease attending Galway University Hospitals.

Author(s)
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Introduction
Inflammatory Bowel Disease (IBD) is a lifelong condition associated with significant morbidity. With the uptake of preventative healthcare (PH), longer-term benefits are expected owing to prevention of primary and secondary prevention of cancers, vaccine preventable infections and other debilitating conditions.

Aims/Background
Determine the uptake of PH in patients on intravenous biologic agents for IBD attending our institute.

Method
A prospective observational study on patients with IBD on intravenous therapy. Patients completed a questionnaire while attending for their infusion.

Results
100 patients were included, 56% were male with a mean age of 39.5years (range 19-19). 59.4% had Crohn's Disease and 83% were receiving Infliximab. 43% (n=40/93) were taking concomitant immuno-modulators.
Influenza vaccine was received in 44.3% (n=43/97) of our patients, 37 receive it annually as recommended. 18.8% (n=18/96) received the pneumococcal vaccine, of which 11 received it within the last 5 years.
Among females, 72.1% (n=31/43) partook in cervical cancer screening. 73.3% (n=22/30) undergo 3 yearly cervical screening with only 8.3% (n=8/31, p=ns) reporting an abnormal result.
DEXA scan is not available publicly in Galway. 15 patients reported a fracture since commencing therapy. 73.4% (n=69/94) of patients consume 3 portions of dairy daily. 50.5%(n=47/93) take dietary supplements with the same number of patients reporting their doctor recommended them. 63.3%(n=57/90) of patients exercise frequently and 16%(n=15/94) smoke.

Conclusions
Significant deficits in uptake of preventive health measures are prevalent in our patient cohort. Vaccination and bone health are particular areas for concern. Identifying these areas for improvement will help us enhance awareness of preventive health behaviours.

ABSTRACT NO. 11 (17W101) POSTER PRESENTATION

Rectal diclofenac and stenting in post-ERCP pancreatitis

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Introduction
Post-ERCP pancreatitis is the most significant complication of ERCP, with rates of up to 9.7%.

Aims/Background
We audited the frequency of post ERCP pancreatitis (PEP). Given our adoption of adoption of post procedure rectal diclofenac +/- pancreatic duct stenting, our secondary aim was to compare these findings with historical data from 2010.

Method
Radiology database displayed all who underwent ERCP between 1/1 and 31/12, 2016. Medical records determined the presence of PEP defined by symptoms of nausea/vomiting and/or abdominal pain & threefold elevation of serum amylase. Pancreatic duct (PD) stenting was performed using 5cm x 5F Geenan stent (Cook Medical, Bloomington, Indiana) whenever a guidewire was sited in the PD (n=16). Diclofenac 100 mg (Astellas Ireland Ltd, Dublin) was administered in all 95 cases; excepting allergy (n=1),EGFR <30 (n=1).

Results
97 therapeutic ERCPs were performed. 1/97 (1%) patients developed mild PEP. This patient had received both diclofenac and stenting. In our historical control series the rate of PEP was 6%; being mild in three cases and moderate in 1. Accordingly, we noted a statistically significant reduction in PEP (P<.03, X2).

Conclusions
A significant reduction in PEP was associated with diclofenac and PD stenting vs neither. As the 2 populations were homogenous and there was a single operator it is likely that the significant reduction in PEP is attributable to rectal diclofenac and prophylactic PD stenting. Unless contraindicated, rectal diclofenac should be routinely used in ERCP. PD stenting is likely only necessary when a wire is placed in the PD.

ABSTRACT NO. 12 (17W104) POSTER PRESENTATION

Effectiveness of Endo PAC Clinic before Colonoscopy procedure in an Irish Hospital.

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Introduction
The demand for Colonoscopy is increasing as evidenced by increasing waiting list. However, there is a possibility that some referrals do not adhere to guideline criteria. This is creating huge pressure on Endoscopic departments and exposing patients to risk (e.g. Bleeding, Perforation and Infection) of unnecessary procedures.

Aims/Background
We sought to determine the proportion of patients referred to our Endoscopy Unit who need to have colonoscopy according to BSG and European guidelines. (1)(2)3

Method
In our service all Referrals for colonoscopy are clinically assessed at an Endoscopy Pre-Assessment clinic (ENDO PAC) to determine the appropriateness of the referrals clinically and to assess suitability in terms of mobility, co-morbidities, anticoagulation etc. From the clinic we evaluated retrospective data of 50 Patients from charts who we seen in our Endo-PAC clinic from October to December 2016 to assess the proportion of inappropriate referrals, out of 220 patients being seen from June-December 2016. We checked for source of Referral, Indication, and Outcome, date of colonoscopy performed, Results and current status.

Results
It Suggests that out of 50(27F+23M), Referrals(44GP+6-Hospital), 24 patients were found clinically inappropriate referrals & 7 patients did not attend their appointment and removed from waiting list after 3 DNA, while 19 patients are booked for procedure.These 24 patients were having symptoms of Weight loss, Constipation, Diarrhoea after antibiotis, Normocytic/Macrocytic Anemia&CRC not fulfilling criteria.These patients had no hospital admission afterwards.

Conclusions
Our data suggests that ENDO PAC Clinic is very useful to rationalize colonoscopy demand & proper utilization of Hospital resources.

ABSTRACT NO. 13 (17W106) POSTER PRESENTATION

How well do we manage sick livers?

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Introduction
Decompensated cirrhosis is increasingly prevalent and has high mortality. Its management is complex. Delays in initiating treatment can be fatal. A 'Cirrhosis Care Bundle' was introduced by the British Society of Gastroenterology (BSG) to improve early identification and management of decompensated livers within 24 hours of admission

Aims/Background
To assess the managment of decompensated cirrhosis.

Method
This audit reviewed all admissions due to decompensated cirrhosis during a 4 month period. Chart reviews were performed 3-5 days post admission to retrospectively assess management. Key elements of the care bundle were selected as surrogate markers for overall management; biochemical parameters, alcohol withdrawal awareness, diagnostic paracentesis, Vitamin K therapy and early referral to Endoscopy

Results
There were 29 admissions identified between March – June 2017 due to decompensated cirrhosis (female n=18, 62%, Age range 42-84). Alcohol (n=19, 65%) was the main aetiology. All (n=29, 100%) had FBC, renal, liver profile within 24 hours of admission. Coagulation studies were not performed in 4 (14%). Alcohol intake was recorded in units in 47% (9/19), with IV Pabrinex and withdrawal scale prescribed for 58% (11/19). With elevated Prothrombin time (n=24), Vitamin K was prescribed in 42% (n=10). For suspected ascites (n=22), diagnostic tap was attempted in 18% (n=4) within 24 hours. Variceal bleed was suspected in 34% (n=10), for whom Terlipressin was prescribed in 30% (n=3), and early referral for Endoscopy was requested in 80% (n=8).

Conclusions
Decompensated cirrhosis is poorly recognised an poorly managed within 24 hours of admission. Greater awareness of the care bundle should improve outcomes.

ABSTRACT NO. 14 (17W107) POSTER PRESENTATION

Chromoendoscopy post-EMR improves detection of incomplete polyp resection

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Introduction
The completeness of a polyp resection is an important determinant of quality and efficient colonoscopy, and may reduce the incidence of interval cancers.

Aims/Background
The aims of this study were to assess incomplete polyp resection rates, and to determine whether chromoendsocopy could improve identification of residual disease at the time of EMR.

Method
This was a prospective interventional study of post presumed complete EMR chromoendoscopy with 0.13% indigo carmine spray for identification of residual disease in a screening population. Endoscopists documented visualised residual disease prior to targeted or random base biopsies. Exclusion criteria: piecemeal resection, visible residual disease prior to chromoendoscopy. Outcomes: overall rates of incomplete resection were documented. Reported rates post chromoendoscopy and actual histological rates were documented and compared.

Results
The resection quality was evaluated in 58 polyps of 41 patients (female n=19 46% Mean Age 60.6 years). Polyps (n=50, 86%) were removed by cold snare, hot snare (n=8, 14%). Most polyps (n=48, 83%) measured between 5-10mm with >10mm (n=6, 10%) and <5mm (n=4, 7%) less represented. Polyps were located in the right colon (n=42, 72%). Overall histological residual disease occurred in 12/58 (20%). These were correctly identified post chromoendoscopy in 8/12 (67%). Only 4/58 (6.8%) of all polyp bases were miss-classified as negative post chromoendoscopy, odds ratio 0.284 (95% CI 0.0857-0.9409) with p=0.03

Conclusions
Our rates of residual disease are significant and consistent with previous publications at 20%. This represents a significant risk for interval cancers. Simple indigo carmine spray chromoendsocopy post-EMR may reduce the rates of missed residual disease by up to 66%.

ABSTRACT NO. 15 (17W108) POSTER PRESENTATION

Detection of sessile lesions in an Irish colonoscopy cohort.

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Introduction
Colorectal cancer can arise from the serrated pathway (30-35%). Sessile lesions (SL) can be hard to identify. Recent guidelines suggest a specific SL detection quality indicator is required to reduce cancer risk.

Aims/Background
To describe a cohort of SL in an unselected colonoscopy population, with reference to prevalence, risk factors, quality indicators and surveillance.

Method
Patients with a confirmed polyp on histology were identified from a database. Histology was reviewed and polyps were classified as adenomas or sessile lesions according to the WHO criteria. Basic demographics, polyp characteristics and Endoscopist grade were compared between groups.

Results
In all 3000 colonoscopies were reviewed (male 53%, mean age 58.6 years). The overall polyp detection rate was 23.3% (687/3000). Sessile lesions occurred in 9.7% of cases (n=292), which was 42% of all polyps, and 13.4% had both polyp types. Of sessile lesions, 92% (n=268) were hyperplastic, and 8% (n=24) were sessile serrated adenomas (SSA). This corresponds to a 3.4% SSA detection rate, which is slightly lower than the recently recommended detection rate of >5%, grade of endoscopist or specialty did not affect detection rate. 12.5% of SSAs (n=3) were high risk (>10mm), and 1 patient (0.03%) met the criteria for HPSS. While there was a male preponderance (60%), we did not find a significant difference in the distribution of the SSA.

Conclusions
As expected SLs are common in an Irish cohort. Their recognition and removal is an important cancer prevention strategy. Our data suggests further work is required to optimise detection rate.

ABSTRACT NO. 16 (17W109) POSTER PRESENTATION

Urea Breath Test post completion of Triple Therapy in Helicobacter pylori positive patients on CLO test following OGD- An Audit

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Introduction
Prevalence of antibiotic- resistant H. Pylori strain is increasing worldwide resulting chronic gastritis, duodenal and gastric ulcers, gastric cancer, etc. Effective tests to monitor antibiotic resistance rates, are required post completion of triple therapy.

Aims/Background
To assess the number of patients, had UBT post completion of clarythromycin based triple therapy (PPI bd + Clarythromycin 500mg bd + amoxicillin 1g bd for x7/7) for being H. Pylori positive based on CLO testing following OGD.

Method
Retrospective study, on H. Pylori positive patients based on CLO test, following upper GI endoscopy for dyspeptic symptoms from January- December 2016 having completed clarythromycin based triple therapy and had follow up H. Pylori eradication with 13C UBT. Data obtained from Unisoft. The Irish National guidelines on Helicobacter pylori working group consensus for the diagnosis and treatment of H. pylori infection in adults were used as reference standard.

Results
Outof a total of 1884 patients, 231 (11. 8%) were H.pylori positive and completed clarythromycin based triple therapy. But only 68 (29.4%) patients had 13C UBT following treatment, where 15 (22%) were UBT postive and 4 results were not available.

Conclusions
Although 6.49% patients failed clarthyromycin based triple therapy, as compared with 9.3% in Irish population based on most recent national data in 2010, it may not reflect the actual number failing treatment as majority of patients (70.5%) did not have 13C UBT post therapy. There is a need for our unit to develop a protocol to ensure UBT is done post triple therapy and to re- audit aiding H. Pylori eradication.

ABSTRACT NO. 17 (17W110) POSTER PRESENTATION

Meta-analysis Of Outcomes Of Endoscopic Ultrasound-Guided Gallbladder Drainage Versus Percutaneous Cholecystostomy For The Management Of Acute Cholecystitis

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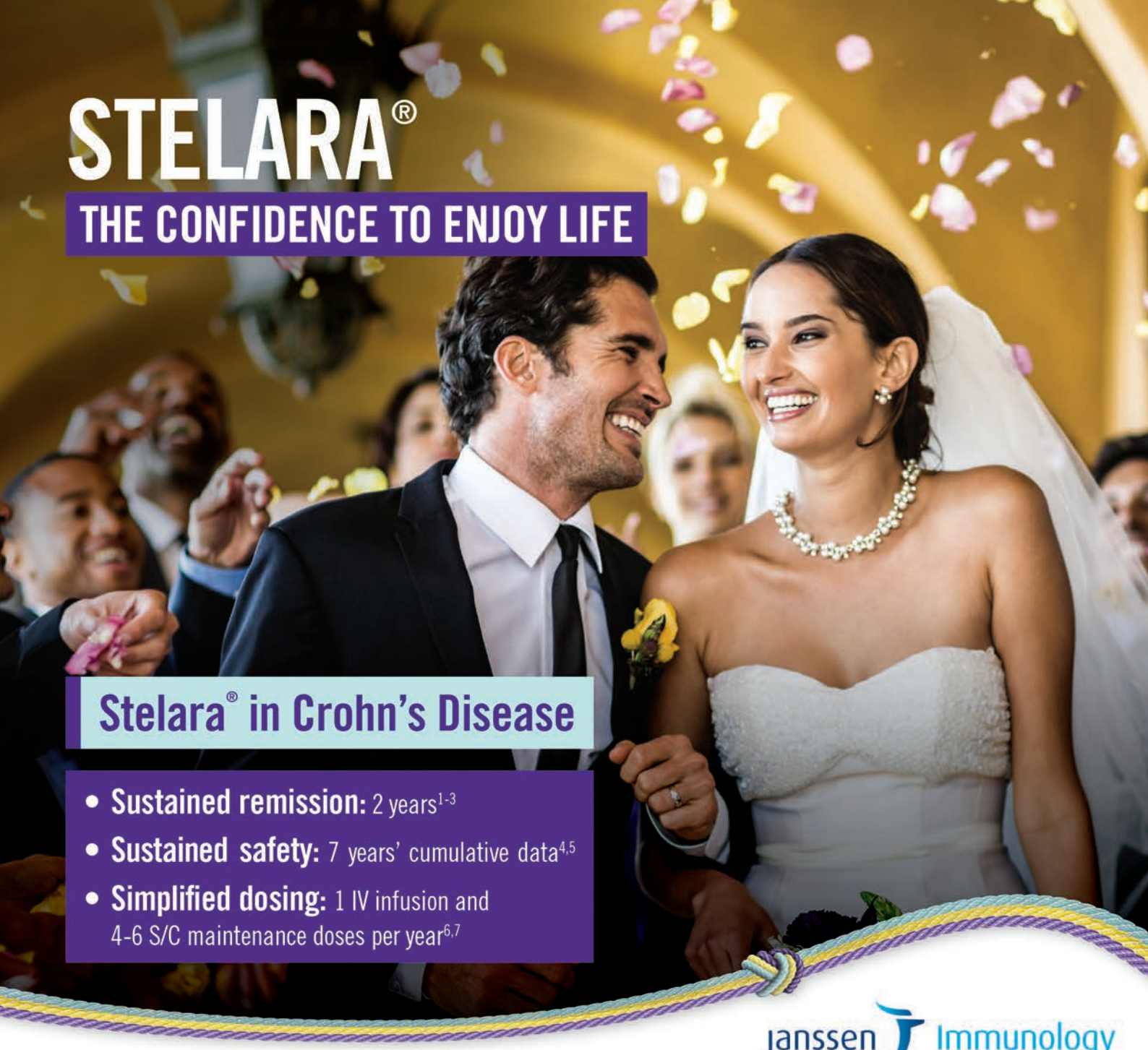
Introduction
Endoscopic ultrasound-guided gallbladder drainage is a novel method of treating acute cholecystitis in patients deemed too high risk for surgery. It involves endoscopic stent placement between the gallbladder and the alimentary tract to internally drain the infection and is an alternative to percutaneous cholecystostomy (PC).

Aims/Background
This meta-analysis assesses the clinical outcomes of high risk patients undergoing endoscopic drainage with an acute cholecystoenterostomy (ACE) compared with PC in acute cholecystitis.



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Consider discontinuation if no response after 28 weeks. **Crohn's Disease:** Initial single intravenous infusion dose based on body weight (260 mg or 390 mg or 520 mg) diluted in sodium chloride solution and given over at least one hour. At week 8 after intravenous dose, 90 mg s.c. dose is given; followed by every 12 weeks (or 8 weeks based on clinical judgement). Consider discontinuation if no response at 16 weeks. Immunomodulators and/or corticosteroids may be continued but consider reducing/discontinuing corticosteroids if responding to Stelara. If therapy interrupted, resume s.c. every 8 weeks if safe/effective. ***Children:*** **<12 years** - Not recommended for psoriasis. **<18 years** - Not recommended for psoriatic arthritis and Crohn's disease. ***Renal & Hepatic impairment:*** Not studied. **CONTRAINDICATIONS:** Hypersensitivity to product; clinically important, active infection. **SPECIAL WARNINGS & PRECAUTIONS:** ***Infections:*** Potential to increase risk of infections and reactivate latent infections. Caution in patients with a chronic infection or history of recurrent infection, particularly TB. Patients should be evaluated for tuberculosis prior to initiation of STELARA. Consider anti-tuberculosis therapy prior to initiation of STELARA in patients with past history of latent or active tuberculosis. Patients should seek medical advice if signs or symptoms suggestive of an infection occur. 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References: 1. Feagan BG *et al*, N Engl J Med 2016;375:1946-60. Ustekinumab as Induction and Maintenance Therapy for Crohn's Disease. **2.** Sands BE *et al*, Oral Presentation OP005, United European Gastroenterology Week (UEGW): 15-19 October 2016; Vienna, Austria. **3.** Sandborn, W.J. *et al*. ECCO 2017. OP010. **4.** Papp K *et al*, J Drugs Dermatol 2015; 14(7): 706-714. **5.** Kalb RE et al, JAMA Dermatol 2015; 151(9): 961-969. **6.** Stelara® 90 mg pre-filled syringe. Summary of Product Characteristics. Available at www.medicines.ie. **7.** Stelara® 130 mg concentrate for solution for infusion. Summary of Product Characteristics. Available at www.medicines.ie.

PHIR/STE/0417/0009(1) | Date of Preparation: October 2017

Method
A literature search was performed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Databases were searched for studies reporting outcomes of patients undergoing ACE or PC. Results were reported as mean differences or pooled odds ratios (OR) with 95% confidence intervals (95% CI).

Results
A total of 1593 citations were reviewed; 5 studies comprising 495 patients were ultimately selected for analysis. There were no differences in technical or clinical success rates between the two groups on pooled meta-analysis. ACE had significantly lower post-procedural pain scores (mean difference -3.0, 95% CI -2.3 - -3.6, $p < 0.001$, on a 10-point pain scale). There were no statistically significant differences in procedure complications between groups. Re-intervention rates were significantly higher in the PC group (OR 4.3, 95% CI 2.0 – 9.3, $p < 0.001$).

Conclusions
ACE is a promising alternative to PC in high risk patients with acute cholecystitis, with equivalent success rates, improved pain scores and lower re-intervention rates, without the morbidities associated with external drainage.

ABSTRACT NO. 18 (17W111) POSTER PRESENTATION

Response Rates in Primary Biliary Cholangitis to Ursodeoxycholic Acid in Cork University Hospital

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Introduction
Primary biliary cholangitis is characterised by a chronic cholangitis affecting interlobular and septal bile ducts with progressive fibrosis. Ursodeoxycholic acid is currently the only approved therapy for PBC. The Toronto criteria for biochemical response to UDCA is defined as an ALP <1.67 times the upper limit of normal after 2 years of treatment. ALP above this cut off predicted histological progression. Non-response to UDCA varies by study from 24-43.5%. It's shown that 12 months of treatment with obeticholic acid alone or combined with UDCA showed an improvement in serum markers at 12 months which was sustained for 2 years.

Aims/Background
The aims of this audit is to assess the numbers of non-responders to UDCA in Cork University Hospital who may benefit from second line agent obeticholic acid.

Method
Data was retrospectively collected from patient charts and the laboratory. Inclusion criteria included anyone attending outpatient services in CUH with a diagnosis of PBC and over the age of 18 years. Exclusion criteria: the deceased and inability to retrieve sufficient data. Responders were deemed as having an ALP value of less than 225.45 IU/L within 2 years of treatment.

Results
After exclusion, 79 patients remained for analysis with an average age of 60.22 years. 86.1% are female. 40.5% have undergone liver biopsy. 29.3% are deemed to be non-responders.

Conclusions
A re-audit of this cohort should be undertaken after the introduction of obeticholic acid to assess if more patients can reach the Toronto criteria and thus have improved survival and liver transplant-free survival.

ABSTRACT NO. 19 (17W113) POSTER PRESENTATION

The value of faecal immunochemical test (FIT) when investigating anaemia or obscure gastrointestinal bleeding with small bowel capsule endoscopy.

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Introduction
Small bowel capsule endoscopy (SBCE) has an established role in investigating obscure gastrointestinal bleeding. Appropriate prioritisation of patients is essential to maximise diagnostic yield. Identifying methods to efficiently triage referrals for SBCE is important in a resource-poor environment.

Aims/Background
To investigate if FIT could help predict likelihood of small bowel pathology on SBCE.

Method
Patients referred for SBCE to investigate anaemia or obscure GI bleeding were prospectively recruited. Patient characteristics, haemoglobin (Hb) and FIT were collected on the day of SBCE. A FIT ≥50ng/dL was considered positive. SBCE was positive if a source of bleeding was identified including angiodysplasia, neoplasms, IBD or non-IBD enteritis.

Results
51 patients were enrolled, mean age 56.6 years, 35.3% male. 15 (29%) had a positive FIT, mean FIT was 464ng/dL and 13 (26%) patients had significant SBCE findings. 9 (60%) FIT positive patients had a positive SBCE (OR 12, p=0.0009) versus 4 (11%) of FIT negative patients (OR 0.056, p=0.0003, NPV 89%). Sensitivity and specificity of FIT at ≥50ng/dL were 69% and 84%, respectively.
Overall 15 (33%) were anaemic, mean Hb 12.7g/dL. Anaemia was a poor predictor of pathology, (PPV 42%) however a normal Hb had a good NPV, 83% (OR 0.30, p=0.09). Combining Hb and FIT had a similar predictive value to FIT alone (OR 9.14, 67% PPV), with a strong NPV (82%, OR 0.02).

Conclusions
FIT 50ng/dl is useful at predicting small bowel pathology on SBCE. It has value as a screening tool and may help to better prioritise patients referred for SBCE.

ABSTRACT NO. 20 (17W114) POSTER PRESENTATION

Does abnormal small bowel radiological imaging correlate with Small Bowel Capsule Endoscopy (SBCE) findings?

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Introduction
The diagnostic yield of SBCE is superior to small bowel cross-sectional imaging. SBCE is often used to characterize abnormal findings from cross-sectional imaging or to further investigate patients with normal radiological findings and ongoing symptoms.

Aims/Background
To correlate SBCE and small bowel cross-sectional imaging in patients with suspected small bowel disease.

Method
Using our SBCE database, we isolated 2 groups of patients; one group with abnormal small bowel cross-sectional imaging as the primary indication and another group with normal cross-sectional small bowel imaging with persistent symptoms. Patient demographics were documented and SBCE and radiological findings compared.

Results
79 SBCE cases (Mean age: 44.8 years; 39 [49%] Female) with small bowel imaging (51% MRE) were identified. 40 abnormal imaging, 39 with persistent symptoms, despite negative radiology. The overall diagnostic yield in this cohort was low at 7.6% (6); 3 Crohn's Disease, 1 NSAID enteritis and 1 tumour. Patients were twice as likely to have a positive SBCE with negative cross-sectional imaging (4/39) 10% versus 5% (3/40) with abnormal imaging, odds ratio: -0.49. Small bowel imaging PPV, NPV, Sensitivity, Specificity was disappointing at 5%, 10%, 33%, 49% respectively and overall correlation with SBCE was poor (k = -0.05). Neither imaging modality, age or gender improved performance.

Conclusions
Positive small bowel cross-sectional imaging has a low diagnostic yield. Disappointingly, radiology and capsule endoscopy findings correlate poorly. In our experience, abnormal radiological findings alone are not a good indication for small bowel capsule endoscopy.

ABSTRACT NO. 21 (17W119) POSTER PRESENTATION

Feed The Fleet

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Introduction
It is well established that nutrition plays a vital role in sporting activities and can influence performance.

Aims/Background
We examined the nutritional background of young competitive sailors as this area has not previously been studied.

Method
Our online survey was emailed to all members of the Royal Cork Yacht Club. We used Survey Monkey for the purposes of distributing our survey and analysis of results.

Results
60 families completed the survey representing 90 children, aged 12-18 years. Most children ate breakfast (72%) and lunch (76%) on a school day with 75% eating breakfast on a sailing day, falling to 58% for lunch. Most children drank water as their main beverage at school and while sailing (76 and 78%). Parents worried more about their child's nutrition on a sailing day with most concerned that they were not eating enough. Most children did not take supplements (75%) and only 8% had a medical condition that would affect their food intake. 58% would take advice on diet from a teacher at school but 80% would take advice from a sailing coach. 84% of families said they would benefit from further advice on nutrition. Further information was collected on food expenditure, eating habits and dietary intake.

Conclusions
This survey highlights the need for further awareness about healthy foods that can be taken and tolerated on the water. It would appear that further education could be delivered most effectively to young sailors via their coaches at the time of training.

ABSTRACT NO. 22 (17W120) POSTER PRESENTATION

Assessment of the Post ERCP Pancreatitis (PEP) rates at a single tertiary referral center.

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Beaumont Hospital Dublin

Introduction
Post ERCP pancreatitis (PEP) has been reported to occur in 3-8% of cases in the international literature. The rate in Ireland is unknown to date due to referral practises to tertiary centres

Aims/Background
The aim of this study was to assess the rate of PEP in patients presenting to Beaumont hospital for ERCP.

Method
Consecutive ERCPs performed in Beaumont hospital, from September 1st 2016- February 28th 2017, were reviewed. A computerised database (ENDORAD) was used to collect demographic and endoscopic information. Where sufficient information was not available, the patients were contacted directly. In the event the ERCP was performed for a malignant stricture, the patient's referring doctor/GP were contacted. Pancreatitis was defined as the fulfillment of two of the following three criteria: a raised amylase 2-3 times the normal level, evidence of pancreatitis on imaging and abdominal pain with prolonged hospital admission.

Results
The total number of ERCPs performed was 212. The most common

indications for ERCP were CBD stones (71%) and malignant strictures (18%). 65% of procedures involved sphincterotomy with stone removal, stent insertion/ removal or both. 12 (5.7%) patients developed post ERCP pancreatitis. 11 (92%) of these were performed for CBD stones. Risk factors for developing pancreatitis included young age and having a normal bilirubin. None of the patients who developed PEP had a history of previous ERCP or pancreatitis from any aetiology

Conclusions
Prior to this audit, the rates of post ERCP pancreatitis in Beaumont were unknown. This audit revealed a PEP rate of 5.7% in keeping with international rates.

ABSTRACT NO. 23 (17W121) POSTER PRESENTATION

Audit Of NCHDs Regarding Their Knowledge About Quantification Of Alcohol Intake And Low-risk Drinking Guidelines

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Introduction
The impact of alcohol-related health problems is significant in Ireland. Healthcare professionals should be familiar with the definition of "standard drinks" and low-risk drinking guidelines in order to accurately assess patient's alcohol intake and provide guidance to reduce alcohol-related harm.

Aims/Background
To assess knowledge among non-consultant hospital doctors (NCHDs) regarding quantification of alcohol intake and low-risk drinking guidelines.

Method
An anonymous online survey from a non-randomised representative cohort of NCHDs in Beaumont Hospital was conducted between June and August 2017. Data was collected and analysed with SurveyMonkey.

Results
Response rate was 32% (80/250). Responders included interns, SHOs, registrars and SpRs from various hospital specialties. 60% of responders were male, 75% Irish graduates. The majority of NCHDs were able to correctly identify the number of units contained in one standard pint of beer (68.75%) and in one standard pub measure of spirits (69.62%). However, the majority of NCHDs couldn't identify the number of units contained in one standard bottle of beer/bottle of wine/glass of wine and bottle of spirits, with correct answer rates of only 26.25%, 32.5%, 8.75% and 27.5%, respectively. The majority (48.1%) of respondents identified the correct low-risk drinking guidelines for women (i.e. 11 standard drinks/week), but only 22.5% answered correctly for men (i.e. 17 standard drinks). There are no consistent trends when analysed regarding grade, gender, speciality and country of primary qualification.

Conclusions
There is discrepancy in the awareness levels of NCHDs regarding alcohol intake and low-risk drinking guidelines. Overall, awareness was sub-optimal and therefore further education and re-auditing is recommended.

ABSTRACT NO. 24 (17W122) POSTER PRESENTATION

Clinicians' attitudes to photo protection in IBD patients on immunosuppression

Author(s)
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3.Department Dermatology Tallaght Hospital, Dublin

Introduction
Immunosuppressive medications increase the risk of developing skin cancer and are increasingly used in IBD. We performed a pilot study that found the majority of our IBD cohort are a high risk phenotype, lack knowledge of their increased risk and have suboptimal photoprotective behaviours. We speculate clinician's lack of knowledge was partly to blame.

Aims/Background
Determine Irish IBD clinicians' knowledge of the skin cancer risk and advised photoprotective behaviours in this cohort.

Method
Cross-sectional descriptive study. We invited IBD clinicians to complete an online survey assessing their knowledge of skin cancer risk and prevention methods recommended by the "Sunsmart" guidelines. Grade of training was noted.

Results
45 clinicians completed the questionnaire. Fifteen (33%) consultants, fourteen (31%) trainees, four (9%) general medical trainees and twelve (27%) IBD nurses.Clinician's knowledge of general factors associated with increased risk of skin cancer was reassuring.Only 53% (n=24) knew anti-TNF medications increase risk of malignant melanoma.The majority knew what changes to look for in a suspicious mole. Only five (11%) perform yearly skin checks.Knowledge of preventative measures was lacking and only 24 (55.8%) had heard of the "Sunsmart" guidelines. Physicians had a greater understanding of patient risk factors ($p<0.03$). Nursing specialists were more likely to emphasise the need for sunprotection ($p<0.0003$). Trainees had a more complete knowledge of all advised preventative measures ($p<0.03$).

Conclusions
Our study highlights IBD clinicians' suboptimal knowledge of immunosuppression risk and their lack of emphasis on preventative measures and skin examination in clinics. A targeted educational programme may address this.

ABSTRACT NO. 25 (17W123) POSTER PRESENTATION

Regression Of Liver Fibrosis In Patients With Chronic Hepatitis C Treated With Direct Acting Anti-Viral Drugs

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Introduction
Since the introduction of direct-acting antivirals drugs(DAA), for the treatment of hepatitis C(HCV) most patients can hope to achieve a sustained virological response (SVR). The use of transient elastography by Fibroscan provides a non-invasive and rapid measurement of the degree of hepatic fibrosis and cirrhosis in this patient group, and helps in the assessment and surveillance of hepatic fibrosis.

Aims/Background
To investigate the impact of SVR after HCV treatment on liver stiffness(LS) and degree of regression.

Method
An observational study was carried out in HCV patients with advanced fibrosis or cirrhosis receiving DAA therapy at Cork University Hospital. LS scores > 12.5kpa indicated LS-defined cirrhosis. LS were analysed pre-treatment to SVR, and on average 6 months after SVR.

Results
The median age was 59 years (IQR 54-66); 45% male, and 55% female. All patients achieved SVR.
Of a total of 68 patients, 57% (n=39) had LS-defined cirrhosis before treatment. LS decreased from the baseline median value of 14.15kPa (IQR 10.42-21.45) to a post-treatment score of 10.40kPa (IQR 7.7-15.7) ($p < 0.0001$).
Despite the change that occurred in many patients, 27 of 39 patients (40%) remained cirrhotic post treatment. Improvement in LS scores were accompanied by a significant decrease in ALT and alphafetoprotein levels ($p<0.05$).

Conclusions
SVR was accompanied by a significant decrease in LS, consistent with the findings of previous studies. The failure of SVR to resolve cirrhosis emphasises the need of early treatment in cirrhosis prevention. Longitudinal studies are needed to further evaluate the degree of regression in this patient cohort.

ABSTRACT NO. 26 (17W124) POSTER PRESENTATION

White Cell Count (WCC) and Mean Corpuscular Volume (MCV) As Surrogate Markers for Thiopurine Monitoring in Inflammatory Bowel Disease Treatment: A Single Centre Experience

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Introduction
Thiopurines (TPs) are commonly used in treatment of Inflammatory Bowel Disease (IBD). Optimal dosing is determined by patients' weight and commonly titrated to achieve target range of 2-2.5mg/kg. Levels of 6-thioguanine nucleotide (6-TGN) can be measured to check for efficacy and toxicity, but this is not widely available. WCC, lymphocyte count (LC) and MCV have emerged as surrogate markers to monitor TP efficacy.

Aims/Background
Previous studies have suggested WCC<4x109/L and MCV>100fl correlate with 6-TGN level and with reduced risk of disease relapse. The aim of our study is to assess these surrogate parameters in our patients on TPs.

Method
200 patients were included in this observational study. Data were obtained from our IBD database and outpatients' clinic lists. Recent WCC, LC and MCV were recorded.

Results
There were 108(54%) females and 92(46%) males.54 patients(27%) diagnosed Ulcerative colitis, 143(71.5%) Crohn's disease and 3(1.5%) indeterminate colitis. The mean WCC count was 6.81x109/L(range 2.8-14.2).Mean LC was 2.86 x109/L(0.5 to 8.8).Mean MCV was 91.11 fl(78.4 to104.3). Only 13/200(6.5%) patients had WCC<4x109/L and 11/200(5.5%)had a MCV≥100fl.

ABSTRACT NO. 27 (17W125) POSTER PRESENTATION

Refeeding syndrome related morbidity and mortality

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Introduction
Refeeding syndrome is a syndrome consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved, severely malnourished or metabolically stressed due to severe illness. It is a serious and life-threatening condition that patients with different gastroenterological conditions are at higher risk to develop during hospitalization. Cardiac, pulmonary and neurological symptoms can be signs of refeeding syndrome.

Aims/Background
Patients admitted to the wards will be screened by a registered dietician for risks for the re-feeding syndrome, and those who are identified were followed up for development of the condition and subsequent complications.

Method
Patients admitted to the wards will be screened by a registered dietician for risks for the re-feeding syndrome, depending on their initial weight, blood test, and total caloric intake, and those who are identified were followed up for development of the condition and related morbidities and mortalities.

Results
46 patients were identified to be at risk of refeeding syndrome, 10 of these patients (22%), died during their hospital stay, of these 8 patients mortality was closely related to refeeding syndrome

complications.
12 patients developed complications related morbidities resulted in longer hospital stay

Conclusions
1. Refeeding syndrome has serious and life-threatening complications.
2. An awareness of the condition and a high index of suspicion are required in order to make the diagnosis.

ABSTRACT NO. 28 (17W130) POSTER PRESENTATION

An Audit Of The Accuracy Of Transient Elastography By Fibroscan For The Diagnosis Of Liver Fibrosis In Chronic Hepatits C

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Introduction
Fibroscan is a validated, non-invasive technique used to measure liver stiffness (LS), which correlates with fibrosis. To achieve a valid LS score, the operator must obtain all the following three criteria: at least 10 stiffness measurements, an interquartile range/median ratio (IQR/M) of < 30%, and > 60% measurement success rate. These are stated by the manufactures. However in the case of Hepatits C (HCV), recent studies report that an IQR/M <21% gives a more accurate diagnosis of the stage of hepatic fibrosis.

Aims/Background
To assess the adherence to the LS validity criteria, especially in maintaining a low IQR/M in routine clinical practice.

Method
We analysed Fibroscans performed on patients with HCV in our outpatient department from 2014 to 2017. These patients had received direct acting antivirals and were reviewed pre and post treatment. This audit focused on the IQR/M value for each LS obtained.

Results
68 patients were identified. They all had 10 successful stiffness measurements. The median IQR/M was 13% (IQR 8-18%) before treatment, and median 12% (IQR 8-15%) after treatment. The average time before the second fibroscan procedure was 6 months. There was no significant difference in terms of score between medical or nurse practitioners performing the Fibroscan.

Conclusions
In keeping with established literature, and manufacturer criteria, our practice maintains successful adherence to the LS validity criteria. This is important to ensure the diagnostic accuracy of Fibroscan in HCV induced liver fibrosis.

ABSTRACT NO. 29 (17W131) POSTER PRESENTATION

High Incidence of Advanced Liver disease in patients with Non-alcoholic Fatty Liver Disease: A single center Irish study

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Introduction
With rising rates of obesity and metabolic syndrome, non-alcoholic-fatty-liver-disease (NAFLD) has become the leading cause of liver disease in the western world. Despite concerning obesity statistics, there is a paucity of data on NAFLD characteristics amongst the Irish population.

Aims/Background
To review of the characteristics of NAFLD patients attending the Hepatology department.

Method
Electronic records were used to conduct a retrospective review of patients attending the Hepatology Department in St. James' Hospital with a diagnosis of NAFLD from 2006 to 2016.

Results
N = 513 patients attended with a diagnosis of NAFLD over the 10- year period: 274 (53.4%) were male, and 239 (46.5%) were female. Median age was 57 years (19-97), with a median BMI of 31.7 (21.9-60.9). 164 (32.0%) patients had diabetes, 203 (39.6%) had dyslipidaemia and 178 (34.7%) were hypertensive. 99 patients had liver biopsies of those 39 (39.4%) had advanced hepatic fibrosis and a further 71 (33.3%) had advanced fibrosis scores. 6 patients were diagnosed with hepatocellular carcinoma, 5 developed decompensated liver disease and 1 proceeded to orthotopic liver transplantation. Man-Whitney U tests showed Fibroscan scores were higher in individuals with IGT/diabetes (U= 10,397, z= 5.3, p<0.0005) and hypertension (U=8,398, z=2.78, p=0.006). Multivariate logistic-regression identified IGT/diabetes as the most significant factor associated with advanced fibrosis scores (OR:2.53, p = 0.01, CI: 1.49-4.27).

Conclusions
At least one third of NAFLD patients attending the Hepatology center had advanced fibrosis identified on biopsy or Fibroscan criteria. Patients with IGT/Diabetes are at significantly increased risk of advanced liver disease and should be screened.

ABSTRACT NO. 30 (17W132) POSTER PRESENTATION

A tertiary hospital experience of Lumen –apposing metal stents (LAMS) in the treatment of pancreatic fluid collections.

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Introduction
EUS guided therapy is becoming the gold standard for management of mature pancreatic fluid collections (PFCs), both pseudocysts (PC) and walled of necrosis (WON). The Hot AXIOS™ system comprises a lumen-apposing, covered, self-expanding metal stent (LAMS) and electrocautery delivery catheter and it may have higher technical success, easier deployment and lower migration rates than plastic stents.

Aims/Background
To retrospectively review the clinical and technical effectiveness and complication rates of EUS-guided placement of Hot Axios™ stents.

Method
All patients who had EUS-guided LAMS placement between December 2015 and July 2017 in Tallaght Hospital were included. Data including indication, collection size, technical success, clinical success (resolution of PFC), stent migration and complications were collated.

Results
Patient data are presented in Table 1. LAMS insertion was successful in 15/16 (93.8%) attempted patients. In the failed case the PFC could only be reached trans-duodenally but extensive varices prevented safe puncture. 13/15 (87%) had trans-gastric stents and 2/15 (13%) had trans-duodenal stenting. Following LAMS insertion the collection resolved in 10/10 (100%) patients with PC and in 3/5 (60%) WON cases. Complications included 3/15(20%) stent blockages (all WON): 1 treated endoscopically, 1 required surgery, and 1 was treated radiologically. 3/15(20%) developed infection post-procedure. 1/15(7%) had stent migration with spontaneous passage of stent after resolution of PFC. Stents was removed after a mean of 16.2 weeks.

Conclusions
The Hot AXIOS™ system is safe with high technical and clinical success rates particularly for PC. Stent blockage occurred only in patients with WON and can be salvaged endoscopically.

Table 1. Patient details

PFC type	PC 10
	WON 6
Sex	Male 11 (69%)
Median age (range)	55 (49-72)
Pancreatitis aetiology	Gallstones 9 (56%) Alcohol 6 (38%) Genetic 1 (6%)
Mean cyst size in cm on EUS (range)	10.1 (7-14)

ABSTRACT NO. 31 (17W133) POSTER PRESENTATION

Non-attendance for endoscopy associated with increasing inefficiency in a tertiary referral endoscopy centre

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Introduction
Patients who Do Not Attend (DNA) scheduled hospital appointments represent a major resource waste. National DNA rates approach 15% for outpatient appointments. Missed appointments cost clinical time, increase waiting lists and delay diagnoses.

Aims/Background
Identify reasons for endoscopy DNAs and corrective measures to improve future attendance. Despite a 40% increase in annual endoscopic procedures over the past 10 years, wait times have extended because of greater demand from GPs and colon cancer screening.

Method
Over 6 weeks, DNAs in the GI Unit were collated, clinical referral details and wait time for endoscopy analysed. Telephone contact was attempted with patients on 2 occasions to ascertain reasons for non-attendance.

Results
Over the study period a total of 817 outpatient endoscopy procedures were scheduled and 162 were DNAs representing 20% of all appointments. Wait time from date of referral to scheduled appointment was >12 weeks in 77% of all DNAs contrasting with 37% of attendees. 76% of DNAs were contactable and of these, commonest reasons for non-attendance were miscommunication error (54%) or "forgot" (39%).

Conclusions
A DNA rate of 20% translates to 52 lost procedure days with an estimated annual staff cost of €499,057. Root cause analysis indicated that patients with wait times >12 weeks are twice as likely to DNA. DNAs could be further reduced by sending a confirmation text serving as both a reminder and notification at a fraction of the cost of the lost procedure days. Addressing these issues would result in approximately 1500 additional endoscopic procedures per year.

ABSTRACT NO. 32 (17W134) POSTER PRESENTATION

Retrospective review of resection margin in NCCS (National Colon Cancer Screening) polypectomy

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Introduction
Various techniques remove colonic polys. In our practise lesions >5mm are usually excised by snaring and those <5mm removed

with biopsy forceps. Regardless of the method used the goal of polypectomy is to achieve an R0 margin meaning that the margin is free from abnormal (precancerous) tissue.

Aims/Background
To determine the achievability of R0 margin using various methods of polypectomy in an NCCS cohort

Method
Retrospective data of all NCCS polypectomies performed since 2014 to 2017 from a single centre were collected. Endoscopy reports and histology reports were assessed. These were used to populate an excel sheet. Minitab software was used for statistical analysis.

Results
We analyzed a total 547 colonoscopies with 1444 polypectomies. The average age was 67 years with 213(39%) females. No polyps were found in 117(21%) procedures. 324(22%) had an R0 margin histologically, and 64(4%) had involvement of the margin. In 938(65%) polyps pathologist were unable to assess the margin and 118 (8%) polyps were not retrieved. In cases where margins were not assessed Correlation with endoscopy was recommended by the pathologist. Achieving an R0 margin was statistically significant only concerning endoscopist (medical endoscopist more than surgical endoscopist, $p<0.05$) with no significance of size and location to reaching an R0 margin.

Conclusions
Only 25% of the Polyps retrieved achieved an R0 margin while in 71% cases pathologist were unable to assess the margin. Polypectomy requires significant focused training and experience to maximize success. In future, this could be included as a key performance indicator for polypectomy

ABSTRACT NO. 33 (17W135) POSTER PRESENTATION

Endoscopic Assessment of Bowel Preparation Quality for Out-Patient Colonoscopies: A Single Center Prospective Study

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Introduction
Suboptimal bowel preparation is associated with a higher risk of incomplete colonoscopy and a lower adenoma detection rate. European guidelines recommend split regimens of bowel preparation as they are associated with better colon cleansing.

Aims/Background
To examine a single center's experience with bowel preparation.

Method
A prospective cohort study was performed including patients who underwent colonoscopy between February and March 2017. Data was compiled from questionnaires completed by patients in the endoscopy waiting room. Questions included demographic data, bowel preparation regimen and compliance, distress while taking the preparation (based on quality of sleep and experience of adverse events), and medications that could affect the quality of bowel preparation. Following each colonoscopy, the endoscopist assessed the quality of bowel preparation using the Boston Bowel Preparation Scale.

Results
137 patients were approached, 131 completed the questionnaire (mean age 55 years, 54% male). The majority of patients received Kleanprep© (81%). Only 3.8% of patients underwent a split dose preparation regimen, while 88.5% were advised to take the whole preparation the night before. 78.8% of patients took the full amount. 20.6% reported moderate distress, 6.1% experienced severe distress. Adverse events included travel interruption (5.3 %) and faecal incontinence (0.8%). 14.5% of patients were taking a concomitant antidepressant and benzodiazepine. The quality of bowel preparation was classified as excellent or good in 79.4% of participants.

Conclusions
Split bowel preparation is not widely employed in our center. We recommend implementing a triage system to identify patients suitable for split dose bowel preparation and those who require an intensified regime.

ABSTRACT NO. 34 (17W136) POSTER PRESENTATION

Outcomes of high risk patients in the National Colorectal Screening Service: a single centre analysis

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Introduction
Bowelscreen was established in Ireland in 2012 and since then, close to 1200 colonoscopies have been carried out in UHG as part of this programme. Repeat surveillance endoscopy represents a significant component of this work.

Aims/Background
The aim of this study was to identify patients categorised as high risk after their index colonoscopy and to quantify the level of findings at subsequent surveillance procedure.

Method
All patients who underwent colorectal screening between 2013 and 2016 in UHG were included. High risk patients requiring yearly surveillance were identified using the UHG ERS.

Results
Between 2013-2016; 1190 patients underwent screening colonoscopy. A total of 138 patients met the definition for high risk and had their follow-up performed at our institution. The outcome at one year showed that 83% of patients required a further polypectomy. Only 24 (17%) of patients had no polyps at time of repeat endoscopy. Of those requiring polypectomy: 40 (32%) patients had 5 or more polyps. No patients had developed an interval cancer. Patients with multiple polyps on their index colonoscopy were more likely to have multiple polyps on their surveillance colonoscopy than patients with a large polyp on their index procedure.

Conclusions
The vast majority of patients in this cohort required a repeat polypectomy at one year, with a third having a significant burden of polyps (5 or more) on their subsequent colonoscopy. Given the above data, a yearly colonoscopy for those meeting the high-risk criteria would seem appropriate and prudent for this cohort of patients.

ABSTRACT NO. 35 (17W138) POSTER PRESENTATION

Is performing haematinics a dying art?

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Introduction
British Society of Gastroenterology guidelines recommends upper and lower gastrointestinal investigations in males and postmenopausal females presenting with confirmed iron deficiency anaemia.

Aims/Background
To determine whether haematinics were performed in anaemic patients prior to referral to our services for upper and lower gastrointestinal endoscopy.

Method
A retrospective review was carried out on all outpatients who presented to the endoscopy department at Louth County with anaemia between July 2016 and July 2017. We analysed both endoscopy and laboratory archives. We examined haematinic investigations performed in the preceding 6 months to endoscopy.

Results
A total of 279 outpatient referrals were evaluated retrospectively. Of these 70 (25%) patients were referred for anaemia. Anaemic patients mean haemoglobin was 10.5(7.3-15)g/dL with a mean MCV of 82.9(68-102)fL. The average age of anaemic patients was 62(29-88) years. Our study found that almost a third of patients (20) did not have the appropriate haematinic screen performed prior to referral for endoscopy.

Conclusions
This study highlights the high number of anaemic patients that do not have a haematinic screen prior to endoscopy referral. In this era of finite healthcare resources it is important to triage patient referrals as per guidelines prior to subjecting them to expensive and invasive procedures.

ABSTRACT NO. 36 (17W139) POSTER PRESENTATION

A Review Of Postoperative Crohn's Disease Surveillance Colonoscopy

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Introduction
ECCO guidelines 2013 outlines the importance of early(6-12 months) postoperative surveillance colonoscopy to detect endoscopic recurrence of Crohn's disease.

Aims/Background
To evaluate all postoperative Crohn's disease patients attending our institution and to determine if the introduction of 2013 ECCO guidelines has influenced our practice to evaluate timing of surveillance colonoscopy, and to assess endoscopic recurrence within 12 months of surgery.

Method
A retrospective review of all postoperative Crohn's disease patients between 1999-2017. We analysed medical notes, endoscopy and histology archives.

Results
70 postoperative Crohn's patients were evaluated retrospectively and divided into two cohorts. 42(60%) patients who required an operation between 1999-2012 and 28(40%) patients who required an operation between 2013-2017.

1999-2012
42 patients(60%) had an average duration of disease of 4.1Y. 25(60%) females vs 17(40%)males. Mean age was 45Y(24-68). In comparison to the second cohort, patients took longer to have their surveillance colonoscopy (average time 41 months) .6(14%) had a colonoscopy within 12 months; 2(33%) had endoscopic recurrence(i2-i4). 36(86%) had a colonoscopy after 12 months .

2013-2017
28 patients(40%) had an average duration of disease of 7.8Y. 21(75%) females vs 7(25%)males. Mean age was 42Y(19-72). Average time taken for surveillance colonoscopy was 11.7 months in keeping with ECCO guidelines .16(57%) had a colonoscopy within 12 months; 8(50%) had endoscopic recurrence (i2-i4).3(11%) had a colonoscopy after 12 months, 7(25%) did not have a scheduled colonoscopy, while 2(7%) were awaiting colonoscopy.

Conclusions
This study shows adherence to ECCO 2013 guidelines as reflected by earlier postoperative surveillance Colonoscopy in the 2013-2017 cohort.

ABSTRACT NO. 37 (17W140) POSTER PRESENTATION

Use of the MUST (Malnutrition Universal Screening Tool)- An Audit

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Introduction
Malnutrition increases morbidity and mortality, slows recovery and prolongs hospital stay. The 'MUST' identifies patients at risk of malnutrition. Our hospital aims to screen all patients for risk of malnutrition using the tool.

Aims/Background
An audit of the uptake of the MUST in CUH, with aim of identifying those at risk of malnutrition.

Method
End of bed records were obtained. Weight, BMI and whether the MUST tool was filled were analysed. Patients were asked regarding recent weight loss and known height. If height was unknown or unreliable ulna length was obtained. If weight was unavailable mid upper arm circumference (MUAC) was obtained. A 'MUST' score was retrospectively calculated.

Results
48 patients were included. Mean age was 78 years. 29 female, 19 male. 89.5% of patients did not have a 'MUST' calculated. 41% of patients had weight recorded. Sufficient data to calculate BMI was available for 43% of patients. 16% had a BMI <20, 22% had a BMI >30. 37.5% of patients reported recent unintentional weight loss. On retrospective scoring, 28 patients had a MUST of 0 (low risk), 12 had a MUST of 1 (medium risk), and 8 had a MUST of 2 or more (high risk). 21% of all patients had dietary record charts. 80% of these were at risk of malnutrition on MUST scoring.

Conclusions
The use of 'MUST' is low. The goal of weighing all patients has not yet been achieved. Posters have been placed on the wards as a reminder to admitting staff and re -education is planned before re-audit.

ABSTRACT NO. 38 (17W142) POSTER PRESENTATION

Comparision Of Transient Elastography Versus Liver Biopsy For The Assessment Of Liver Fibrosis/Cirrhosis. A single Centre Experience

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Introduction
Guidelines have moved away from Liver Biopsy to non-invasive measures for assessment of hepatic fibrosis. Transient elastography(TE) by Fibroscan® is an established non-invasive method of assessing hepatic fibrosis.

Aims/Background
To assess real world data comparing Transient Elastography with Liver Biopsy as a measure of liver fibrosis/cirrhosis.

Method
We performed a retrospective analysis of patients who underwent liver biopsy in Our Lady of Lourdes from 2013 to present for diagnosis of liver disease or assessment of liver fibrosis. Comparison was made between findings at biopsy and Transient Elastography performed within 1 year of biopsy.

Results
Of a total 98 liver biopsies for liver disease; 30 patients (33% female, mean age 55years) had Transient Elastography performed within 12 months of Biopsy date. A direct comparison was made between findings at liver biopsy and those found by Elastography. This was compared to level of fibrosis on biopsy by METAVIR scoring system. An Elastography score of >12.5KPa was deemed to indicated cirrhosis as per local radiology reporting guidelines. This resulted in a sensitivity of 67% and a Specificity of 90% for Liver Cirrhosis. (METAVIR fibrosis score =4)
An Elastography score of >/=8kPa indicating likely significant fibrosis gave a Sensitivity of 88% and a Specificity of 67% in comparison with Biopsy (METAVIR fibrosis score >/=2).

Conclusions
Liver Biopsy is an expensive, invasive means of measuring liver fibrosis. Transient Elastography provides a cost effective, non-invasive measure of liver fibrosis useful in diagnosis and monitoring progression.

ABSTRACT NO. 39 (17W143) POSTER PRESENTATION

Is The Neutrophil-Lymphocyte Ratio A Useful Biomarker To Predict Sub-Therapeutic Infliximab Trough Levels In Inflammatory Bowel Disease Patients?

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Introduction
The neutrophil-lymphocyte ratio (NLR) has been investigated previously as a possible biomarker for loss of response to Infliximab (IFX) therapy in patients with Inflammatory Bowel Disease (IBD), predicting severity of disease and for its diagnostic value in patients with Crohn's disease.

Aims/Background
The aim of our study was to identify if NLR could be used as a biomarker for early recognition of sub-therapeutic IFX trough levels in our cohort of IBD patients receiving IFX.

Method
A retrospective study was performed on patients with IBD receiving IFX between 2015 and 2017 in our Infusion Unit.

Results
113 patients with IBD were included in the study. The prevalence of sub-therapeutic IFX trough levels was 30% (N=34) at the time of first trough level measurement. The Receiver Operating Characteristic (ROC) curve was used to identify the optimal cut-off point for the NLR which was calculated as a NLR ^{3} 2.3. This cut-off point had a sensitivity of 59.3% (95% CI : 0.41- 0.76) and specificity of 53.9% (95% CI: 0.42-0.64) for identifying IBD patients with a sub-therapeutic IFX trough level. The negative predictive value was 76.79% (95% CI: 0.67- 0.84).

Conclusions
Sub-therapeutic IFX levels were a common occurrence in our study cohort (30%). The results would suggest that the NLR ratio would not be adequate as a sole biomarker for early recognition of sub-therapeutic IFX trough levels. However, it may be more effective if utilised in conjunction with other biomarkers having the advantage of being readily available and at low cost.

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

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*Conor Byrne**

Prescribing Information **Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe or Humira 40mg/0.8ml solution for injection for paediatric use. Refer to Summary of Product Characteristics (SmPC) for full information. Presentation:** Each 0.4 ml single dose pre-filled pen or pre-filled syringe contains 40mg of adalimumab. Each 0.8 ml single dose vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA), adults: In combination with methotrexate (MTX) for moderate to severe, active RA with inadequate response to disease-modifying anti-rheumatic drugs (DMARDs) including MTX. In combination with MTX for severe, active and progressive RA when not previously treated with MTX. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Reduces rate of progression of joint damage on X-ray and improves physical function, in combination with MTX. Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above: In combination with MTX, for active pJIA, with inadequate response to one or more DMARDs; or monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Enthesitis-related arthritis (ERA), paediatrics 6 years and above: For active ERA with inadequate response or intolerance to, conventional therapy. Psoriatic arthritis (PsA), adults: For active and progressive PsA with inadequate response to DMARDs. Reduces rate of progression of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function. Ankylosing spondylitis (AS), adults: For severe active AS with inadequate response to conventional therapy. Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: For severe nr-axSpA with objective signs of inflammation (elevated CRP and / or MRI), and an inadequate response to, or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs). Crohn's disease (CD), adults: For moderately to severely, active CD with inadequate response, contraindication or intolerance to corticosteroid and/or an immunosuppressant therapy. Crohn's disease (CD), Paediatrics 6 years and above: For moderately to severely active CD with inadequate response, contraindication or intolerance to conventional therapy including primary nutrition therapy and a corticosteroid, and/or an immunomodulator. Psoriasis (Ps), adults: For moderate to severe chronic plaque psoriasis who are candidates for systemic therapy. Psoriasis, paediatrics 4 years and above: For severe chronic plaque psoriasis with inadequate response, or if topical therapy and phototherapies are inappropriate. Hidradenitis suppurativa (HS), adults and adolescents from 12 years of age: For active moderate to severe hidradenitis suppurativa (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Ulcerative colitis (UC), adults: For moderately to severely active UC with inadequate response, contraindication or intolerance to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Uveitis, adults: For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. **Dosage and administration:** Specialist physicians experienced in the diagnosis and treatment of the condition, to initiate and supervise treatment. Ophthalmologists to consult with an appropriate specialist before initiation of treatment. Provide patients with special alert card. Patients may self-inject after proper injection training, with physician approval and appropriate medical follow-up. Optimise other concomitant therapies. RA, adults: 40mg dose every other week. Concomitant MTX should be continued. During monotherapy patients may require 40 mg each week if they experience a decrease in clinical response. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Consider need for dose interruption, e.g. before surgery or if serious infection occurs. Re-introduction after 70 days dose interruption gave same magnitudes of clinical response and similar safety profile as before dose interruption. pJIA, paediatrics 2 years and above: Treatment beyond 12 weeks reconsidered if no clinical response in that time. pJIA, paediatrics 2-<4 years: 24mg/m² body surface area up to 20mg maximum single dose every other week (see vial SmPC for height/weight dosing chart). pJIA, paediatrics 4-12 years: 24mg/m² body surface area up to 40 mg maximum single dose every other week (see vial SmPC for height/weight dosing chart). pJIA, paediatrics 13 years and above: 40mg every other week regardless of body surface area. ERA, paediatrics 6 years and above: 24mg/m² body surface area up to a maximum single dose of 40mg every other week. (see vial SmPC for height/weight dosing chart). PsA, AS and nr-axSpA, adults: 40 mg every other week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD: Adults: Induction: 80mg at Week 0 followed by 40mg at Week 2. For a more rapid response, 160mg at Week 0 (either as 4 injections in 1 day or 2 injections/day for 2 consecutive days), 80mg at Week 2; risk of adverse events higher during induction. Maintenance: 40mg every other week. If decrease in clinical response, can increase dose to 40 mg weekly. Corticosteroids may be tapered in maintenance phase in accordance with clinical guidelines. Patients with no response by Week 4 may benefit from continued therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above<40Kg: Induction: 40mg at Week 0, 20mg at Week 2. For a more rapid response: 80mg at Week 0 (2 injections in 1 day), 40mg at Week 2; risk of adverse events higher during induction. Maintenance: 20mg every other week. If insufficient response, consider 20mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above ≥40Kg: Induction: 80 mg Week 0, 40 mg at Week 2. For a more rapid response: 160 mg at Week 0 (4 injections in 1 day or 2 injections/day for 2 consecutive days), 80 mg at Week 2; risk of adverse events higher during induction. Maintenance: 40 mg every other week. If insufficient response, consider 40 mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Psoriasis, adults: 80mg induction dose at week 0, 40mg every other week from week 1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. Beyond 16 weeks, patients with inadequate response can increase dosing frequency to 40 mg every week. If adequate response is achieved with an increased dosing frequency, dose may subsequently be reduced to 40 mg every other week. If there is inadequate response to the increased frequency, carefully reconsider treatment. Psoriasis, Paediatrics 4 years and above: 0.8 mg per kg body weight (maximum of 40 mg/dose) weekly for the first 2 doses and then every other week (see vial SmPC for weight dosing chart). Treatment beyond 16 weeks should be reconsidered if no response in that time. HS: Adults: 160mg initially at Day 1 (four 40mg injections in one day or two 40mg injections per day for two consecutive days), followed by 80 mg two weeks later at Day 15 (two 40mg injections in one day). Two weeks later (Day 29) continue with a dose of 40 mg every week. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions should be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Reintroduction after interruption: 40 mg every week. Evaluate periodically the benefit and risk of continued long-term treatment. HS, adolescents from 12 years of age weighing at least 30 kg: 80 mg initially at week 0 (given as two 40 mg injections on day one). 40 mg injection in week 1 followed by 40mg every other week. In adolescent patients with inadequate response to Humira 40 mg every other week an increase in

*Not a real patient.

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

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dosing frequency to 40 mg every week may be considered. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions should be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. UC: Adults: Induction: 160mg at week 0 (4 injections in 1 day or 2 injections / day for 2 consecutive days) and 80mg at week 2. Maintenance: 40mg every other week. During maintenance, corticosteroids may be tapered in accordance with clinical practice guidelines. If insufficient response, consider 40mg every week. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time. Uveitis: Adults: 80 mg induction dose at week 0, 40 mg every other week from week 1. Experience of initiating treatment with Humira alone is limited. Treatment can be initiated in combination with corticosteroids and/or other non-biologic immunomodulatory agents. Two weeks after initiating treatment, concomitant corticosteroids may be tapered in accordance with clinical guidelines. Evaluate on a yearly basis, the benefit and risk of continued long term treatment. **Contraindications:** Active tuberculosis (TB), severe infections (e.g. sepsis), and opportunistic infections; moderate to severe heart failure (NYHA class III/IV); hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings:** Clearly record trade name and batch number of administered product to improve traceability of biological medicinal product. ***Infections:*** Patients are more susceptible to serious infections especially if impaired lung function. Monitor for infections, including TB, before, during and for 4 months after treatment. Do not initiate treatment with an active infection, until it is controlled. Consider risk/benefit prior to treatment in patients exposed to high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections. ***Serious infections:*** Serious infections, including those with hospitalisation or death reported in patients receiving treatment. ***TB:*** Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (disseminated) reported. Screen all patients before therapy initiation for active or latent TB. If active TB is diagnosed Humira therapy must not be initiated. If latent TB is suspected, consult a physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Humira. Despite prophylaxis TB reactivation has occurred on Humira. ***Other opportunistic infections:*** Opportunistic infections observed in patients receiving Humira. Stop treatment in patients with signs and symptoms of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients. ***Hepatitis B Reactivation:*** Reactivation has occurred in chronic carriers (i.e. surface antigen positive) tested for HBV infection before initiating treatment. HBV carriers should consult with a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of Humira. If reactivation occurs stop treatment and initiate appropriate anti-viral and supportive treatment. ***Neurological events:*** Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders and consider stopping treatment if these disorders develop. Rare association with new onset or exacerbation of symptoms and/or radiographic evidence of central and peripheral demyelinating disease. Known association between intermediate uveitis and central demyelinating disorders. Evaluate patients with non-infectious intermediate uveitis before therapy initiation and regularly during treatment to assess for pre-existing or developing central demyelinating disorders. ***Allergic reactions:*** Reports of serious allergic reactions including anaphylaxis received. For serious allergic or anaphylactic reaction stop Humira immediately and initiate appropriate therapy. ***Malignancies and lymphoproliferative disorders:*** A possible risk of malignancy, including lymphoma and leukaemia, in all patients including paediatric patients, treated with TNF antagonists. Monitor all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment for non-melanoma skin cancer prior to and during Humira therapy, caution in COPD patients, and in patients with increased risk of malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Humira (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk for developing dysplasia or colon cancer is unknown. Patients with UC, prior history of dysplasia or colon carcinoma to be screened for dysplasia before therapy and during treatment. ***Haematologic reactions:*** Adverse events of the haematologic system reported with Humira. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias. ***Vaccinations:*** Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to Humira treatment. ***Congestive heart failure:*** See contraindications. Caution is advised in mild heart failure (NYHA class I/II). Discontinue treatment for new or worsening symptoms of congestive heart failure. ***Autoimmune processes:*** Autoimmune antibodies may form. Stop treatment if development of a lupus-like syndrome with positive antibodies against double-stranded DNA. ***Surgery:*** Consider the long half-life of Humira for planned surgical procedures. Closely monitor for infections. ***Small bowel obstruction:*** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture requiring surgical treatment. ***Elderly:*** Serious infections were higher in patients over 65 years of age, some of whom had fatal outcomes. Consider risk of infection. **Interactions:** Combination of adalimumab with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Fertility, pregnancy and lactation:** Not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. Women must not breast-feed for at least five months after the last treatment. **Side Effects:** *Very common ≥ 1/10:* Infections, leukopenia, anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction. **Serious, including fatal, side effects have been reported** including infections/sepsis, intestinal perforation, opportunistic infections, TB, endemic mycoses, demyelinating disease, malignancies including lymphoma (including hepatosplenic T-cell lymphoma), leukaemia and skin cancer (including melanoma and merkel cell carcinoma), cytopenias, worsening heart failure, myocardial infarction, pulmonary embolism, pleural effusion, pulmonary fibrosis, cerebrovascular accident, interstitial lung disease, lupus, Stevens-Johnson syndrome, angioedema, anaphylaxis, sarcoidosis, hepatitis, liver failure and worsening of symptoms of dermatomyositis. **Prescribers should consult the SmPC for the complete list of reported side effects. Legal Category:** POM. **Marketing Authorisation Numbers/Presentations**: Vial: EU/1/03/256/001; Pre-filled Syringe: EU/1/03/256/013; Pre-filled Pen: EU/1/03/256/017. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24. **HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Date of revision of PI:** January 2017, PI/256/018

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ABSTRACT NO. 40 (17W144) POSTER PRESENTATION

Accumulation Of Lactate In The Tumour Microenvironment Induces Apoptosis Of Liver Resident Natural Killer Cells.

Author(s)
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Introduction
Natural Killer (NK) cells are enriched in human liver, accounting for 30-50% of intra-hepatic lymphocytes. We identified a population of liver resident (lr) NK cells with a unique phenotype. These cells rapidly degranulate and kill tumour cells.

Aims/Background
Here we investigate changes in lrNK cells in liver malignancies with a view to identifying novel immunotherapeutic targets for CRLM.

Method
Liver biopsies were obtained from patients undergoing resection for colorectal metastasis (CRLM) (n=15) and hepatocellular carcinoma (HCC) (n=6). Donor liver perfusate and biopsies were taken during transplantation. Conditioned media (CM) was generated by culturing healthy (LCM) or malignant tissue (TCM) for 72hrs. LrNK cells isolated from liver perfusate were treated with either LCM or TCM and cell viability and function analysed.

Results
Changes in the liver microenvironment in CRLM appear to specifically affect lrNK cells. NK cells are depleted from CRLM (10.9±2.3%) but not surrounding healthy tissue (26.2±5.8%, p=0.0019), with the largest depletion in lrNK cells. This depletion is not seen in HCC. TCM from CLRM induces significant apoptosis of lrNK cells (43.7±4.7%) compared to non-resident NK cells (8.1±2.4%). Lactate, a by-product of tumour metabolism, is increased in tumour tissue. In vitro lactic acid induces significant apoptosis in lrNK cells.

Conclusions
We have described resident NK cells which show enhanced degranulation in healthy human liver. These lrNK cells are reduced in CRLM but not HCC. LrNK cells appear sensitive to changes in the microenvironment caused by metastatic tumour metabolism. Therapeutically targeting tumour metabolism could therefore restore local immunosurveillance and enhance the efficacy of immunotherapy.

ABSTRACT NO. 41 (17W148) POSTER PRESENTATION

Management of Patients with Peripheral Oedema associated with Liver Cirrhosis, in an Outpatient Setting.

Author(s)
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Introduction
Progressive, severe peripheral oedema due to decompensated cirrhosis refractory to oral diuretics is debilitating and can lead to repeated prolonged hospitalisation.
Human Albumin Solution (HAS) is indicated during paracentesis and in the treatment of Hepatorenal Syndrome and Spontaneous bacterial peritonitis, preserving effective circulating volume. HAS is also used as an adjunct in inpatients for the treatment of peripheral oedema.

Aims/Background
To demonstrate the benefits of ambulatory Forced Diuresis (FD) for the management of severe peripheral oedema in cirrhotic patients.

Method
Patients were identified by consultant hepatologists. Treatment was IV Furosemide 40-60mg alongside 10g HAS 2-3 times per week in the Ambulatory Care Centre (ACC). Weights, biochemical and clinical assessments were performed at each visit.

Results
Patient 1 with Alpha-1-Antitripsin deficiency/NASH cirrhosis, refractory peripheral oedema and ascites was referred for outpatient FD following 5 hospitalisations for FD and paracentesis. Between November 2015 and June 2016, she attended ACC 40 times and had only 2 admissions to hospital during this time, both for encephalopathy. She underwent successful transplantation in June 2016
Patient 2 with Primary Biliary Cholangitis associated cirrhosis and peripheral oedema requiring two 8 day admissions for FD. He attended ACC 70 times for FD performed June 2016-March 2017 with only 1 further admission due to epistaxis. He underwent successful transplantation in April 2017.

Conclusions
Ambulatory FD resulted in decreased hospitalisation and improved overall quality of life prior to liver transplantation. It is an option for management of peripheral oedema in selected decompensated cirrhotics, however further studies are required.

ABSTRACT NO. 42 (17W149) POSTER PRESENTATION

CT impact in the management of diarrhea in the emergency setting

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Introduction
CT use is widespread for the diagnosis and staging of multiple diseases, however its role for assessment of patients with or without bloody diarrhea is limited.

Aims/Background
Review all patients with diarrhea who had a CT scan done in A&E and its correlative endoscopic findings.

Method
We collected retrospective data of all patients who presented to A&E in 2016 with or without bloody diarrhea and also had a CT scan performed. Endoscopy reports, microbiological and bloods results were analyzed.

Results
77 patients had a CT while in A&E; 13 patients (16%) had a normal CT, 34 (40%) bowel thickening (3 of them isolated small bowel thickening), 9 (12%) diverticulitis, 5 (6%) appendicitis and 16 (21%) other pathology. Amongst the patients with normal CT only 1 patient had UC.
12 patients (39%) out of the 31 patients who had large bowel thickening on the CT presented with bloody diarrhea and abdominal pain and 14 patients (35%) had pancolitis on CT. 7 patients (22%) had positive bacterial stool culture. Out of the 22 patients (71%) who had colonoscopy because of CT findings 8 patients (36%) had normal colonoscopy while 3 (17%) had IBD and another 3 (17%) ischaemic colitis. Rest had non-specific findings on colonoscopy.

Conclusions
Bowel thickening on CT is a nonspecific finding reported in almost 40% of patients with diarrhea in our group. Its diagnostic significance is poor as 36% of them had a normal scope. However, despite a normal CT, a colonoscopy/sigmoidoscopy might be warranted in selected patients.

ABSTRACT NO. 43 (17W150) POSTER PRESENTATION

Clinical outcome of older cohort of patients with Inflammatory Bowel Disease on anti- tumour necrosis factor treatment

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Introduction
Ageing population coupled with increasing incidence and prevalence of inflammatory bowel disease (IBD) will lead to an increase in the number of older patients with this condition. Anti-tumor necrosis factor (TNF) therapy has revolutionized the treatment of IBD. However, information about ef?cacy and safety of anti-TNF therapy in elderly cohort is limited.

Aims/Background
To evaluate clinical outcome and safety for the older IBD patients (60 years old and above) commencing on anti-TNF treatment.

Method
Clinical and laboratory database were reviewed to identify study subjects. Clinical benefit is defined as 3&12 months remission by impression of physician, continuous use of drug, and absent of surgery.

Results
24 patients were identified,13 female (54%),mean age at anti-TNF initiation of 67.84(minimum 60.20, maximum 81.10),with mean duration of disease 16.12 years(minimum 0.46, maximum 47.71). 19 have Ulcerative Colitis (79%), 5 with Crohn's Disease (21%). 12 were on adalimumab, 9 on infliximab and 3 on golimumab. Indications of treatment were steroid refractory (7),steroid dependant(4),failure or side effect of conventional treatment therapy(11),and secondary loss of response to other biologic(2).7 were on concurrent immunomodulators. 71% were on steroid during the commencement of anti-TNF therapy. 3 and 12 months remission rate was 67% and 46% respectively.50% of Anti-TNF therapy was discontinued. Mean time on drug was 1.69 years. 5 patients (21%) required surgical intervention after anti-TNF. There were 3 cases (12.5%) associated with adverse events (urosepsis, rash, arthralgia), with no mortality.

Conclusions
Anti-TNF is effective in elderly cohort, but it should be used with careful consideration of the risks involved.

ABSTRACT NO. 44 (17W153) POSTER PRESENTATION

The urea breath test in diagnosis of Helicobacter pylori infection: Can it also predict success of treatment?

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Introduction
The urea breath test (UBT) is the gold standard non-invasive test for H. pylori infection in Ireland. The DOB value is potentially reflective of the amount of bacteria present in the stomach and could predict whether the infection is eradicated.

Aims/Background
This study investigated whether there is an association between DOB and eradication of H. pylori infection in Ireland.

Method
Results from treatment naïve adult patients undergoing UBT were reviewed. Positive patients (DOB value of >4.0 ‰) were categorised into low (<16 ‰), intermediate (16-35 ‰) and high (>35 ‰) groups. A follow-up breath test was performed at least 8-weeks post-treatment to confirm eradication.

Results
Pre- and post-treatment UBT results from 155 H. pylori-positive patients who had undergone eradication therapy were available for analysis (mean age 44.2 ±15.1 years, 39.4% male). There was no significant difference in age and gender between the three groups (p=0.07 and p=0.52 respectively). Regardless of DOB values, the overall eradication rate was 61.3% (95%CI: 53.4-68.6%, per-protocol analysis). Eradication rates in the low, intermediate and high UBT groups were 65.7% (46/70), 57.7 % (30/52) and 57.6 % (19/33) respectively (p=0.59). When eradication was successful, the average DOB value was lower, at 22.7 ‰ compared to 25.8‰ when eradication was unsuccessful, however no significant difference was observed (p=0.3, 95% CI-2.6 to 8.9).

Conclusions
This study found no significant association between DOB value and

the eradication rate of H. pylori. Although there was a trend towards increasing DOB values and decreasing eradication rate, this was not statistically significant (p=0.59).

ABSTRACT NO. 45 (17W154) POSTER PRESENTATION

The Changing Patterns Of A Model-3 Outpatient Hepatology Unit, 2002-2016: A Retrospective Descriptive Study

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Introduction
Liver disease causes substantial health and economic burden worldwide; mortality rates have recently increased four-fold and it is the third most common cause of premature death in the UK. Similar trends are observed in Ireland. Specialised outpatient follow-up is associated with improved outcomes and reduced healthcare costs. Nurse-based and nurse-led clinics have been introduced in our hospital to serve the growing demand.

Aims/Background
To assess the outpatient hepatology clinic throughput in a model-3 hospital over a fourteen-year period and to:
- Describe the number of consultations seen annually
- Characterise consultations as either medical, nurse-led or nurse-based annually
- Examine the changing care of chronic liver disease

Method
Information was obtained from outpatient hepatology patients over a fourteen-year period including: nursing consultations, medical consultations, viral/alcoholic liver disease (ALD) status and liver biopsy counselling.

Results
- Hepatology clinic throughput has grown by 44% (781-1401); this is reflected in the three-fold increase in new patients (149-535) and the development of nurse-based care, where a forty-fold growth increase (22-906) was observed.
- Interestingly, ALD attendance fell over the period; however, is now increasing again.
- The use of liver biopsies has fallen considerably (by 75%, 47-11 p.a.) over the 14-years.

Conclusions
The introduction of nurse-led clinics has facilitated the growing specialist outpatient care of patients with liver disease. Furthermore specialist nurses deliver many services (including counselling) and unrecorded interactions not measured in this study. Close liaison between medical and nursing specialist enables the on-going management of patients despite the large increase in burden of liver disease.

ABSTRACT NO. 46 (17W155) POSTER PRESENTATION

Tumour Infiltrating Cd11c+ Cells Correlate With Cd8+ T Cells In A Subset Of Colorectal Cancer (Crc) Tumours

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Introduction
Tumours highly infiltrated with cytotoxic CD8+ T-lymphocytes are strongly associated with a better prognosis in colorectal cancer (CRC). However, the role of the myeloid response has yet to be fully elucidated. Previous work carried out by our lab employing flow cytometer, identified a CD11c+HLA-DR+ myeloid cell subset unique to the CRC tumour microenvironment with a distinct immunoregulatory phenotype.

Aims/Background
The purpose of this study was to investigate the localisation of CD11c+ cells in-situ and their relationship with CD68 macrophages and CD8 cytotoxic T-lymphocytes.

Method
Whole paraffin embedded tissue sections were stained for CD11c, CD8 and CD68 using immunohistochemistry in a cohort of 71 CRC patients. Additional inflammatory parameters were assessed including, Crohn's-like lymphoid response, Klintrup-Mackinen score, neutrophils, eosinophils, and plasma cells.

Results
Both CD11c and CD68 identify 2 distinct non-overlapping cell populations in normal tissue. In tumour tissue this clear separation in cell lineage is lost, both CD11c and CD68 show a striking similarity in staining pattern. Based on CD11c and CD8 expression 4 immune groups were identified; CD11chiCD8hi (21%), CD11cloCD8lo (42%), CD11cloCD8hi (13%), CD11chiCD8lo (24%). In the CD11chiCD8hi immune group, 75% were proximal tumours. Proximal tumours were smaller in size (<5cm) (p=0.013), and associated with positive prognostic features including microsatellite instability (p<0.001), absence of budding (p=.030) and extramural venous invasion (p=.026).

Conclusions
This study highlights a potential role for CD11c+ cells in driving a protective immune response in a subset of CRC tumours. Future investigation of the impact of these immune groups on patient prognosis and survival will be beneficial.

ABSTRACT NO. 47 (17W156) POSTER PRESENTATION

Are We Over Investigating Young Patients with Dyspepsia?

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Introduction
Dyspepsia is a common reason for referral for OGD in young patients in our trust.
NICE 2014 guidelines for dyspepsia suggest non-invasive testing for helicobacter pylori and eradication if positive, along with empirical treatment with PPI therapy ('test and treat' strategy). Patients who have alarm symptoms or persistent symptoms despite acid suppression should be referred for endoscopy.
We reviewed the referrals and results of OGDs for dyspepsia and other indications in patients under 40 years of age.

Aims/Background
To review indications and results of young patients undergoing OGDs.
Assess current use of pre-endoscopy NICE guidelines in dyspepsia.
Method
200 outpatient procedures were selected randomly from January to June 2016. Data collection involved reviewing clinical notes from the Northern Ireland Electronic Care Record and endoscopy reports from the online endoscopy reporting tool.

Results
The most common indication was dyspepsia (54%) followed by dysphagia (12%) and abdominal pain (9.5%).
24% of patients who had an endoscopy for dyspepsia had a prior Urea breath test (UBT).
Most common priority of referral was on an urgent basis (83%) followed by Red Flag referrals (11%).
41% of patients had a normal OGD.
Common abnormalities were gastritis (15%), Hiatus Hernia (14%) and Reflux Oesophagitis (13%).
No upper GI cancers were identified.

Conclusions
This study demonstrates a low yield for significant pathology at endoscopy when performed in patients under 40 years of age.
There is poor adherence to the 'test and treat' strategy. Education on NICE guidance may reduce unnecessary endoscopy.

ABSTRACT NO. 48 (17W157) POSTER PRESENTATION

Fenestrated Endoscopic Sphincterotomy facilitates high duct clearance of large common bile duct stones 10 to 20mm in size in patients with naïve ampullas.

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Introduction
Our unit performs a Fenestrated Endoscopic Sphincterotomy (FES), whereby a complete sphincterotomy is performed with further use of the sphincterotome to make further smaller incisions of the sphincter at different angles. These additional smaller incisions facilitate the clearance of large CBD stones with decreased need for additional modalities such as mechanical lithotripsy (ML).

Aims/Background
To assess the duct clearance of large CBD stones 10mm to 20mm in size.

Method
Electronic recording system (EndoRaad) was used to identify all patients that meet our inclusion criteria: CBD stone =10mm and =20mm. Exclusion criteria: previous sphincterotomy, biliary strictures and where the intention was to provide biliary drainage alone and not duct clearance (pregnancy, coagulopathy and patients deemed too frail for intervention). Demographics, duct clearance rates (at index and subsequent procedures), number and size of CBD stones, and anatomical variants were recorded. SPSS v22 was used for statistical analysis.

Results
105 consecutive patients were analysed. Duct clearance rate was 82.9% (87/105) at index ERCP, and 95.2% (100/105) with further ERCP. Only 11.4% 912/105) of patients required use of ML at index ERCP. 13 patients achieved duct clearance on further ERCP; 2 required ML and sphincteroplasty, 5 ML alone and 2 sphincteroplasty alone. 3 patients didn't require further modality beyond balloon trawl to clear duct on repeat ERCP. 5 patients failed endoscopic therapy to clear duct; 4 had distal CBD tapering and 1 patient had an impacted stone.

Conclusions
FES enables high duct clearance with low utilization of further endoscopic modalities in CBD stones 10mm to 20mm in size.

ABSTRACT NO. 49 (17W158) POSTER PRESENTATION

Compliance with National Quality Guidelines in patients undergoing colonoscopy in St. Luke's Hospital Kilkenny.

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Introduction
Quality improvement guidelines for endoscopy are updated regularly. The targets for colonoscopy outlined in these guidelines include caecal intubation (CI) rate, comfort score, polyp detection rate (PDR), quality of bowel preparation and sedation/analgesia administered.

Aims/Background
To compare the quality of colonoscopy provided by our Gastroenterology team with National Standards guidelines.

Method
Electronic reporting system was used to extract data on all coloscopies performed by the gastroenterology team from July 2016 to June 2017. SPSS was used for statistical analysis.

Results
Demographics: 53.8% female (232/431), 24% =70 years (105/431). The mean age was 55.1,years (standard deviation 18.4). CI was achieved in 91% of cases (target =90%). A comfort score of 1/2 was observed in 81% of patients (target =80%). The PDR was 18.1% (target 20%), and 23% (61/265) if patients less than 50 years were excluded. An excellent/adequate bowel preparation was observed in 84% (361/431) which is below target of 90%. Regarding sedation/analgesia, in the =70-year olds, the median midazolam dose was

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4mg (target =5mg), and median fentanyl dose was 100mcg (target =100mcg). In the over =70-year olds, the median midazolam was 3mg (target =3mg), and median fentanyl was 50mcg (target =50mcg). 37 colonoscopies (8.5%) were incomplete. Patients =70 years were less likely to have an adequate bowel prep or complete colonoscopy compared to younger patients (77.1 vs 85.9% and 81.9% vs 94.5% respectively, both p<0.001).

Conclusions
Sedation and CI targets were met. Further study to assess reasons for poor rates of bowel prep and CI in older patients is warranted.

ABSTRACT NO. 50 (17W159) POSTER PRESENTATION

Needs MUST – An Audit Of Nutritional Screening In An Acute Hospital

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Introduction
Malnutrition is common amongst hospital inpatients, affecting up to one in four patients. It is associated with increased complication rates and delayed recoveries. High risk patients include those with gastrointestinal disease, malignancy and dementia. National (and international) guidelines recommend that nutritional screening should be performed for all patients within 24hours of admission. The gold standard screening tool is the 'Malnutrition Universal Screening Tool' (MUST). If a patient is at high risk for malnutrition on screening, referral should be made to a dietician.

Aims/Background
We aimed to review compliance with our nutritional screening programme.

Method
This was an audit performed over a 24-hour period. Both medical and surgical wards were audited. Data including patient demographics, nutritional screening pro forma (in admission nursing notes) and co-morbidities were collected directly from patient medical records. Chi-squared testing was used to assess categorical data.

Results
113 patients were included in this study. 42.9% (n=48) were male. The mean age was 69.3 years (SD 18.7). Only 22.12% (n=25) of MUSTs were completed; with 92% of them completed within the recommended 24hours. No difference was observed in patients with or without a MUST completed in terms of age, admitting diagnosis, co-morbidities or duration of hospital stay.

Conclusions
There was poor compliance with guidelines. This presents a missed opportunity to improve outcomes and costs. A further re-audit after intervention is required. "My poor body, madam, requires it: I am driven on by the flesh; and he MUST NEEDS go that the devil drive." – Shakespeare, All's Well That Ends Well.

ABSTRACT NO. 51 (17W160) POSTER PRESENTATION

An Audit of Compliance with Key Quality Targets in Upper GI Endoscopy

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Introduction
The National Guidelines in Gastrointestinal Endoscopy Quality Improvement aim to ensure high quality upper GI endoscopy.

Aims/Background
To compare the quality of gastroscopy provided by our Gastroenterology service with the National Standards as published by the conjoint board of RCPI and RCSI in 2017 – version 5.0.

Method
EndoRaad was used to compile data on all patients who underwent gastroscopy by the Gastroenterology department in St. Luke's Hospital, Kilkenny from July 2016 to June 2017. The midazolam dosage, as well as percentage of cases with successful oesophageal and D2 intubations were compared with the National Standards. Coefficient of Variation (CoV) was used to assess for variability amongst endoscopists.

Results
574 gastroscopies were performed in a 12 month period, with 36% (205/574) performed in patients above 70 years. The median quantity of Midazolam both above and below 70 years of age was 4mg. This complies with the standards in patients <70 years of age. However in patients >70 years, the median quantity of Midazolam exceeds the recommended dosage for this patient cohort. There was a 99.6% and 96.9% success rate in oesophageal and D2 intubations respectively. CoV revealed no significant variation between endoscopists.

Conclusions
Needs for relatively high sedation rates in older pateints warrants further study, ancedotal evidence suggests social factors may play a role.

ABSTRACT NO. 52 (17W161) POSTER PRESENTATION

The Importance of Patient Selection In PEG Insertion

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Introduction
When inappropriately inserted, Percutaneous endoscopic gastrostomy (PEG) can be associated with significant morbidity and mortality. All PEG requests should be reviewed prior to insertion. The Sheffield Gastrostomy Scoring System (SGSS) predicts 30-day mortality following PEG insertion, using a patient's age and serum albumin level.

Aims/Background
To review consecutive PEG insertions.

Method
We performed a retrospective review of PEG insertion in our department from January 2016 to September 2017. Data on patient demographics, indications, pre-PEG albumin levels and procedure information were collected. Using the SGSS, gastrostomy scores were calculated and compared to actual 30-day mortality rates.

Results
36 PEG insertions were included. The mean age was 67.6years (SD 17.5), with 80.6% (n=29) of patients greater than 60 years. The main indications included acute neurological events (n=25, 69.4%), neurodegenerative disorders (n=5, 13.9%) and the re-insertion of pre-existing PEGs (n=4, 11.1%). No immediate complications were documented. There was a 97.2% (n=35) PEG insertion success rate. The overall 30-day mortality was 8.3% (n=3). A PEG was not inserted in one of these patients (failed PEG n=1) due to post-surgical distorted anatomy. This patient was included in the review due to an intention to treat basis. 13.9% of patients (n=5) had a SGSS score of 3. In this group, a 40% (2/5) 30-day mortality rate was observed; correlating with the SGSS predicted mortality of 37.3%.

Conclusions
This review demonstrates our strict patient selection for PEG insertion. The SGSS can help in conjunction with clinical review to highlight patients who are high risk for PEG insertion.

ABSTRACT NO. 53 (17W162) POSTER PRESENTATION

Expert Dietician Department Reduce PEG Referral Burden on Gastroenterology Department

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Introduction
Multidisciplinary teams are crucial in the management of percutaneous endoscopic gastrostomies (PEGs). In St Luke's Hospital, we have a Nutrition and Dietetics Department with special interest in the care of patients with PEGs. They run a dietician-led PEG service, providing both inpatient and outpatient care. In the community, they have educated more than 200 nurses to manage PEG tubes.

Aims/Background
To review all referrals made to our Nutrition and Dietetics Department for PEG related complications.

Method
We performed a retrospective study of PEG complication referrals. Data was collected by our senior dietician. Data collected included patient demographics, complications and management.

Results
323 PEG complication referrals were made from January 2014 to September 2017, with a total of 413 complications observed. The majority of patients (n=113, 34.98%) were seen in our specialised dietician-led PEG clinic. Referrals were also made from adult inpatient wards (n=106, 32.8), the paediatric ward (n=53, 16.4%), the Acute Medical Assessment Unit (n=41, 12.7%), and other sites (n=10, 3.1%). The most common complication was 'missing components' (n=76, 18.4%), followed by 'dislodgement' (n=60, 14.5%) and hyper-granulation/erythema (n=59, 14.3%). 89.5% (n=289) of referrals were solely managed by dieticians, including PEG changes. Doctors were involved in cases regarding medication changes and complex anatomy/PEG sites.

Conclusions
The majority of PEG related complications observed over approximately 3.5 years were managed by our dietician-led PEG service. This greatly reduces the burden of PEG referrals on the Gastroenterology department.

ABSTRACT NO. 54 (17W163) POSTER PRESENTATION

Osteoporosis Screening In Inflammatory Bowel Disease

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Introduction
Patients with inflammatory bowel disease (IBD) are at increased risk of osteoporosis and osteoporotic fractures. The European Crohn's and Colitis Organisation recommend Dual-energy X-ray absorptiometry (DEXA) Screening for IBD patients with risk factors for osteoporosis, including those requiring greater than three months of corticosteroid treatment and patients over 65 years.

Aims/Background
To assess the proportion of at-risk IBD patients undergoing DEXA scanning in a specialised IBD centre.

Method
IBD patients diagnosed and subsequently treated in St. Vincent's University Hospital (SVUH) in 2015 were identified from a prospectively maintained database. All patients that were either over 65 years of age and/or received > 3 months continuous or cumulative cortocosteroid treatment were identified and cross-referenced with the institutional radiology reporting system to see if they underwent DEXA scanning.

Results
Eighty-nine patients were diagnosed with IBD in 2015 in SVUH. Thirty four (38.2%) underwent treatment with oral corticosteroids for greater than three months, but only four of these patients have undergone DEXA scanning (5.88%). Five patients in this cohort were over the age of 65, but none underwent DEXA scanning despite three being on long-term corticosteroid treatment.

Conclusions
The IBD population are at risk of developing osteoporosis, particularly the elderly and those on long-term corticosteroids. The current level of DEXA scanning at our unit is not in line with guidelines suggesting that greater awareness regarding the risk of osteoporosis in IBD is needed.

ABSTRACT NO. 55 (17W165) POSTER PRESENTATION

Does Indication Have An Association With Small Bowel Capsule Transit Time (SBCTT) and Diagnostic Yield?

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Introduction
There are clear ESGE guidelines for the use of Small Bowel Capsule Endoscopy (SBCE), the use of bowel prep is routinely recommended but there are queries about its overall efficacy. Studies have suggested that longer transit times can increases diagnostic yield. Factors that influence SBCTT are not fully understood.

Aims/Background
To evaluate whether indication affects SBCTT and diagnostic yield.

Method
We collected data from all capsule endoscopies performed in Tallaght Hospital from 2015 to 2016 inclusively. We excluded capsules with incomplete reports. SBCTT and diagnostic yield was compared according to referral group. A p value of <0.05 was considered significant.

Results
649 SBCE's with complete data sets were identified, 313(48%) males, and mean age 52.9(16-93). Indication for SBCE; IBD diagnosis and assessment 233(36%), Coeliac Disease diagnosis and assessment 16(2%), obscure occult GI bleeding including anaemia 330(51%), obscure overt GI bleeding 22 (3%), lesion assessment 9(1%), abnormal radiology 9(1%), and others 30(5%).
Overall mean SBCTT was 241 (21-717) minutes and overall 288(44%) had a positive SBCE. There were no significant difference in SBCTT according to referral groups except for coeliac disease which was significantly longer (296v240, p< 0.01). Mean overall SBCTT was significantly longer for positive studies, (256v229, p=0.006 95% CI 12.01- 43.4) and within the IBD group (222.3v256.6 p<0.02) but not for other indications.

Conclusions
SBCTT is positively associated with diagnostic yield. Indication can affect SBCTT. This study brings into question the regular use of prep pre-SBCE which can reduce transit times and suggests selective use according to indication should be considered.

ABSTRACT NO. 56 (17W166) POSTER PRESENTATION

Percutaneous Transhepatic Cholangiography For Malignant Biliary Obstruction –A Large Single Centre Study

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Introduction
Percutaneous transhepatic cholangiography (PTC) may be used for drainage of malignant biliary disease where endoscopic intervention has failed or is unlikely to benefit.

Aims/Background
We examined the indications, complications and outcomes in PTC patients in a large single centre study.

Method
A 5-year retrospective review of patients undergoing PTC drainage in a large district general hospital was completed. Data including demographics, indications, diagnoses, procedural details, lab results and days survived was retrieved from laboratory, radiology and electronic care record systems. This data was reviewed and statistically analysed where appropriate.

Results
42 patients were included in the study with median age of 73. 40.5% (17) had primary pancreatic carcinoma, 33.3% (14) had primary cholangiocarcinoma and 26.2% (11) had metastatic disease from other sites. The mean number of procedures was 2.19 and serum bilirubin fell from 309.8 to 141.4 (micromol/L; p<0.001). Mean hospital stay was 22.3 days with a noted complication rate of 23.8%. 30-day mortality was 23.8%. The median time of procedure to death was 88 days (Mean 159) with one patient still alive. No statistically significant differences were found in survival rates when comparing diagnoses.

Conclusions
This study confirms that PTC is successful at relieving biliary obstruction in the majority of cases. Our complication rate and mortality was similar to other published data and highlights the need for appropriate discussion between clinician and patient with respect to complication rate, mortality and clinical benefit of the procedure.

ABSTRACT NO. 57 (17W168) POSTER PRESENTATION

Clinical Efficacy of Vedolizumab in Anti-TNF Refractory Inflammatory Bowel Disease: A Single Centre, Three Year Study

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Introduction
Vedolizumab for anti-TNF refractory Inflammatory Bowel Disease (IBD) is now a well established treatment option.

Aims/Background
We evaluated the efficacy and safety of Vedolizumab in a cohort of anti-TNF refractory IBD since 2014.

Method
We evaluated clinical response to Vedolizumab for anti-TNF refractory IBD over three years using initial clinical response, serial CRP, endoscopic and radiological response, steroid-free remission, hospitalisation and surgery post-Vedolizumab induction at six, twelve, 18 and 24 months where applicable.

Results
22 patients are receiving Vedolizumab (45% female), median age 34.5 at induction (IQR 30-44.75). 86% have Crohn's Disease and 14% Ulcerative Colitis. 100% were exposed to anti-TNFs. At induction, all patients had clinically active disease; mean CRP 25.8 (range 0.3 – 125, SD +/- 32.5), endoscopically active (UC Mayo >1, CD SESCD 11) +/- active disease on MRE. Median duration of treatment is twelve months (IQR 5 – 22, range 3 – 37). 32% required steroids post-induction. 18% required hospitalisation. 18% required surgery. Mean CRP at week 6 was 16.5 (SD +/- 16.8), one year 8.85 (SD +/- 8.63). 62.5% showed laboratory remission (CRP <5) at one year. 70% had significant endoscopic response post-induction. 43% had improved MRE findings. Association between initial clinical response and endoscopic response post-induction is not significant. CRP at six weeks is associated with laboratory remission at one year (p = 0.002). Reduction in CRP by =50% at week six is associated with endoscopic response (p = 0.01).

Conclusions
Vedolizumab is an effective and safe alternative to anti-TNF therapy in refractory disease. CRP at six weeks may identify those with sustained endoscopic response.

ABSTRACT NO. 58 (17W169) POSTER PRESENTATION

"PSC"; Please Schedule Colonoscopy For Patients With Primary Sclerosing Cholangitis

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Introduction
Primary Sclerosing Cholangitis (PSC) is a chronic inflammatory disorder of the intra and extrahepatic bile ducts. There is a strong association between PSC and inflammatory bowel disease (IBD). This leads to an increased risk of colorectal cancer. Current guidelines recommend that patients with both PSC and IBD should have annual colonoscopy and those without IBD should have colonoscopy every 5 years.

Aims/Background
An audit was performed on whether or not PSC patients had had a colonoscopy during a 5 year time period (2012-2017). If they had a colonoscopy, we looked at whether it followed current guidelines.

Method
We conducted an audit from a database of patients with PSC in a single tertiary referral centre from 5 years. A list of 30 patients was generated. We searched through an online endoscopy reporting software for colonoscopy reports. An Excel spreadsheet was generated and the data was analysed.

Results
30 patients were included in analysis. 24 patients had had a colonoscopy, 4 had not had a colonoscopy and 2 had only a sigmoidoscopy. 16 patients had concurrent IBD (16 ulcerative colitis, 3 Crohn's disease). Over half (56.67%) of patients had colonoscopy performed in accordance within current guidelines. Only 6 patients with IBD had had a colonoscopy every year (37.5%).

Conclusions
This audit highlights that patients with PSC are not having colonoscopies within current recommendations. Whether this is a reflection on a lack of resources, loss to follow up or poor patient engagement remains to be seen and will be an area for future targeted research.

ABSTRACT NO. 59 (17W170) POSTER PRESENTATION

Intention to Tweet: The Use of Twitter by Gastroenterology Journals and Effect on Impact Factor

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Introduction
The effect of twitter on impact factor

Aims/Background
Social media is becoming increasingly important for academic publications in order to reach a greater audience. The aim of the study was to analyse the use of twitter by gastroenterological journals and the effect on impact factor.

Method
The 50 gastroenterological journals with the highest impact factors were selected. The journals, or associated organisations, with and without twitter profiles were identified. Comparison was made between the two sets of journals as regards impact factor. The change in impact factor both before and after joining twitter was also analysed to assess the effect, if any, presence on twitter has had on impact factor. The association between followers and impact factor was also examined. Results were analysed in SPSS using Student's t test and Pearson correlations.

Results
24 journals (48%) had twitter profiles directly associated with the journal or its affiliated organisation. These journals had a significantly higher impact factor than those without (5.7 vs 3.4, p=0.032). The journals with twitter profiles also saw an increase in their impact factor since they joined twitter, though this was not statistically significant (5.97 vs 4.72, p=0.342).
There was also a statistically significant relationship between number of followers and impact factor.

Conclusions
Journals with twitter profiles have significantly higher impact factors than those without. Number of followers also had a significant relationship with impact factor. While journals with twitter profiles saw a non-significant increase in their impact factor since joining the medium, other factors that increase impact factor require further investigation.

ABSTRACT NO. 60 (17W171) POSTER PRESENTATION

Frailty and not advanced age is a marker of poor outcomes in ERCP

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Introduction
ERCP may be associated with significant risks; despite this there is evolving evidence that advanced age alone is not associated with poorer outcomes post ERCP.

Aims/Background
To examine the demographics and co-morbidities in patients having ERCP performed, and assess the role that age and co-morbidity may play.

Method
Data on all patients who had an ERCP in 2017 were included in the study. Clinical information and demographics was gathered using the hospital ERS and EHR. Charlson comorbidity index was calculated to assess "frailty".

Results
We identified 136 (83 female) patients who underwent ERCP. The mean age was 64.6 years (range 17-92 years).
ERCP was technically successful in 128 patients (94.2%). Post procedure 22 (16.2%) were readmitted within 30 days of ERCP, 8 with issues unrelated to ERCP/gallbladder disease. 2.2% developed pancreatitis.
In our cohort; 26 (19.1%) were aged ≥80 years. Of these, there were no unsuccessful procedures. Readmission within 30 days was observed in 3 (11.5%), with only one related to their gallbladder pathology and one patient died, unrelated to ERCP/findings. We observed no cases of pancreatitis in this cohort.
However, in patients with a Charlson score >5 (n=36), 5 (13.9%) procedures were unsuccessful. Re-admission within 30 days was seen in 10 (27.8%) of these patients.

Conclusions
ERCP was well tolerated in our cohort with high success rates and low readmission rates and 30-day mortality with similar outcomes observed in an elderly sub-population. Frailty however was associated with substantially poorer outcomes.

ABSTRACT NO. 61 (17W172) POSTER PRESENTATION

Comparison of two transport media for successful culture of Helicobacter pylori from gastric biopsies

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Introduction
Culture of H. pylori from gastric biopsy samples is used for obtaining antibiotic susceptibilities, in order to guide clinicians in their choice of treatment. While culture is highly specific, sensitivity can vary and depends on sampling site, transport media and growth conditions etc.

Aims/Background
To compare the effectiveness of Portagerm pylori- a commercially available semi-solid agar- with DENT broth- an in-house liquid media- for successful culture of H. pylori.

Method
Following ethical approval, 4 gastric biopsy samples (2 from antrum and corpus) were obtained from H. pylori positive patients and 2 were placed into either Portagerm pylori or DENT transport media. Biopsies from each transport media were plated onto Columbia Blood Agar (CBA) and incubated under optimum conditions. Successful culture was defined as presence of H. pylori colonies within 7 days. Culture yield and contamination was compared visually between plates.

Results
Biopsy samples were obtained from 15 H. pylori positive patients. In those transported using Portagerm pylori and DENT, H. pylori was recovered from 73.3% (11/15) and 66.6% (10/15) respectively. In the Portagerm pylori subset, a high yield was obtained in 54.5% (6/11), medium in 18.2% (2/11) and low in 27.3% (3/11). In the DENT subset, a high yield was obtained in 40% (4/10), medium in 10% (1/10) and low in 50% (5/10). Contamination was observed in 80% (12/15) and 73.3% (11/15) of samples transported in Portagerm pylori and DENT respectively.

Conclusions
Although culture positivity rates were similar between media (p=0.99), transport of biopsies in Portagerm pylori obtains a higher yield of bacteria (p=0.66).

ABSTRACT NO. 62 (17W173) POSTER PRESENTATION

The Use of Faecal Calprotectin to Assess Crohn's Disease Activity in Patients with an Ileostomy

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Introduction
Faecal calprotectin(FCP) is increasingly used as a non-invasive tool to monitor ulcerative colitis. However, to date the use of FCP to monitor patients with an ileostomy due to Crohn's disease (CD) has not been established.

Aims/Background
To assess the performance characteristics of FCP in patients with Crohn's disease and an ileostomy.

Method
Patients with an ileostomy due to CD, attending a single academic centre were identified. Patient demographics were recorded using a prospectively-maintained database of >3800 IBD patients. Endoscopy was categorised using modified Rutgeert's score. Radiological investigations included MRE/CT, and classified as active or inactive CD.

Results
17 patients were identified. Patient demographics, disease characteristics and baseline biochemistry as per Table 1. 19 contemporaneous endoscopic and FCP results from 15 patients were analysed. 63.2% had i0/1 disease, 15.7% i2 and 21.1% i3/i4. Furthermore, no significant correlation was identified between endoscopic scores and FCP results. (R= 0.312; p=0.19) N=5 patients

underwent radiological and FCP assessment simultaneously. There was no significant correlation identified. (R= 0.866; p=0.33) The utility of FCP to detect endoscopic activity was assessed. A FCP of 117.5 ug/g had a sensitivity of 67% and specificity of 63%; AUROC= 0.75.

Conclusions
In this study, there was poor correlation between FCP and established tools in assessing disease activity. FCP measurement alone has only moderate sensitivity/specificity for the detection of disease activity in patients with CD and an ileostomy. FCP is best utilised in conjunction with other objective tools in this particular patient cohort.

ABSTRACT NO. 63 (17W176) POSTER PRESENTATION

Device assisted enteroscopy is a useful mean to characterise small bowel lesions detected on imaging but has a low diagnostic yield for other radiological abnormalities.

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Introduction
Device assisted enteroscopy (DAE) is a useful but invasive technique to manage small bowel pathology. Abnormal small bowel radiology is an indication for DAE. The correlation between the two techniques is unclear.

Aims/Background
To evaluate findings on Double Balloon Enteroscopy (DBE) in patients referred primarily for abnormal small bowel radiology.

Method
DBEs performed for abnormal radiology were identified from a database at Tallaght Hospital from 2015-2016 inclusively. Patient demographics, findings including histology and diagnostic yield were recorded. Correlation between DBE and radiology was assessed.

Results
In all 27(15%) of 183 DBEs were performed for abnormal radiology, 13(48%) men, mean age 47.8(21-80), 9(33%) had MRE, 16(59%) had CT and 2(7%) had PET. Radiological findings were; non-specific jejunal thickening 11(41%), jejunal lesion 7(30%), jejunal stricture 2(7%), inflammation 3(11%) AVM 1(3%), unspecified 3(11%). DBEs were abnormal in 10(37%) cases. Small bowel tumours were detected in 6(22%) cases; 2(7%) adenocarcinoma, 1(3.7%) neuroendocrine tumour, 2(7%) small bowel polyps, 1(3.7%) lymphoma. Other findings were 1(3.7%) of AVM and 3(11%) enteritis. 7 patients with jejunal lesion on imaging 4(57%) had tumours on DBE (k=0.49). In all, 8 patients had a capsule endoscopy performed after DBE, 7 were normal and 1 non-specific enteritis.

Conclusions
Overall the diagnostic yield of DBE for abnormal radiology is low (37%). For indications other than suspected lesions for which there is a good correlation, other tests should also be applied including serum and stool biomarkers and capsule endoscopy prior to DAE.

ABSTRACT NO. 64 (17W177) POSTER PRESENTATION

Analysis of positive/negative rapid urease tests frequencies and observed incidence of H. pylori infection in Cork area

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Introduction
Helicobacter pylori (H. pylori) is the most common chronic bacterial infection in humans and is associated with peptic ulcer disease, chronic gastritis, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue (MALT) lymphoma. In patients undergoing upper endoscopy (OGD) the diagnosis of H. pylori can be established by biopsy urease test or histology (less common by bacterial culture). Rapid urease test (RUT) only detects the presence of active infection. To avoid false-negative results (patients with acute upper gastrointestinal bleeding or with the use of PPIs, antibiotics, or bismuth-containing compounds) it is recommended that samples be taken from the both the gastric antrum and the fundus.

Aims/Background
The aim of the current analysis was to establish the frequency of positive/negative RUTs and explore the observed incidence of H. pylori infection in Cork area.

Method
This was a retrospective analysis. All OGD's/ RUTs performed between 19/07/2016 and 10/03/2017 were recorded in a designated register made available in the endoscopy room. Results were coded 'positive' or 'negative'.

Results
Frequencies were computed for recorded data. Out of the 325 entries in the register, 24 (7.38%) were positive and 273 (84%) were negative. Data was missing in 28 (8.61%) cases. Analysis will also explore the observed incidence of H. pylori infection vs failled treatment cases. We further discuss tratment choice and potential implications.

Conclusions
Our analysis is the first to explore the frequency of positive/negative RUTs in Cork Univeristy Hospital during a 8 month period. Potential implications such as incidence/prevalence and further treatment of H. pylori will be discussed.

ABSTRACT NO. 65 (17W179) POSTER PRESENTATION

Vedolizumab: Effects on liver function in an IBD and IBD/PSC cohort.

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Introduction
Primary sclerosing cholangitis (PSC) is a disease characterized by inflammation and destruction of the hepatic bile ducts often associated with inflammatory bowel disease (IBD). Vedolizumab is a gut-selective antibody for the treatment of ulcerative colitis (UC) and Crohn's disease (CD).

Aims/Background
We sought to look at the effects of vedolizumab therapy on liver biochemistry in patients with IBD and IBD/PSC.

Method
We conducted a retrospective study of all patients at SVUH treated with vedolizumab. Basic demographics alongside phenotypes of IBD and PSC were collected. Liver biochemistry was analysed at 0, 2, 8, 12, 24 and 36weeks.

Results
A total of 47 patients were treated with vedolizumab (13 CD, 31 UC and 2 IBD-U). Median age was 37.5years (17-70). 29.8%(n=14) had a concurrent diagnosis of PSC. 10 patients were post liver transplant. The median alkaline phosphatase(ALP) level at 0 weeks for IBD cohort was 68 versus 126 in IBD/PSC cohort. Median levels of ALP at 36weeks in IBD cohort was 79 versus 190 in IBD/PSC cohort.
The IBD alone cohort showed no statistical change in ALP at any time over 36weeks. In our IBD/PSC cohort, there was a statistically significant rise in ALP levels at 8, 12, 24 and 36 weeks (p-values 0.019, 0.045, 0.005 and 0.028 respectively).

Conclusions
Vedolizumab therapy has no effect on liver biochemistry in patients with IBD alone. In individuals with PSC serum ALP increased significantly while on vedolizumab therapy. Further work is warranted to investigate if this is natural history of the disease versus effect of therapy.

ABSTRACT NO. 66 (17W180) POSTER PRESENTATION

Photographic Documentation Of Caecal Intubation: Has Bowelscreen Changed Documentation Practice in the Symptomatic Service?

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Introduction
The introduction of colon cancer screening (Bowelscreen) has brought further focus on quality assurance in colonoscopy. Bowelscreen quality assurance guidelines includes a number of key performance indicators (KPIs) to assess standards in the performance of colonoscopy. These include photographic evidence of certain landmarks as a record of Caecal intubation.

Aims/Background
To compare recording of photographic evidence of caecal intubation pre and post introduction of Bowelscreen in colonoscopy performed in the symptomatic service.

Method
A retrospective analysis of photographic recording of caecal intubation was performed. Data was extracted from EndoRAAD. 60 sequential colonoscopies prior to (Q4 2013) and post (Q4 2016) the introduction of Bowelscreen were assessed for photographic documentation of caecal intubation by an independent competent endoscopist. Photographic evidence of either the ileo-caecal valve and/or appendix orifice and/or terminal ileum and/or anastomosis were recorded.
Colonoscopies which didn't reach the caecum and those performed as part of Bowelscreen were excluded. Comparison was then made between the Pre (n=51) and Post (n = 54) Bowelscreen groups.

Results
The Post Bowelscreen group showed a statistically significant improvement in photographic documentation of caecal intubation in comparison to the pre Bowelscreen group. Recording of a single marker of caecal intubation improved to 96.1% from 75.9% (p= 0.0027). Recording of 2 or more markers also showed a statistically significant improvement to 76.5% from 18.2% (p<0.0001). Unadjusted caecal intubation rates were not significantly different (89% vs 90%).

Conclusions
Our analysis has shown a significant improvement in photographic recording of caecal landmarks since the introduction of the Bowelscreen programme.

ABSTRACT NO. 67 (17W186) POSTER PRESENTATION

Symptoms Are A Poor Predictor Of Clinically Significant Disease On Colonoscopy

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Introduction
Lower gastrointestinal symptoms are a common cause of referral. NICE guidelines are available to stratify patients in order to prioritise those with colorectal cancer (CRC) and inflammatory bowel disease (IBD) for investigations. Some studies have reported that symptoms alone are a poor marker of clinically significant disease (CSD) but symptoms remain the main way to prioritise referrals.

Aims/Background
To correlate symptoms stratified according to NICE guidelines with colonoscopy findings in Tallaght Hospital.

Method
Colonoscopy data over a 2 year period was obtained from our Unisoft database. Only patients with assessment of symptoms as their primary indication for colonoscopy were included. Patient records were retrospectively reviewed. Exclusion criteria: IBD, familial cancer syndromes, prior colonoscopy within 5 years. Demographics, symptoms and colonoscopy findings were recorded and analysed.

Results
To date 1113 cases have been reviewed, 493(44%) males, age 54.3(range 16-91), 592(53%) patients fitted the criteria for urgent referral for CRC and 520(47%) for IBD. CSD occurred in only 161(16%); 19(1.7%) cancer, 65(5.8%) IBD, 40(3.6%) high-risk adenoma, 6(0.5%) angiodysplasia, 9(0.8%) microscopic colitis,

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Ref: UK/XIF5/0116/0173(2) **Date of preparation:** August 2017

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1. National Institute for Health and Care Excellence. Rifaximin for preventing episodes of overt hepatic encephalopathy: appraisal guidance TA337 for rifaximin. Available from: http://www.nice.org.uk/guidance/ta337
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Date of preparation: September 2017.

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22(2%) non-specific inflammation. Diarrhoea gave the highest positivity 23%(OR 1.75, p=0.003), then pr bleeding 21%(OR 1.5 p=0.04) and constipation the lowest 8%(OR 0.569, p=0.235). While high risk criteria improved detection, overall diagnostic yield remained low(7%); CRC 3% versus 0.1%(OR 16,p<0.06), IBD 13% versus 3%(OR 5,p<0.001).

Conclusions
The prevalence of CSD in symptomatic patients is low (16%). A holistic approach including combining symptoms, demographics and blood biomarkers with novel tools including faecal calprotectin, FIT and CT and/or PillCam Colon should be applied to avoid unnecessary colonoscopy.

ABSTRACT NO. 68 (17W188) POSTER PRESENTATION

Fallibility of Preoperative Localisation (including Ink Tattoo) ahead of Laparoscopic Resection of Colon Tumors

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2. Audit Office, Mater Misericordiae University Hospital, Eccles Street, Dublin 1, Ireland

Introduction
Precise preoperative localisation of colonic cancer is a prerequisite for correct oncological resection.

Aims/Background
Effective endoscopic lesional tattoo is vital for small, radiologically unseen tumors planned for laparoscopic resection but its practice may be imperfect.

Method
Retrospective review of consecutive patients with preoperative endoscopic lesional tattoo who underwent laparoscopic colonic resection identified from our prospectively-maintained cancer database.

Results
169 patients (95 males, mean age 68 years, median BMI 27.8 kg/m2, 77 left sided lesions, 36 screen detected, 21 benign polyps, 23% conversion rate). In 104 operations (60%) tattoo visibility was documented with tattoo absence noted in nine (8.5%) although identifiable by pathology in four. In those "missing tattoos", six of the lesions were radiologically occult and in three the tumor was in a different colonic segment then had been judged at colonoscopy. Four patients had on-table colonoscopy and five were converted to laparotomy (55% conversion rate, p<0.005). Mean postoperative length of stay was 15.5 (range 4-38) days. One patient's segmental resection contained only benign pathology requiring a second operation to remove the cancer. On univariate analysis, time between endoscopy and surgery (but not patient age, gender, BMI, endoscopist or surgeon seniority, tumor size or location) was significantly associated with absence of tattoo intraoperatively (p=0.006).

Conclusions
Recording related to tattoo is variable but definite lack of gross tattoo visualisation significantly impacts the procedure.

ABSTRACT NO. 69 (17W189) POSTER PRESENTATION

Selective Colorectal Cancer Fluorescence by Calibrated Dose and Timing of Indocyanine Green with Standard Near-infrared Endoscopic Illumination Alone

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Haseeb Kothar, Ronan Cahill

Department(s)/Institutions
Mater Misericordiae University Hospital

Introduction
Confident, optical discrimination of malignant from benign tissue within the colorectum could be useful during colonoscopy for the easy identification of live cancer cell deposits within neoplastic sites.

Aims/Background
We show how the enhanced permeability retention (EPR) phenomenon, a hallmark characteristic of cancer, can be reliably exploited by intelligent dose-delay utilization of near infrared (NIR) with indocyanine green (ICG) providing for endoscopic visualization of colorectal cancer tissue with high selectivity versus background, adjacent non-neoplastic tissue.

Method
NIR viewing was achieved using the PINPOINT Endoscopic System (Novadaq) for NIR illumination. ICG was administered as a systemic aliquot via peripheral cannula at a dose of 0.25 mg/kg and the region of interest is visualised 15 minutes afterwards.

Results
Careful dose/interval combination induces primary tumour fluorescence in a variety of settings including direct serosal visualisation of colonic cancers in both open and laparoscopic surgery and identification of out-of field metastatic relapse in the retroperitoneum in a patient after prior radical D3 resection of a right colon cancer. Prior dose-related work has shown that earlier administration (40-180 minutes before examination) gives no useful tumour fluorescence.

Conclusions
Targeting the tumour microenvironment as a package obviates the issue of variable expression cellular phenotypes while use of a safe and approved agent avoids toxicity concerns and allows clinicians focus on determination of clinical usefulness including indicative cost-economic profiling ahead of new agent commercialisation. In this way, NIR-ICG offers itself as a similar oncologic diagnostic modality as FDG-PET while remaining the benchmark fluorescent agent for intraprocedural tissue evaluation.

ABSTRACT NO. 70 (17W190) POSTER PRESENTATION

Preoperative Inflammatory Markers as Predictors of Postoperative Complications in Colon Cancer Patients

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Mater Misericordiae University Hospital, Eccles St, Dublin 7.

Introduction
A prognostic value of inflammatory markers in colorectal cancer (CRC) patients has been proposed.

Aims/Background
The association between preoperative inflammatory markers and clinical outcomes of CRC patients undergoing resection has not yet been established. This retrospective study aims to determine the predictive value of preoperative inflammatory markers in postoperative complications of CRC patients in terms of type and severity.

Method
Patients (n=186) who electively underwent potentially curative resection in the Mater Misericordiae University Hospital between 2009 and 2016 were reviewed. C-reactive protein (CRP), white blood count (WBC), platelets, neutrophils, lymphocytes, platelets-to-lymphocyte ratio (PLR), neutrophil-to-lymphocyte ratio (NLR), hemoglobin, and carcinoembryonic antigen (CEA) levels were collected. Other variables accounted for were age, sex, BMI, smoking status, pre-existing medical issues, type of operation, and tumour characteristics. All 30-day postoperative complications were included and patients were assigned Clavien-Dindo grades accordingly. Analysis was performed using SPSS version 20.

Results
Multivariate analysis results indicate that CRP correlated to sepsis (p=0.002), thromboembolism (p=0.047), and urinary, respiratory, and cardiovascular complications (p=0.006, 0.002, and 0.004 respectively). WBC correlated to cardiovascular and respiratory complications (p=0.005 and p=0.015 respectively). Platelets correlated to embolism and neurological complications (p=0.05 and p=0.003, respectively). Lymphocytes correlated to wound infection (p=0.016), CEA to anastomotic leak (p=0.006), and neutrophils to cardiovascular complications (p=0.007). None of the blood parameters have a statistically significant association to wound dehiscence, ileus, or hernia. Neither PLR nor NLR are predictors of any complication.

Conclusions
Preoperative levels of these markers, most prominently CRP, are independent predictors of postoperative complications for CRC patients.

ABSTRACT NO. 71 (17W191) POSTER PRESENTATION

Identifying Anaemia In Patients With Rectal Cancer

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Introduction
Iron deficiency anaemia is a common feature of rectal cancer. However, the timely detection and management of preoperative anaemia is still frequently ignored, with indiscriminate usage of allogenic blood transfusions as a solution. Prevalence of anaemia in patients with rectal cancer was determined to serve as a guide for possible positive interventions to be made.

Aims/Background
To determine the prevalence of iron deficiency anaemia in rectal cancer patients who underwent curative resection at the Mater Misericordiae University Hospital.

Method
Patients Centre Hospital Information System was utilized to identify a set of 140 patients who were diagnosed with rectal cancer between 2008 to 2016 undergoing potentially curative resection. Retrospective review of the healthcare records determined if patients had preoperative anaemia.

Results
A total of 42 patients (30%) consisting of 22 males and 20 females, had preoperative anaemia that was a direct cause of rectal cancer where 22 patients had mild anaemia, 19 patients had moderate anaemia and 1 patient had severe anaemia.
Among the 42 patients who had preoperative anaemia, 26 patients (62%) had neoadjuvant radiotherapy or chemotherapy or both prior to the surgery.

The mean number of days between the date of onset of anaemia and the date of surgery is 25 days.

Conclusions
Given the significant percentage of rectal cancer patients with anaemia, pragmatic implementation of the diagnosis and treatment of anaemia is recommended to commence as early as possible in the preoperative period with adequate allocation of resources from the hospital administrators.

ABSTRACT NO. 72 (17W192) POSTER PRESENTATION

Endoscopic mucosal resection of large polyps – resource implications and outcomes in a single centre.

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Department(s)/Institutions
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Aims/Background
To assess EMR procedure times, equipment use and outcomes for large non-pedunculated colonic polyps (LNPCPs) in a single centre.

Method
Review of large and rescue EMRs preformed from 2015 – 2017. Procedure-related data and outcomes were collated from the ERS and electronic patient record.

Results
69 EMRs performed - 50 colonosocpies and 19 sigmoidoscopies.

Median age 66.5 years (range 38 - 86).
27 patients from symptomatic service, 27 from BowelScreen and 18 other institutions. 4 referred after incomplete polypectomy. Of non-BowelScreen patients, 27 were referred by a Gastroenterologist and 19 by a Surgeon.
Polyp size - 15mm-60mm. Polyp histology – 57 adenomas, 9 sessile serrated lesions, 1 hyperplastic polyp and 2 polyp cancers.
Median procedure duration 80 minutes (range 17-140). Median procedure times for full colonoscopies and sigmoidoscopies were 88 minutes (range 29-140) and 58.5 minutes (17-115) respectively.
Clips were applied in 35 cases (median 4, range 2-8). APC used in majority of cases.

Complications;
5 delayed bleeds – 4 admitted, 2 transfused.
1 localised perforation - managed conservatively.
3 incomplete EMRs – 1 repeat EMR at 3 months and 2 for surveillance.

Follow up:
3-6 month scheduled follow-up in 45/56 cases. No residual adenoma in 36 patients. Of 9 patients with residual adenoma, 2 underwent surgery – 1 carcinoma, 1 repeat EMR, 3 remants <5mm excised, 2 microscopic foci on biopsy and 1 clips at site.for

Conclusions
EMR for LNPCPs has major resource implications, most importantly time. This needs to be factored into the further development of colonoscopy services.

ABSTRACT NO. 73 (17W193) POSTER PRESENTATION

Long-term outcomes of Ileal pouch-anal anastomosis for ulcerative colitis.

Author(s)
Jack Horan, Ann Brannigan, Jurgen Mulsow, Conor Shields, Ronan Cahill

Department(s)/Institutions
Mater Misericordaie University Hospital

Introduction
Ileal pouch-anal anastomosis (IPAA) is a procedure following proctocoloectomy that restores bowel continuity and prevents the need for a permanent ileostomy.

Aims/Background
The purpose of this retrospective study was to assess the outcomes of IPAA in our institution over a 15-year period.

Method
Retrospective review of our institutional database, HIPE codes and clinical charts over the period January 2002 to August 2017 in patients that underwent IPAA. All patient, operative and surgical outcome information were obtained from the institutional database.

Results
The majority of patients in our study were male (63.6%). The mean total age at IPAA was 34.8 ± 13.5 years. Laparoscopic techniques accounted for 39.4 % of the procedures in the study increasing from a baseline of 0 to 75% in the time-period 2013-17 and were associated with a lower length of stay compared to open (10.6±8 vs. 12.7±6.5 days) and lower amount of postoperative drains (69% vs. 90%). A stapled anastomosis was performed in 95% and 92.3% of open and laparoscopic surgeries respectively. The total mean length of ileostomy is 27.3±22.5 months. 2013-17 had the highest mean length of ileostomy time at 35.0±16.2 months with the length being longer after an open index procedure. The overall pouchitis rate in our study was 54.5% (n=18) with rates at 1, 5, 10 and 15 years being 18.2%, 39.4%, 51.5% and 54.5% respectively. Pouch failure rates at 1, 5 and 10 years were 3.0%, 12.1% and 18.2%.

Conclusions
Overall outcomes and practice in this study are consistent with previously published studies on IPAA

ABSTRACT NO. 74 (17W198) POSTER PRESENTATION

Helicobacter pylori infection inhibits Notch signalling in gastric epithelial cells.

Author(s)
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Department(s)/Institutions
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Introduction
H. pylori treatment has become a challenge in recent years due to the emergence of antibiotic-resistant infections. The development of alternative strategies for the management of H. pylori-driven disease requires a more lucid understanding of host-pathogen interactions. The Notch pathway regulates key cellular processes such as proliferation, development and survival. As a result, dysregulated Notch signalling causes disease. The role of Notch signalling in H. pylori immunity and pathogenesis is currently unclear.

Aims/Background
The aim of this study was to determine whether Notch signalling is modulated during H. pylori infection.

Method
Expression of Notch pathway components was monitored in AGS and MKN45 gastric epithelial cells by quantitative PCR following infection with H. pylori strains NCTC11637, NCTC11638 and ATCC60190 or stimulation with H. pylori LPS.

Results
H. pylori infection of AGS and MKN45 cells led to decreased expression of key components of the Notch signalling pathway, including the Notch ligands Jag1, Jag2 and DLL1, the Notch1 and Notch2 receptors and the Notch-target genes Hes1. H. pylori LPS did not affect expression of any of the Notch pathway components tested.

Conclusions
H. pylori inhibits Notch signalling in gastric epithelial cells independent of its LPS activity. Further studies are required to elucidate the impact of decreased Notch signalling on H. pylori-associated inflammation and disease progression.

ABSTRACT NO. 75 (17W200) POSTER PRESENTATION

The role of capsule endoscopy in the detection of small bowel tumours in an Irish institution

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Introduction
Small bowel tumours (SBT) are very rare & often have a variable mode of presentation. Small bowel capsule endoscopy (SBCE) has enabled earlier detection of SBT and has been shown to affect the therapeutic course.

Aims/Background
To review the frequency of SBT diagnosed by SBCE in a high-volume tertiary centre, and to assess the clinical presentation and outcome of patients.

Method
A retrospective review of the database in our institution was completed. All patients who had a SBCE from 2011-2016 were identified. SBCE reports for all indications were reviewed.A chart review was then performed,information was obtained on patient demographics and relevant history and Investigations.

Results
In all,1670 SBCEs were performed. 1% (19) of SBCE reports identified a possible SBT. 71% were female,mean age was 58yrs. Indications for SBCE which identified SBT were as follows;OGIB 86%(occult bleeding in 57%,overt bleeding in 29%),abnormal imaging 7%,persistent diarrhoea 7%. Mean Hb at diagnosis was 10.6g/dL. 50% underwent cross-sectional imaging prior to SBCE,3 had a reported no small bowel abnormalities. 60% underwent a double balloon enteroscopy.Adenocarcinomas were found in 43%,Neurendocrine tumours in 29%,GISTs in 14%,lymphoma in 14%. All underwent surgical resection,80% remain well at present,after a mean follow up time of 15 months

Conclusions
Capsule endoscopy has a definite role in SBT detection and has an incremental yield over radiological imaging for their diagnosis

ABSTRACT NO. 76 (17W201) POSTER PRESENTATION

Vedolizumab Therapy in Ulcerative Colitis – Real World Experience

Author(s)
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Department of Gastroenterology, St Vincent's University Hospital
Department of Gastroenterology, University Hospital Galway
Department of Gastroenterology, Beaumont Hospital

Introduction
Vedolizumab is a monoclonal antibody designed to block α4β7 integrin and result in gut-selective anti-inflammatory activity. There is limited real-world data on the effect of vedolizumab(VDZ) in patients with ulcerative colitis(UC).

Aims/Background
To analyse the outcomes of patients with ulcerative colitis treated with vedolizumab.

Method
We conducted a multicentre, retrospective study to investigate outcomes of patients with UC treated with VDZ(n=62). Patients with at least 6-months follow up were included in the final cohort(n=58). Demographics and disease characteristics were collected pre-induction, and at 3 and 6months following induction. Primary endpoints were defined as 3-month clinical response; and 6-month clinical remission based upon the impression of the treating physician and continued therapy with VDZ.

Results
58 patients were included in the study. Median age was 46 years [range 17-79]; 55.2% were male and 10.7% were smokers. The proportion of patients with proctitis, left-sided colitis, and pancolitis was 0%, 48.7%, and 61.5%, respectively. Median baseline clinical Mayo subscore was 5[1-8], and baseline Mayo endoscopic score was 2[0-3]. 40% of subjects were receiving prednisolone at induction (median dose 20mg [5-40mg]); 68.9% oral 5-ASA; and 36.4% immunomodulator therapy. 26% of patients were anti-TNF naive; while 38.8%, 32% and 4% had failed 1, 2 and 3 anti-TNF agents, respectively. 48.7% achieved 3-month clinical response and 58% achieved 6-month clinical remission. The rate of adverse events was 7%; with 1 patient requiring admission for sepsis.

Conclusions
This study demonstrates that vedolizumab is an effective and safe treatment choice for patients with UC, including those with previous exposure to anti-TNF agents.

ABSTRACT NO. 77 (17W202) POSTER PRESENTATION

Short-term Efficacy of Vedolizumab in Crohn's Disease

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Department of Gastroenterology, University Hospital Galway
Department of Gastroenterology, Beaumont Hospital

Introduction
Vedolizumab is a monoclonal antibody designed to block α4β7 integrin and result in gut-selective anti-inflammatory activity. There is limited real-world data on the effect of vedolizumab in patients with Crohn's disease(CD).

Aims/Background
To analyse the outcomes of patients treated with vedolizumab for CD.

Method
We conducted a multicentre, retrospective study across 4 Irish hospitals (n=32). Patients with at least 3-months follow up were included in the final study cohort (n=30). Demographics and disease characteristics were collected pre-induction and at 3 months following induction. Primary endpoint was defined as 3-month clinical response based upon the impression of the treating physician and ongoing therapy with vedolizumab at 3 months.

Results
30 patients were included in the study cohort. Median [range] age was 49 years [22-76]; 50% male and 35.7% were smokers. 58.3% of patients had ileocolonic disease, 19% had perianal disease. Median baseline CRP and albumin were 8.1mg/L[1-159] and 36mg/L[20-48], respectively. Medications at vedolizumab induction were oral 5-ASA(18.8%), immunomodulators(42.9%), prednisolone 38.1% (median dose 10mg [5-40mg]), and multimatrix budesonide(23.8%). 19.2% of patients were anti-TNF treatment naïve; 34.6%, 38.5% and 8% were exposed to 1, 2 and 3 anti-TNF therapies, respectively. 3-month clinical response was achieved in 55.6% of subjects, however, there was no significant reduction in CRP from baseline to 3 months(8.1 to 8.0mg/L, p=0.69). The rate of adverse events was 6%, all of which were minor.

Conclusions
This small study demonstrates that in a refractory CD cohort, vedolizumab had a short term clinical benefit; however this was not reflected objectively in an improvement in inflammatory biomarkers.

ABSTRACT NO. 78 (17W204) POSTER PRESENTATION

Dynamic Gastrointestinal Serotonergic Responses to an Acute Stressor: Role of Host Genetics

Author(s)
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Introduction
Host genetics influence acute stress response which may alter gastrointestinal function. Gut-derived serotonin (5-HT) exerts physiologically and clinically important local and systemic effects. The role of host genetics on gastrointestinal serotonergic response to acute stress is poorly understood.

Aims/Background
We sought to define the gastrointestinal serotonergic response to and recovery from acute stress in genetically-distinct mice strains.

Method
Adult male NIH Swiss-Webster, BALB/c, and C57/BL6 mice were randomly allocated to the unstressed control or stress group. Stressed animals were subjected to 15min restraint stress (n=4-8 mice/timepoint/strain) and sacrificed post-stressor +0, 5, 15, 30, 45, 60, or 240min. Plasma corticosterone (CORT), a canonical measure of hypothalamic-pituitary-adrenal-(HPA)-axis activation, was assayed using ELISA. Colonic and ileal 5-HT and 5-HIAA were measured via HPLC. Results were analyzed by student's t-test or ANOVA, where applicable, and statistical significance was set at $p<0.05$.

Results
CORT was elevated ($p<0.05$) after restraint stress compared to control in each strain. C57/BL6 exhibited greater ($p<0.05$) CORT post-stressor compared to BALB/c or NIH Swiss-Webster. Colonic 5-HT was higher than ileal in all mouse strains. Intestinal 5-HT and 5-HIAA were elevated ($p<0.05$) post-stress in C57/BL6 compared to other strains.

Conclusions
Confirming that host genetics influence stress response, the C57/BL6 strain displayed the largest HPA-axis post-stress activity. C57/BL6 also had higher colonic and ileal 5-HT post-stressor. Further studies are required to understand the implications of these findings for the control of stress-induced 5-HT-mediated gastrointestinal symptoms and to assess how the gastrointestinal microbiota and microbial metabolites might regulate gastrointestinal serotonergic response to acute stressors.

ABSTRACT NO. 79 (17W205) POSTER PRESENTATION

Medium to long-term outcomes in patients receiving accelerated dose induction of Infliximab for Acute Severe Ulcerative Colitis (ASUC)

Author(s)
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Department(s)/Institutions
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Introduction
Use of accelerated dose(AD)induction of infliximab(IFX) reduces short-term colectomy rates in ASUC,but long-term data is not reported.

Aims/Background
Evaluate medium to long-term outcomes in patients receiving IFX induction for ASUC,comparing AD induction and standard dose(SD) induction.

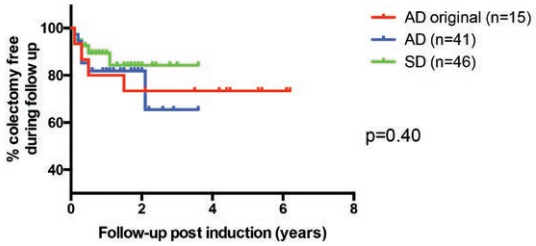
Method
Retrospective review of all patients admitted with ASUC in 2 tertiary referral centres who received rescue IFX either as Standard dose(SD) induction(weeks 0,2,6)or AD induction(<42 days)from January 2014 to present.As a comparison, the original 15 consecutive patients who received AD induction were also followed.All patients had steroid-refractory disease,with endoscopic assessment prior to IFX induction.

Results
102 patients were admitted with steroid refractory ASUC,and received rescue IFX.15 patients were in the AD original group 41 patients received AD induction as an intention-to-treat group,while 46 received SD induction.There was no difference in age or gender across the 2 groups.Median follow-up was 0.9 years in those receiving SD induction,1.2 years in those receiving AD induction,and 4.5 years

in the original AD induction group.Colectomy rates during follow-up were similar across the groups;21% SD,27% AD and26%AD original.Kaplan-Meier survival analysis revealed no significant difference in colectomy rates across the 3 groups(p=0.40)(figure 1).However,overall colectomy rates were lower than published steroid refractory ASUC cohorts.

Conclusions
We observe low rates of colectomy within our cohort compared to international standards.Although there was no detectable difference in long-term colectomy rates in patients receiving AD and SD induction,this may relate to patients with more severe disease receiving AD induction.The true effect that AD induction has on long-term colectomy rates can only be determined by an RCT.

Figure 1. Kaplan-Meier Curve showing estimates of proportion of patients requiring colectomy with time, across the 3 groups



ABSTRACT NO. 80 (17W206) POSTER PRESENTATION

Therapeutic Drug Monitoring in IBD- The Beaumont Experience

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Introduction
Therapeutic drug monitoring (TDM) of Infliximab (IFX) allows for objective decision making in patients with inflammatory bowel disease (IBD).

Aims/Background
To evaluate our experience in TDM in our cohort of IBD patients on Infliximab therapy.

Method
Retrospective study of 67 IBD (41 Crohn's CD, 26 Ulcerative Colitis (UC)) patients attending Beaumont Hospital who had serum infliximab levels measured between March 2015 and May 2017. Levels were measured proactively and reactively during this period. Clinical scores, endoscopy findings and biochemical parameters were extracted from medical record review. We assigned a level of three or more as therapeutic in CD and 5 or more in UC.

Results
We found that longer duration (> 3 years) of Infliximab therapy was associated with significantly lower levels (p= 0.0001) for UC and (p= 0.0124) for CD. We found no significant difference in CRP or haemoglobin levels but albumin levels were lower in the CD patients with subtherapeutic levels (p=0.04), in UC no differences were found in CRP, albumin or HB levels between groups. Therapeutic levels were associated with lower levels of antibody formation (p=0.017).

Conclusions
Initial analysis of TDM in our IBD patients show that longer duration of therapy is associated with lower levels and antibody formation. CRP and haemoglobin did not correlate with levels but low albumin mirrored low levels in CD patients. Further studies in this group will focus on the effects of combination therapy on levels and antibodies and the relationship of fecal calprotectin to levels.

ABSTRACT NO. 81 (17W207) POSTER PRESENTATION

High Prevalence of Abnormal Liver Enzymes Amongst the Diabetic Population

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Introduction
The prevalence of abnormal liver enzymes in the general population has been estimated to be between 10-20%. The prevalence in the diabetic population is known to be higher however there are still few studies available on this topic.

Aims/Background
To evaluate the prevalence of abnormal liver enzymes amongst the diabetic population attending the endocrinology services in St. James's Hospital, Dublin.

Method
Electronic records were used to conduct a retrospective study of all patients who had blood tests performed under the care of the Endocrinology service in St. James Hospital in 2016. Blood results from 1600 patients were reviewed for the presence of abnormal liver function tests. 1044 patients who had a diagnosis of diabetes were included, 645 patients were male (61.8%), 399 female (38.2%) with a mean age of 53 (17-88). APRI and FIB-4 scans were then calulated.

Results
386 (37.0%) patients had elevated liver enzymes. 183 (17.5%) patients had abnormal ALT levels, median 19 (7-127 IU/mL). 55 (5.3%) had elevated AST levels, median 19 (9-125 IU/mL) and 148 (14.2%) had abnormal GGT levels, median 23 (6-175 IU/mL).
390 (37.4%) patients who attended had no platelet counts performed as part of their assessment. Of the remaining 654 (62.6%) patients, 176 (26.9%) had FIB4 scores greater than 1.3 but less than 2.67 and 12 patients (1.83%) had scores of greater than 2.67.

Conclusions
Our results demonstrate an increased prevalence of abnormal liver enzymes in the diabetic population compared with the general population. It may also be beneficial to add platelets to the routine diabetic screen.

Intercept

AFTER 20 YEARS, A NEW APPROACH IN PBC[1,2]

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OCALIVA offers a new option for patients with inadequately controlled PBC on UDCA or as monotherapy[1]

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OCALIVA is a first-in-class selective and potent FXR agonist, is thought to plays a crucial role in bile acid homeostasis and pathways controlling inflammation and fibrosis[1,3]

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OCALIVA is indicated for the treatment of primary biliary cholangitis (also known as primary biliary cirrhosis) in combination with UDCA in adults with an inadequate response to UDCA or as monotherapy in adults unable to tolerate UDCA.[1] OCALIVA has a conditional licence.

*UDCA was withheld from patients intolerant to UDCA.[4]
†35 patients receiving OCALIVA 10 mg + UDCA (48%) and 46 patients receiving OCALIVA titration + UDCA (46%) achieved the primary composite endpoint of ALP <1.67 x ULN with a ≥15% reduction from baseline and total bilirubin ≤ULN compared with 7 patients on placebo + UDCA (10%); UDCA was withheld from patients intolerant to UDCA.[4]

OCALIVA® ▼
obeticholic acid

Abbreviated Prescribing Information
OCALIVA® ▼ (obeticholic acid)
(Please refer to the Full Summary of Product Characteristics (SmPC) before prescribing)

Presentation: OCALIVA supplied as film-coated tablets containing 5 mg and 10 mg obeticholic acid.
Indication: For the treatment of primary biliary cholangitis (also known as primary biliary cirrhosis) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA or as monotherapy in adults unable to tolerate UDCA.
Dosage and administration: Oral administration. The starting dose is 5 mg once daily. Based on an assessment of tolerability after 6 months, the dose should be increased to 10 mg once daily to achieve optimal response. No dose adjustment of concomitant UDCA is required in patients receiving obeticholic acid. For cases of severe pruritus, dose management includes dose adjustment such as reduced dosage, temporal interruption or discontinuation for persistent intolerable pruritus; use of bile acid binding agents or antihistamines (see SmPC). No dosage adjustment for elderly.
Renal impairment: No dose adjustments are required. **Hepatic impairment:** No dose adjustment for mild hepatic impairment (Child-Pugh Class A). The recommended starting dosage for moderate/and severe (Child-Pugh Class B/C) hepatic impairment is 5 mg once weekly. Titrate to 5 mg and subsequently to 10 mg twice weekly (at least 3 days between doses) if patient does not achieve adequate reductions in alkaline phosphatase and/or total bilirubin after 3 months, depending on response and tolerability. **Paediatric population:** No data. **Contraindications:** Hypersensitivity to the active substance or any excipients. Complete biliary obstruction.
Special warnings and precautions for use: Liver-related adverse events occurring as early as within the first month of treatment; elevations in alanine amino transferase (ALT), aspartate aminotransferase (AST) and hepatic decompensation have been observed and patients should be monitored during treatment with OCALIVA. Severe pruritus; see recommendations for dosage reduction and use of bile acid binding resins or antihistamines.
Interactions: Following co-administration of warfarin and obeticholic acid. International normalised ratio (INR) should be monitored and the dose of warfarin adjusted, if needed, to maintain the target INR range. Therapeutic monitoring of CYP1A2 substrates with narrow therapeutic index (e.g. theophylline and tizanidine) is recommended. Obeticholic acid should be taken at least 4–6 hours before or after taking a bile acid binding resin, or at as great an interval as possible.
Fertility, pregnancy and lactation: Avoid use in pregnancy. Either discontinue breast-feeding or discontinue/abstain from obeticholic acid therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. No clinical data on fertility effects.
Undesirable effects: Very common (≥1/10) adverse reactions were pruritus, fatigue, and abdominal pain and discomfort. The most common adverse reaction leading to discontinuation was pruritus. The majority of pruritus occurred within the first month of treatment and tended to resolve over time with continued dosing. Other commonly (≥ 1/100 to < 1/10) reported adverse reactions are, thyroid function abnormality, dizziness, palpitations, oropharyngeal pain, constipation, eczema, rash, arthralgia, peripheral oedema, and pyrexia.
Overdose: Liver-related adverse reactions were reported with higher than recommended doses of obeticholic acid. Patients should be carefully observed and supportive care administered, as appropriate.
Legal category: POM
Marketing authorisation numbers: EU/1/16/1139/001 & 002
Marketing authorisation holder: Intercept Pharma Ltd, 2 Pancras Square, London, N1C 4AG, United Kingdom
Package Quantities and Basic NHS cost: OCALIVA 5 mg and 10 mg £2,384.04 per bottle of 30 tablets.
Date of revision: 20/DEC/2016

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Intercept Pharma Ltd on +44 (0)330 100 3694 or email: drugsafety@interceptpharma.com

Abbreviations. ALP, alkaline phosphatase; FXR, farnesoid X receptor; PBC, primary biliary cholangitis; UDCA, ursodeoxycholic acid.

References. 1. OCALIVA (obeticholic acid). Summary of Product Characteristics. 2016; **2.** FDA Drug Approval Package: Urso (ursodiol) NDA# 020675 http://www.accessdata.fda.gov/drugsatfda_docs/nda/97/20675a.cfm [Last accessed 4 April 2016]; **3.** Ding L, *et al.* Bile acid nuclear receptor FXR and digestive system diseases. *Acta Pharma Sin B* 2015;**5**:135–44; **4.** Nevens F, *et al.* A Placebo-controlled trial of obeticholic acid in primary biliary cholangitis. *N Engl J Med* 2016;375:631–43

UK-PP-PB-0068 March 2017

ABSTRACT NO. 82 (17W208) POSTER PRESENTATION

Appropriateness of Referral to Endoscopy.

Author(s)
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Department(s)/Institutions
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Introduction
The safe and appropriate investigation of patients is vital to the management of an efficient and effective endoscopy service. With time and resources being challenged by budgetary constraints it is important to validate (justify) the yield from our endoscopy referrals

Aims/Background
To evaluate the appropriateness of our referral system in meeting the needs of our patients and referrers. The HIQA (Health Technology Assessment of scheduled procedure guidelines for upper and lower symptoms suspected of indicating a malignancy) guidelines for referrals to endoscopy service were used in deeming clients appropriate.

Method
400 (20%) referrals to our unit were retrospectively audited on the day of admission. Only direct access and surveillance referrals were included. Indication for referral, findings and follow-up (as stated endoraad) were assessed.

Results
- 20% (n=82) were deemed inappropriate. Of these referrals 62% were mainly referrals for dyspepsia/heartburn who either received or did not receive PPIs, no patients had "test and treat" which is recognised as appropriate.
- 56% (225) of patients were referred back to GP .
- Only 5% of our audit included surveillance. Direct assess taking up 95%.
- Despite a low yield from direct access 196 referrals were deemed Priority 1 status.

Conclusions
Adherence to the HIQA guidelines will reduce the inappropriate demand on the direct assess service and will allow us to accommodate our surveillance commitments to those with chronic disease. Referrers' to our service need to be informed and compliant with current practices and guidelines.

ABSTRACT NO. 83 (17W209) POSTER PRESENTATION

Performance Measures for Upper Gastrointestinal Endoscopy: The Death Knell for Unsedated OGDs?

Author(s)
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Department(s)/Institutions
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2. School of Medicine and Medical Science, University College Dublin, Co. Dublin

Introduction
Several performance measures for colonoscopy have been identified (e.g. caecal intubation rate, withdrawal time). Recently, the European Society of Gastrointestinal Endoscopy (ESGE) proposed similar measures for upper GI endoscopy (OGD). Two of the proposed measures include inspection time of ≥7 minutes, and photo documentation comprising ≥10 images.

Aims/Background
We aimed to analyse OGD data from the endoscopy unit of a tertiary teaching hospital to assess for differences in performance measures between sedated and unsedated OGDs, with a view to the potential impact on productivity.

Method
OGD performance data was retrospectively collected from the Endoscopic Reporting System. Data was analysed using Microsoft Excel.

Results
10,482 procedures were included for analysis. 11.4% had accurate photo documentation (≥10 images, target >90%) with a median of 5 images. 75.35% had adequate inspection time (≥7 minutes, target >90%) with a median of 10 minutes. Median inspection time for sedated procedures was 10 minutes vs. 8 minutes for unsedated procedures. 78% of sedated procedures met the target of 7 minute inspection time vs. 66% of unsedated procedures (p-value < .00001). Both groups had a median of 5 images recorded. 12% of sedated procedures recorded ≥10 images vs. 8% of unsedated procedures (p-value < .00001).

Conclusions
Sedated OGDs are associated with significantly improved performance measures. One third of unsedated OGDs failed to meet the target inspection time. Strict adherence to the proposed performance measures would favour the use of sedation which could place extra demands on the endoscopy service due to the increased complexity of sedated procedures.

ABSTRACT NO. 84 (17W210) POSTER PRESENTATION

UK Clinical Experience At 12 Weeks With Linaclotide For Irritable Bowel Syndrome With Constipation

Author(s)
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Department(s)/Institutions
1. University College London Hospitals NHS Foundation Trust, London, UK
2. Salford Royal NHS Foundation Trust, Salford, UK
3. pH Associates Ltd, Marlow, UK
4. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Doncaster, UK
5. South Eastern Health and Social Care Trust, Belfast UK (*presenting author)
6. London North West Healthcare NHS trust, St Marks Hospital, London, UK
7. Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK
8. Lothian University Hospitals Trust, Edinburgh, UK
9. University Hospitals of North Midlands NHS Trust, Stoke-on-Trent, UK
10. County Durham and Darlington NHS Foundation Trust, Durham, UK

Introduction
Linaclotide, a guanylate cyclase-C agonist, has been shown in clinical trials to relieve constipation and improve abdominal pain in patients with irritable bowel syndrome with constipation (IBS-C), but there are limited UK specific 'real-world' data to support this. The aim of the study was to describe real-world clinical experience of linaclotide in the UK.

Methods
A multi-centre, observational, uncontrolled, prospective 52-week study across 8 centres in the UK. The primary objective was to describe the change from baseline in IBS-Symptom Severity Scale (IBS-SSS) score at 12 weeks after linaclotide initiation. Patients aged ≥18 years initiated on linaclotide for IBS-C as part of usual clinical care were recruited. Patient demographic and clinical characteristics, concomitant medication, patient reported outcomes and adverse events were collected.

Results
202 patients were evaluated. Baseline characteristics were: median age 44.9 (18-77) years; median time since IBS-C diagnosis 2.6 months (0-68 years); 84 patients reported laxative use at baseline. Mean baseline IBS-SSS score was 339 (SD: 92). At 12 weeks, mean IBS-SSS score was 266 (SD: 119). There was a significant decrease in IBS-SSS scores between initiation of linaclotide treatment and 12-weeks (P<0.001; n=120 with paired data); 154 patients returned the 12-week follow-up questionnaires. Of these, 87 remained on linaclotide and 67 patients discontinued linaclotide by 12 weeks. 127 AEs possibly related to linaclotide were reported in 74 patients with diarrhoea being most common.

Conclusion
Linaclotide significantly reduced mean IBS-SSS score at 12 weeks. Linaclotide was reasonably well tolerated; diarrhoea was the most commonly reported AE.

Patients with AEs reported	No laxatives at baseline (n=118)	Laxatives at baseline (n=84)	Overall (n=202)
Diarrhoea, n (%)	18 (15%)	26 (31%)**	44 (22%)
Abdominal cramps/pain, n (%)	8 (7%)	11 (13%)	19 (9%)
Drug ineffective, n (%)	8 (7%)	5 (6%)	13 (6%)
**Chi-square test *P*=0.008			

ABSTRACT NO. 85 (17W211) POSTER PRESENTATION

Reduction of surveillance endoscopy waiting time through the effective use of international guidelines

Authors:
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Department(s)/Institutions:
Department of Endoscopy, St Luke's General Hospital, Kilkenny.

Background:
Colorectal cancer (CRC) affects up to 2,500 patients each year in Ireland. It is also the second most common cause of cancer death in Ireland. Patients with family history (FHx) of colorectal cancer warrant timely endoscopic surveillance however are currently on the waiting list for delayed periods. The latest British Society of Gastroenterology (BSG) guidelines recommend endoscopic surveillance to be performed at 5 year interval for intermediate risk individuals.

Aim:
To review endoscopy referral forms for appropriateness of the procedure, FHx, and timing of endscopy performed and to assess compliance with BSG guidelines.

Methods:
St. Luke's Hospital surveillance endoscopy booking forms were interrogated to identify all patients with positive FHx for gastrointestinal cancer. All were due for endoscopy between 2010-2015. 122 patients from the surveillance list were invited back to the out patient department (OPD) from May-2016 and Aug-2016 to determine whether their endoscopic procedure was still warranted.

Results:
A total of 112 patients (92%) attended and were reviewed in the FHx OPD. 91 patients correctly qualified for screening endoscopy out of which 2 patients were already added to the waiting list. 1 patient was referred for CT colonography and 18 were discharged back to their general practitioner (GP). The 10 patients that did not attend the OPD were discharged back to their GP.
Of the 112 patients seen in OPD 22 booking forms had incorrect/insignificant FHx, however 4 patients were symptomatic and were subsequently referred for endoscopy. Morever, seven patients were incorrectly listed for endosopy for the year 2015 and rescheduled for 2018.
73 patients had their procedure carried out to date out of which:

- 23 patients endoscopy procedures were normal and these patients were referred back to their GP
- 1 patient will require yearly endoscopy due to genetic disorder.
- 47 patients will remain on 5 early surveillance programme due to FHx with 16 of these coming under the category of polyp surveillance.
- 1 patient endoscopy was incomplete- awaiting a repeat appointment.
- 1 patient ulcerative colitis-asymptomatic.

Conclusion:
There are a large number of patients on the waiting lists awaiting endoscopy. Significant proportion of these patients are overdue their endoscopy, or are incorrectly booked or do not even require an endoscopy. Such disparieties have significant ramifications to an already over burdened health care service. Health care personnelle should be provided with frequent updates regarding international guidelines and abiding to these will aid in accurate endoscopy waiting times and improved resource allocation.

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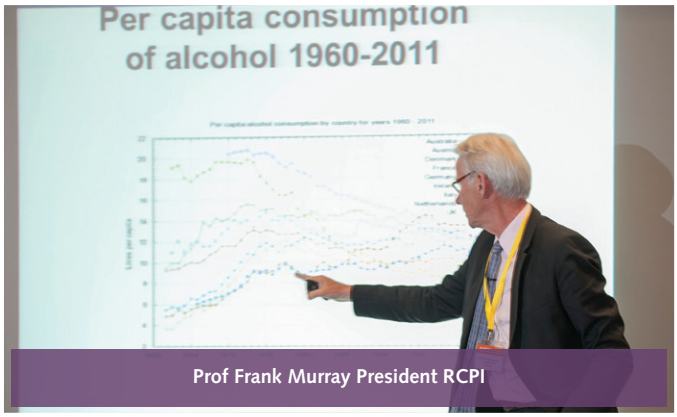
Prof John O'Grady

BIG Meeting 2017



Prof Frank Murray President RCPI

Prof Martin Lombard Pres. BSG


Dr Nadeem Iqbal

Dr Gideon Hirchfield


Audience View

BIG Meeting 2017

Prof Padraic MacMathuna Pres ISG, Dr Jenny Addley, Hon Treas USG

Dr Paul Lynch & Dr Brian Johnston

Prof Jan Tack

Dr Orla Craig

Prof Eamon Quigley, Houston Texas.

Dr Peter Watson Pres. USG

Dr David Kevans

Prof Laurence Egan, Incoming Pres. ISG

BIG Meeting 2017

Dr Alaa Alakari receiving 1st Prize Oral from Peter Watson

Dr Kevin Walsh & Dr Gavin Harewood

Dr John & Mrs Lennon

Dr Lisa Coffey

Mr Martin Caldwell, Dr Kevin Walsh & Dr Vikrant Pariher

Dr Suzanne O'Reilly

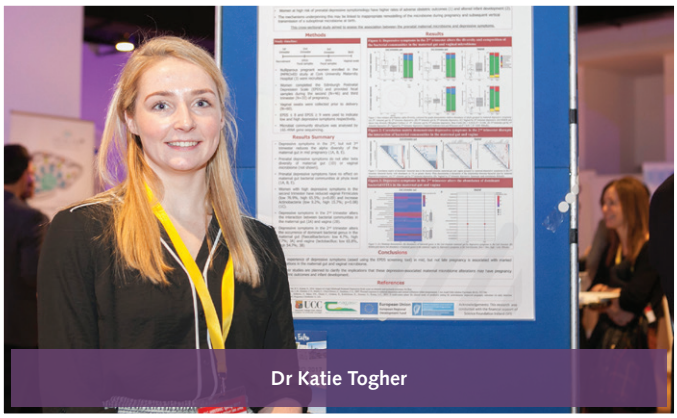
Dr Jack Satsangi

BIG Meeting 2017

Dr Johnny Cash


Ann Marie Ryan & Michelle from Fleetwood HealthCare


Dr Nessa McGettigan & Dr Aisling Murphy


Dr Katie Togher


Dr Deirdre O'Donovan, Dr Maire Buckley & Prof Jan Tack

Dr Patrick Allen & Dr Jenny Addley


Dr Sara Naimimohasses, Dr Roisin Stack & Dr Clodagh Murphy


Dr Vikrant Pariher & Dr Alaa Alakkari

BIG Meeting 2017

Delegate registration

Takeda satelitte Meeting

Fleetwood HealthCare Stand

Dr Stephen Stewart, Prof John Crowe & Prof Padraic MacMathuna

Dinner at Queens

Asacolon 400mg & 800mg GR Tablets

Once daily treatment for the maintenance of remission of mild to moderate ulcerative colitis in adults & children aged 6-18 years

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

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

INDICATIONS: For the treatment of mild to moderate acute ulcerative colitis. Maintenance of remission of ulcerative colitis. Maintenance of surgically-induced remission of Crohn's disease. **POSOLOGY AND ADMINISTRATION:** Oral use. To be swallowed whole (not chewed) with liquid before food. **Adults: Ulcerative colitis: Induction of remission:** 2.4 g daily in divided doses. If required the dose may be increased to 4.8 g daily. **Maintenance of remission:** 400 mg tablets: 1.2 to 2.4 g per day, once daily or in divided doses. 800 mg tablets: 1.6 to 2.4 g per day, once daily or in divided doses. **Crohn's Disease: Maintenance of post-surgical remission:** 2.4 g per day, once daily or in divided doses. **Elderly:** As for adults, unless renal or hepatic function is impaired. **Children:** Limited data. **Children aged 6 years and over: Active disease:** titrate to individual, initial dose 30 to 50 mg/kg/day in divided doses, maximum 75 mg/kg/day, do not exceed 4.0 g/day. **Maintenance:** titrate to individual, initial dose 15 to 30 mg/kg/day in divided doses, do not exceed 2.0 g/day. **CONTRAINDICATIONS:** Hypersensitivity to salicylates, mesalazine or any excipient. Severe renal or hepatic impairment. Children aged under two years. **SPECIAL WARNINGS AND PRECAUTIONS:** Conduct blood count, liver function tests, serum creatinine and urinary status (dip stick) prior to and during treatment. Follow up after 14 days, then every 4 weeks for 12 weeks, 3 monthly thereafter or immediately if signs appear. Not for use in patients with renal impairment. Caution in patients with raised serum creatinine or proteinuria. Stop treatment **immediately** if signs of renal impairment develop, or if there is suspicion or evidence of blood dyscrasia. Caution in patients with hepatic impairment, gastric or duodenal ulcer. Not for use in patients with a history of mesalazine-induced cardiac hypersensitivity. Caution in patients with any previous myo- and pericarditis of allergic background. Monitor closely: Patients with pulmonary disease, particularly asthma; patients sensitive to sulfasalazine. Stop treatment immediately if acute symptoms of intolerance (e.g. abdominal cramps, acute abdominal pain, fever, severe headache and rash). Not for use in patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. Tablets in stools may be empty shells. Caution in elderly; use subject to renal and hepatic function. Limited data in children (aged 6 to 18 years). **INTERACTIONS:** Mesalazine can increase the myelosuppressive effects of azathioprine, 6-mercaptopurine, or thioguanine. Life-threatening infection can occur. Monitor closely for signs of infection and myelosuppression. Haematological parameters, especially the leukocyte, thrombocyte and lymphocyte cell counts should be monitored weekly, especially at initiation of combination therapy. **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-5-aminosalicylic acid and mesalazine are excreted in breast milk. The clinical significance has not been determined. Hypersensitivity reactions such as diarrhoea in the infant cannot be excluded. Use only if the benefit outweighs the risk. If the infant develops diarrhoea, discontinue breast-feeding. **UNDESIRABLE EFFECTS: Common:** dyspepsia, rash. **Uncommon:** eosinophilia, paraesthesia, urticaria, pruritus, pyrexia, chest pain. **Rare:** headache, dizziness, myocarditis, pericarditis, abdominal pain, diarrhoea, flatulence, nausea, vomiting. **Very rare:** blood dyscrasias, hypersensitivity reactions, fever, lupus erythematosus, pancolitis, peripheral neuropathy, lung reactions, pneumonia, pancreatitis, changes in hepatic and renal function, hepatitis, nephrotic syndrome, renal failure, oligospermia, alopecia, myalgia, arthralgia. **Frequency not known:** pleurisy, lupus-like syndrome, mesalazine intolerance. Refer to Summary of Product Characteristics for details.

LEGAL CATEGORY: POM.
MARKETING AUTHORISATION NUMBER: Asacolon® 400 mg GR Tablets PA 2018/1/1, Asacolon® 800 mg GR Tablets PA 2018/1/2.
MA HOLDER: TILLOTTS PHARMA GMBH, Warmbacher Strasse 80, DE- 79618 Rheinfelden, Germany.
DATE OF PREPARATION: May 2017. CODE: 2017/9.
FULL PRESCRIBING INFORMATION AVAILABLE ON REQUEST FROM THE MARKETING AUTHORISATION HOLDER OR FROM TILLOTTS PHARMA LIMITED, 25 SANDYFORD OFFICE PARK, DUBLIN 18, IRELAND, TEL: (00 353 1) 294 2015.
Asacolon® is a trademark.

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

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

ZERIA GROUP
TILLOTTS PHARMA
GI-health is our passion™

NEW IN HCV

MAVIRET®

glecaprevir/pibrentasvir

DON'T LOOK BACK

ONE REGIMEN ALL GENOTYPES 8-WEEKS

FOR TREATMENT-NAÏVE, NON-CIRRHOTIC PATIENTS[1]

8 WEEK TREATMENT[1]

- TREATMENT-NAÏVE NON-CIRRHOTIC GT 1-6
- TREATMENT-EXPERIENCED* NON-CIRRHOTIC GT 1, 2, 4, 5, 6

12 WEEK TREATMENT[1]

- TREATMENT-NAÏVE CIRRHOTIC GT 1-6
- TREATMENT-EXPERIENCED* CIRRHOTIC GT 1, 2, 4, 5, 6

16 WEEK TREATMENT[1]

- TREATMENT-EXPERIENCED NON-CIRRHOTIC GT 3
- TREATMENT-EXPERIENCED* CIRRHOTIC GT 3

**Treatment-experienced refers to patients who failed prior therapy with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin. Cirrhotic refers to compensated cirrhotic (Child-Pugh A).*

STRAIGHTFORWARD ONCE-DAILY REGIMEN[1]

- No baseline resistance or viral load testing required
- No ribavirin required
- 0.1% discontinuation of treatment due to adverse reactions
- The most common adverse reactions (≥10% of patients) were headache and fatigue

Maviret® ▼ 100mg/40mg film-coated tablets PRESCRIBING INFORMATION

PRESENTATION: Each film-coated tablet contains 100 mg glecaprevir and 40 mg pibrentasvir. Please refer to the Summary of Product Characteristics (SmPC) before prescribing. **INDICATION:** For treatment of Chronic Hepatitis C Virus (HCV) in adults. **DOSAGE AND ADMINISTRATION:** Oral. Treatment to be initiated and monitored by physician experienced in the management of patients with HCV infection. See SmPC for full posology. **Dosage:** The recommended dose of Maviret is 300 mg/120 mg (three 100 mg/40 mg tablets), taken orally, once daily with food. **Treatment Duration:** Patients without prior HCV therapy (GT 1-6): **No cirrhosis:** 8 weeks. **Cirrhosis:** 12 weeks. Patients who failed prior therapy with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin: GT 1, 2, 4-6: **No cirrhosis:** 8 weeks. **Cirrhosis:** 12 weeks. GT 3: **No cirrhosis:** 16 weeks. **Cirrhosis:** 16 weeks. **Special Populations:** HIV-1 Co-infection: Follow the dosing recommendations as above. For dosing recommendations with HIV antiviral agents, refer to SmPC for additional information. Elderly: No dose adjustment required. Renal impairment: No dose adjustment required. Hepatic impairment: No dose adjustment recommended in patients with mild hepatic impairment (Child-Pugh A). Maviret is not recommended in patients with moderate hepatic impairment (Child-Pugh B) and is contraindicated in patients with severe hepatic impairment (Child-Pugh C). Liver transplant patients: 12 weeks minimum in liver transplant recipients, with 16 week treatment duration to be considered for GT 3-infected patients who are treatment experienced with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin. Paediatric Population: No data available. **CONTRAINDICATIONS:** Hypersensitivity to the active substances or to any of the excipients. Patients with severe hepatic impairment (Child-Pugh C). Concomitant use with atazanavir containing products, atorvastatin, simvastatin, dabigatran etexilate, ethinyl oestradiol-containing products, strong P-gp and CYP3A inducers (e.g., rifampicin, carbamazepine, St. John's wort (Hypericum perforatum), phenobarbital, phenytoin, and primidone). **SPECIAL WARNINGS AND PRECAUTIONS:** Hepatitis B Virus reactivation: HBV screening should be performed in all patients before initiation of treatment. HBV/HCV co-infected patients are at risk of HBV reactivation, and should, therefore, be monitored and managed according to current clinical guidelines. Liver transplant patients: The safety and efficacy of Maviret in patients who are post-liver transplant have not yet been assessed. Treatment with Maviret in this population in accordance with the recommended posology should be guided by an assessment of the potential benefits and risks for the individual patient. Hepatic impairment: Maviret is not recommended in patients with moderate hepatic impairment (Child-Pugh B) and is contraindicated in patients with severe hepatic impairment (Child-Pugh C). Patients who failed a prior regimen containing an NS5A- and/or an NS3/4A-inhibitor: GT 1-infected (and a very limited number of GT 4-infected) patients with prior failure on regimens that may confer resistance to glecaprevir/pibrentasvir were studied in the MAGELLAN-1 study. The risk of failure was, as expected, highest for those exposed to both classes. A resistance algorithm predictive of the risk for failure by baseline resistance has not been established. Accumulating double class resistance was a general finding for patients who failed re-treatment with glecaprevir/pibrentasvir in MAGELLAN-1. No re-treatment data is available for patients infected with GT 2, 3, 5 or 6. Maviret is not recommended for the re-treatment of patients with prior exposure to NS3/4A- and/or NS5A-inhibitors. Lactose: Maviret contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **INTERACTIONS:** See SmPC for full details. Contraindicated: Dabigatran etexilate, carbamazepine, phenytoin, phenobarbital, primidone, rifampicin, ethinyloestradiol-containing products, St. John's wort, atazanavir, atorvastatin, simvastatin. Not Recommended: darunavir, efavirenz, lopinavir/ritonavir, lovastatin, ciclosporin doses > 100 mg per day, omeprazole doses ≥ 40 mg daily. Use Caution: digoxin, pravastatin, rosuvastatin, fluvastatin, pitavastatin, tacrolimus. Monitor Levels: Digoxin, Monitor INR with all vitamin K antagonists. No dose adjustment: Losartan, valsartan, sofosbuvir, raltegravir, elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide, levonorgestrel, norethidrone or norgestimate as contraceptive progestogen. **FERTILITY, PREGNANCY AND LACTATION:** Maviret is not recommended in pregnancy. It is not known whether Maviret and its metabolites are excreted in breast milk. No human data on the effect of glecaprevir and/or pibrentasvir on fertility are available. **SIDE EFFECTS:** See SmPC for full details. ***Very common side effects*** *(≥1/10):* headache, fatigue. ***Common side effects*** *(≥1/100 to <1/10):* diarrhoea, nausea, asthenia. **HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL – Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Suspected adverse events should also be reported to AbbVie Limited on 01-4287900. LEGAL CATEGORY:** POM. **MARKETING AUTHORISATION NUMBER/ PRESENTATIONS:** EU/1/17/1213/001 – blister packs containing 84 (4 x 21) film-coated tablets. **MARKETING AUTHORISATION HOLDER:** AbbVie Ltd, Maidenhead, SL6 4UB, UK. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. **DATE OF REVISION:** July 2017. PI/1213/001

REFERENCE: 1. MAVIRET Summary of Product Characteristics, available on www.medicines.ie

IREMAV170618 **Date of Preparation:** November 2017

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