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Irish Society of Gastroenterology

Winter Meeting

22-23 November 2018
Fitzpatrick Castle Hotel
Killiney, Co. Dublin

MSD

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

ASACOLON®

mesalazine 400mg & 800mg GR tablets

On Target for Remission

90%
of patients with mild to moderate UC maintain remission at 6 months at doses of 1.6g-2.4g/day[1]

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

ASACOLON® 400 mg and 800 mg GR Tablets:

Reddish brown, oblong, coated tablets each containing 400 mg or 800 mg mesalazine.

INDICATIONS: Adults and children over six years: Treatment of mild to moderate acute ulcerative colitis, maintenance of remission of ulcerative colitis. Maintenance of surgically-induced remission of Crohn's disease. DOSAGE AND ADMINISTRATION: Oral use. To be swallowed whole (not chewed) with liquid before food. Adults: Ulcerative colitis: Induction of remission: 2.4 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. May decrease the anticoagulant effect of warfarin. USE DURING PREGNANCY AND LACTATION: Limited data on use in pregnancy. One case of neonatal renal failure was reported. Mesalazine crosses the placental barrier, 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: photosensitivity (more severe in patients with atopic dermatitis or eczema), 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, nephritis, 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, Wermbacher Strasse 80, DE- 79618 Rheinfelden, Germany. DATE OF PREPARATION: February 2018. CODE: 2018/4. 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™

Welcome Message

Dear members and guests,

It is my great pleasure to welcome you to the 2018 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, the IBD Nurses Association of Ireland and the Irish Hepatology Nurses Association who also hold their meetings today and tomorrow alongside the ISG.

I would like to bring to your attention one special achievement for recognition: our past President, Prof. Colm Ó Moráin was awarded the UEG Lifetime Achievement Award at the congress this year. Please join me in congratulating Colm on this outstanding recognition of his tremendous service to our specialty in Ireland and abroad.

Gastroenterologists in Ireland are facing many challenges in 2018. Foremost among these is the challenge of meeting increasing demand for endoscopic services. This includes both routine diagnostic procedures, but also more advanced techniques such as endoscopic mucosal resection and others. One particular issue that is perhaps underdeveloped in Ireland and not always managed in a uniform way across our hospitals is the management of acute GI bleeding. The programme of this meeting includes speakers who will address those topics.

Gastrointestinal surgeons in Ireland are embracing new technological approaches to achieve less morbid operations. The repertoire of minimally invasive approaches continues to expand and bariatric surgery also is increasingly performed in our hospitals and can result in profound changes to GI function. We look forward to two surgical lectures at this meeting that will update us on those new techniques.

At this meeting, we also return to a few important clinical topics that need to be updated: portal hypertension, liver disease in pregnancy, IBD, and medication safety.

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

Yours sincerely,
Prof. Laurence Egan
President ISG

It Began With... Entyvio®▼

(vedolizumab)

Give your UC and CD patients outcomes that matter

AIM for mucosal healing and the chance of improved long-term outcomes[1,2]

ACHIEVE long-lasting remission for years, not months[3,4]

REASSURE with a positive benefit-risk profile upheld by over 208,000 patient-years' experience[5]

Entyvio® is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis (UC) or Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or anti-TNFα therapy.

Entyvio vedolizumab

BEGIN THE CHANGE

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, upper respiratory tract infection, 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: respiratory tract infection, infusion site reaction, infusion-related reaction, pneumonia, anaphylactic reaction, anaphylactic shock. **Refer to the SmPC for details on full side effect profile and interactions. UK Basic NHS Price:** £2,050 for one vial (300mg powder for concentrate for solution for infusion). **Legal Classification:** POM. **Marketing Authorisation:** EU/1/14/923/001 **Additional information is available on request from:** Takeda UK Ltd, Building 3, Glory Park, Glory Park Avenue, Wooburn Green, Buckinghamshire, HP10 0DF. Tel: 01628 537900 Fax: 01628 526617. Takeda Products Ireland Ltd. 3013 Lake Drive, Citywest Business Campus, Dublin 24. Tel: +353 (0)1 642 0021 Fax: +353 (0)1 642 0020. **PI Approval Code:** UK/EYV/1712/0182(1) **Date of revision:** September 2018

UK: 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

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

References: 1. Dulai P, Meserve J, Hartke J, *et al.* Poster presented at European Crohn's and Colitis Organisation (ECCO); 15–18 February 2017; Barcelona, Spain. Abstract DOP023. **2.** Dulai PS, Singh S, Jiang X, *et al.* Am J Gastroenterol. 2016;111(8):1147–1155. **3.** Loftus EV, Colombel JF, Feagan B, *et al.* Poster presented at the European Crohn's and Colitis Organisation (ECCO); 15–18 February 2017; Barcelona, Spain. Poster P209. **4.** Vermeire S, Loftus EV, Colombel JF, *et al.* Poster presented at Digestive Disease Week (DDW); 6–9 May 2017; Chicago, IL, USA. Poster Su1931. **5.** Takeda UK Data on File UK/DF/1804/0008(1).

UK/EYV/1808/0089.
Date of preparation: September 2018.

Takeda

Programme for the ISG Winter Meeting
21-23 November 2018
Fitzpatrick Castle Hotel, Dublin

Wednesday Nov 21st

19.00 MSD Satellite Meeting
Prof. Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin
"New Techniques in Today's Gastroenterology"

Prof. Alexander Moschen
Medical University Innsbruck,
Innsbruck, Austria
Department of Internal Medicine
"Why do we need to achieve continuous control of disease activity in Ulcerative Colitis? The importance of Dose optimisation"

Thursday Nov 22nd

08.00 **Registration Open**

08.55 Official Opening by
Prof Larry Egan,
President ISG.

09.00 **Oral Free papers (1 – 5)**

10.00 **Endoscopy Session**
Dr Eoin Slattery,
Consultant Gastroenterologist, NUIG
"EMR: tips and tricks. How I do it"

Dr John Morris,
Consultant Gastroenterologist
Royal Infirmary. Glasgow
"Acute Upper GI Bleeding"

11.30 **Coffee Break, Poster viewing and meet the Industry.**

12.00 **Oral free papers (6- 10)**

13.00 **Lunch, poster round and meet the Industry**

14.30 **Update in GI Surgery**
Mr Chris Collins,
Consultant Surgeon,
Galway Clinic.
"Bariatric Surgery for the Gastroenterologist"

15.15 **Coffee break, Poster viewing and meet the Industry**

15.45 **Mr John Burke,**
Colorectal Surgeon,
Beaumont Hospital Dublin
"Transanal Minimally invasive surgery"

16.30 **Dr Colin Howden,**
Gastroenterologist Specialist,
University of Tennessee, Memphis
"Safety of PPI's"

17.30 AbbVie Satellite Meeting
Prof. Laurent Peyrin-Biroulet
University Hospital of Nancy, France
"Navigating UC: Exploring the burden and assessing progression"

20.00 **Conference Dinner**

Friday Nov 23rd

09.15 **Endoscopy Video Clips – ISG innovation**

10.00 **Liver Session**
Dr David Patch,
Consultant Hepatologist,
The Royal Free Hospital, London
"Chronic Liver disease - Variceal bleeding- recent updates"

Dr Michael Heneghan,
Consultant Hepatologist.
Medical Advisor to the
Primary Biliary Cirhosis (PBC) Foundation. UK
"Liver disease in Pregnancy"

11.15 **Coffee Break, Poster viewing and meet the Industry.**

11.45 **IBD Session**
Dr Anthony O'Connor,
Consultant Gastroenterologist
Tallaght University Hospital, Dublin.
"Quality of Life in IBD"

Dr Casper Steenholdt,
Dept of Gastroenterology,
Herlev University Hospital, Denmark.
"Therapeutic Drug monitoring in IBD"

13.00 **Presentation of Awards**

13.15 **Close of Meeting**

14.00 **INITIative Network Meeting**

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 filled 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 thrombocytopenia, in patients receiving TNF-blockers. Cytopenias including pancytopenia 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, thrombocytopenia, pancytopenia, aplastic anaemia, serious systemic hypersensitivity reactions (including anaphylactic reactions), 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-RE/02-17* © Merck Sharp & Dohme Ireland (Human Health) Limited 2017. All rights reserved. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie

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

IAD1-1226145-1004

Irish Society of Endoscopy Nurses
Agenda

08.30 **Registration**

09.00 **Fiona Spellman,** Chair
Clement Anburaj
CNM 2 Endoscopy Unit St.
Columcilles Hospital
Welcome to Dublin

09:15 **Devika Ghosh,** Chair
Carla Flanagan
National Nurse Lead
The Endoscopy Programme, HSE
The Endoscopy Programme Update

10:15 **Devika Ghosh,** Chair
Ann Joyce
RANP Gastroenterology
Connolly Hospital
GORD Symptoms and Management

10:45 **COFFEE**

11:15 **Liz Waters,** Chair
Caroline Conneely
National Decontamination Quality Lead

Mark Hichens
CBiol, MSB, MSc
Microbiologist
Decontamination & Open Discussion Forum

12.15 **Bridget Meehan,** Chair
Dr Conor O'Brien
Consultant Gastroenterologist
Colorectal Cancer Screening

12.50 **Mary Hackett Brennan**
Out Going Chairperson

13:00 **LUNCH**

14:00 **Liz Waters,** Chair
ISEN committee
ISGENA Feedback

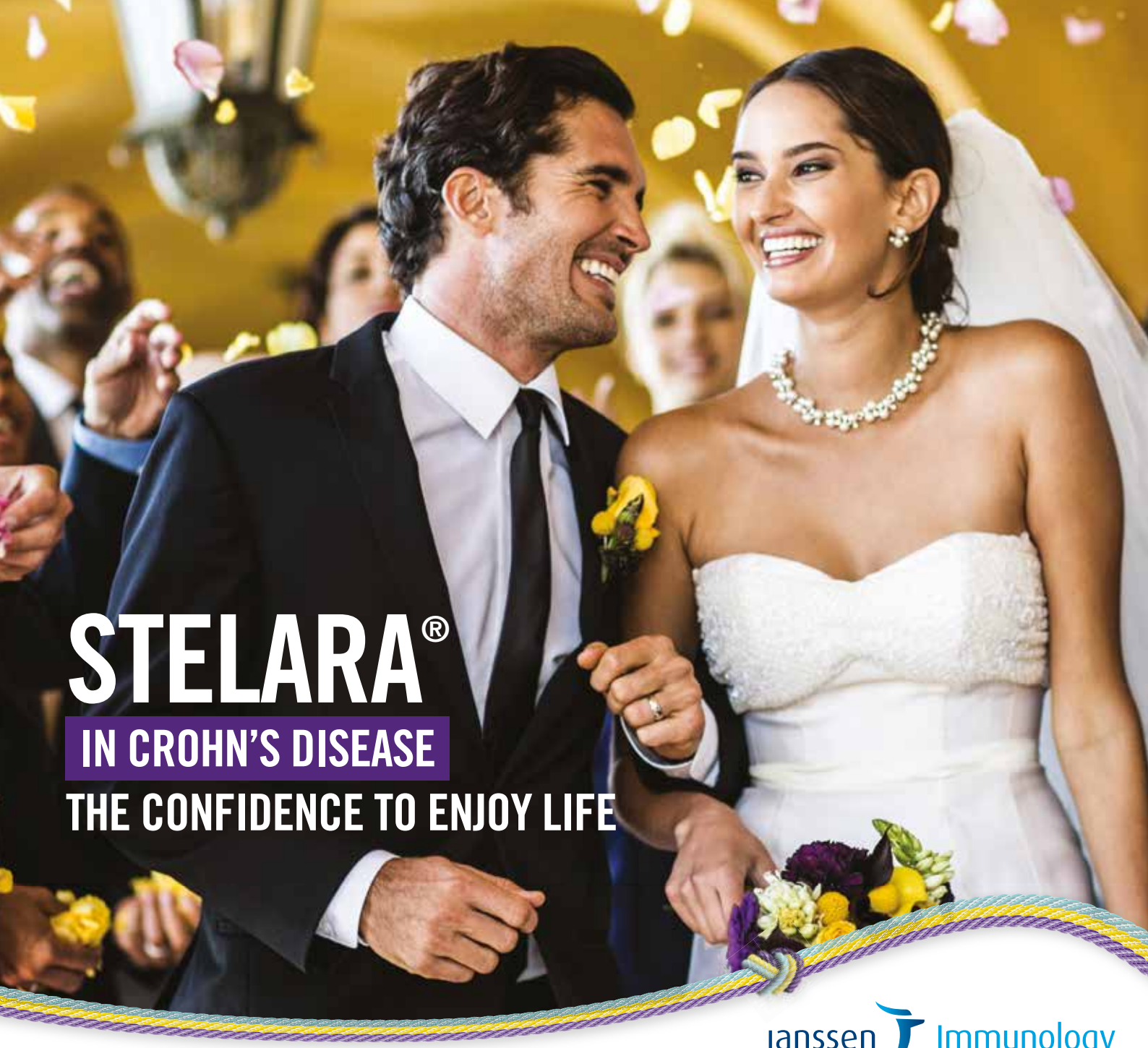
14.15 **Mary Hackett Brennan,** Chair
Ronan Leen
Locum Physician/Gastroenterologist
St Luke's Hospital Kilkenny
Pegasus (P.E.G.)

15:00 **Glenda Hahn,** Chair
Prof A. Qasim
Consultant Gastroenterologist
IBD

15:50 **Mary Shea,** Chair
Treasurers Report


ISEN Attendance


ISEN Attendance



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ACTIVE INGREDIENT(S): Ustekinumab. Please refer to Summary of Product Characteristics (SmPC) before prescribing. **INDICATION(S): Plaque psoriasis adults:** Treatment of moderate to severe plaque psoriasis in adults who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapies including ciclosporin, methotrexate or PUVA. **Plaque psoriasis paediatrics:** Moderate to severe plaque psoriasis in adolescent patients from 12 years of age, who are inadequately controlled by, or are intolerant to, other systemic therapies or phototherapies. **Psoriatic arthritis:** Alone or in combination with methotrexate for treatment of active psoriatic arthritis in adult patients when response to previous non-biological disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **Crohn's Disease:** Treatment of adult patients with moderately to severely active Crohn's disease who had inadequate response with/lost response to/were intolerant to either conventional therapy or TNFα antagonist or have contraindications to such therapies. **DOSAGE & ADMINISTRATION:** ***Adults:*** Under guidance and supervision of a physician experienced in diagnosis and treatment of psoriasis/psoriatic arthritis/Crohn's disease. **Psoriasis or psoriatic arthritis:** Subcutaneous (s.c.) injection. Avoid areas with psoriasis. Self-injecting patients or caregivers ensure appropriate training. Physicians are required to follow-up and monitor patients. **Plaque psoriasis, adults & elderly:** Patients < 100kg, 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Patients >100 kg, 90 mg at week 0 followed by a 90 mg dose at week 4, then every 12 weeks (45 mg was less effective in these patients). **Plaque psoriasis paediatrics (12 years and older):** Patients <60 kg, 0.75 mg/kg at week 0, followed by 0.75 mg/kg at week 4 then every 12 weeks thereafter. Patients ≥60 - ≤100kg, 45 mg at week 0 followed by 45 mg at week 4, then every 12 weeks. Patients >100 kg, 90mg at week 0, followed by 90mg at week 4, then every 12 weeks. **Psoriatic arthritis, adults & elderly:** 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Alternatively, 90 mg may be used in patients with a body weight >100 kg. 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. If a serious infection develops, closely monitor and STELARA should not be administered until infection resolves. ***Malignancies:*** Potential to increase risk of malignancy. No studies in patients with history of malignancy or in patients who develop malignancy while receiving STELARA. Monitor all patients, in particular those older than 60, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment for non-melanoma skin cancer. ***Concomitant immunosuppressive therapy:*** Caution, including when changing immunosuppressive biologic agents. ***Hypersensitivity reactions:*** Serious hypersensitivity reactions (anaphylaxis and angioedema) reported, in some cases several days after treatment. If these occur appropriate therapy should be instituted and STELARA discontinued. ***Latex sensitivity:*** Needle cover contains natural rubber (latex), may cause allergic reactions. ***Immunotherapy:*** Not known whether STELARA affects allergy immunotherapy. ***Serious skin conditions:*** Exfoliative dermatitis reported following treatment. Discontinue STELARA if drug reaction is suspected. **SIDE EFFECTS:** ***Common:*** upper respiratory tract infection, nasopharyngitis, dizziness, headache, oropharyngeal pain, diarrhoea, nausea, vomiting, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, injection site pain. ***Other side effects:*** cellulitis, serious hypersensitivity reactions (including anaphylaxis, angioedema), skin exfoliation, exfoliative dermatitis, lower respiratory tract infection. Studies show adverse events reported in ≥12 year olds with plaque psoriasis were similar to those seen in previous studies in adults with plaque psoriasis. **Refer to SmPC for other side effects. FERTILITY:** The effect of ustekinumab has not been evaluated. **PREGNANCY:** Should be avoided. Women of childbearing potential: Use effective contraception during treatment and for at least 15 weeks post-treatment. **LACTATION:** Limited data in humans. **INTERACTIONS:** *In vitro,* STELARA had no effect on CYP450 activities. ***Vaccinations:*** Live vaccines should not be given concurrently with STELARA, and should be withheld for at least 15 weeks after last dose of STELARA. STELARA can resume at least 2 weeks after such vaccinations. No data on secondary transmission of infection by live vaccines in patients receiving STELARA. ***Concomitant immunosuppressive therapy:*** Psoriasis: Safety and efficacy of STELARA in combination with other immunosuppressants, including biologics, or phototherapy have not been evaluated. Psoriatic arthritis: concomitant MTX did not appear to affect STELARA. Crohn's disease: concomitant immunosuppressive or corticosteroid therapy did not appear to affect STELARA. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** Prescription Only Medicine. **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S):** 45 mg, 1 x vial, EU/1/08/494/001. 45 mg, 1 x 0.5 ml pre-filled syringe, EU/1/08/494/003. 90 mg, 1 x 1.0 ml pre-filled syringe, EU/1/08/494/004. 130 mg, 1 x vial, EU/1/08/494/005. **MARKETING AUTHORISATION HOLDER:** JANSSEN-CILAG INTERNATIONAL NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen-Cilag Limited, 50 – 100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK.
Prescribing information last revised: 09/2017

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events 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 Janssen-Cilag Limited on +44 1494 567447 or at dsafety@its.jnj.com.

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(2) | Date of Preparation: May 2018

Biographical Sketches

Dr Eoin Slattery
Consultant Gastroenterologist, NUIG

Dr Eoin Slattery graduated with honours from University College Dublin in 2002. He completed his internship and general professional training at St Vincent's University Hospital. He became a member of the Royal College of Physicians of Ireland in 2005. Thereafter, he commenced higher specialist training in gastroenterology, rotating through St Vincent's Hospital, Beaumont Hospital and St Luke's Hospital Kilkenny.
During his training he obtained a post-graduate Doctorate of Medicine as the Abbott Newman fellow in Inflammatory Bowel Disease at University College Dublin. His translational research project focused on the beneficial effects of cigarette smoke on Ulcerative Colitis.
Following completion of higher specialist training, Dr Slattery embarked on sub-specialist fellowship training. He was appointed as the Irish Society of Gastroenterology Boston Scientific Advanced endoscopy fellow rotating through the Mater Hospital, Dublin and then on to Beth Israel Deaconess Medical Centre/ Harvard Medical School, Boston, MA. He then proceeded to spend 2 years as the Advanced GI nutrition support fellow in New York Presbyterian Hospital/ Columbia University Medical Centre.
He returned home to Ireland in 2015 where he was appointed as a consultant gastroenterologist at University Hospital Galway and Saolta group clinical lead for Endoscopy.

Dr John Morris
Consultant Gastroenterologist
Royal Infirmary. Glasgow

Dr John Morris is a Consultant Gastroenterologist and Honorary Senior Lecturer at Glasgow Royal Infirmary. He is President of the Scottish Society of Gastroenterology, Director of the West of Scotland Regional Endoscopy Training Centre and Gastroenterology Specialty Advisor to Greater Glasgow and Clyde Health Board. Dr Morris was previously Clinical Director for Digestive Diseases at Glasgow Royal Infirmary and visiting Associate Professor of Medicine at the Medical University of South Carolina, USA.
Dr Morris has a strong clinical commitment in luminal Gastroenterology, and in particular, therapeutic endoscopy. He has been responsible for the introduction of several innovative techniques and procedures such as NOTES, Hemospray for nonvariceal upper GI bleeding and duodenal mucosal resurfacing for Diabetes Mellitus.
Dr Morris has demonstrated a strong commitment to Endoscopy Education and has been a member of the British Society of Gastroenterology and European Society of Gastrointestinal Endoscopy Committees. He has delivered several National and International Live Endoscopy Workshops on behalf of these organisations.
Dr Morris has published and has ongoing research interests in the field of Capsule Endoscopy and Small Bowel Enteroscopy, Barrett's Endotherapy ,NOTES and metabolic endoscopy.
Currently he is leading a Multi-Society Acute Upper GI Bleeding Endoscopy Quality Improvement Project in the UK.

Mr Chris Collins
Consultant Surgeon,
Galway Clinic.

Mr Collins practices as Consultant General and Upper GI surgeon in the Bon Secours Hospital and Galway University Hospital as well as Portiuncula Hospital in Ballinasloe. Chris is currently the Upper GI lead for the HSE West and a member of the National ICU Committee. He is also a lecturer in Surgery at National University Ireland, Galway and University of Limerick.
Clinical Expertise
Mr Collins' major areas of expertise include upper gastrointestinal swallowing difficulties including achalasia, dysmotility and oesophageal reflux, as well as the diagnosis and treatment of oesophageal (gullet) and Gastric (stomach) cancers.
Mr Collins has extensive laparoscopic experience in general surgery and performs laparoscopic cholecystectomy (keyhole gallstone disease) as well as laparoscopic repair of groin and abdominal wall herniae. He offers direct access gastroscopy and colonoscopy in suitable patients for quick and easy diagnosis.
Mr Collins began his surgical training in Cork completing his basic surgical training and research in surgery there. Following his PhD, he completed the Higher Surgical Training Scheme in General and Upper Gastrointestinal Surgery along with a Masters in Quality in Healthcare. He then did a fellowship in Guys and St Thomas' in London with Professor Bob Mason concentrating on oesophago-gastric as well as bariatric surgery. He was subsequently appointed to Addenbrooke's Hospital, Cambridge as a Consultant Surgeon, where his main areas of interest were minimally invasive oesophago-gastric surgery as well as the early diagnosis and treatment of Barretts Oesophagus using Endoscopic Mucosal Resection and Radio-frequency Ablation. He was vice-chairman of the Anglia Oesophago-Gastric Group and was a founding member of the Cambridge Hernia Centre specialising in Laparoscopic Inguinal and Incisional Herniae.
Chris is a graduate of UCC engineering and medical schools. On completing his basic training he undertook research at the Cork Cancer Research Centre with Professor

Gerry O'Sullivan and developed the electrochemotherapy programme there, which culminated in a successful clinical trial and the development of new medical devices for the laparoscopic and endoscopic delivery of this treatment. He was awarded the St Luke's Young Investigator Medal in 2005 and has published in excess of 30 peer-reviewed papers as well as being involved in the successful awarding of grants from the EU as well as Enterprise Ireland for the development of electroporation devices as well as educational animation software.

He is very involved in clinical research and teaching in Galway University Hospital and Portiuncula Hospital, Ballinasloe in the areas of patient safety, minimally invasive day case and upper gastrointestinal surgery.

Mr John Burke
Colorectal Surgeon,
Beaumont Hospital Dublin

Year of Graduation: 2004
Medical School: University College Dublin
Fellowship Higher specialist training:

- Higher Surgical Training Program in General Surgery (FRCSI), RCSI
- Fellow in Advanced Colorectal Surgery, Cleveland Clinic, Ohio
- Fellow in Minimally Invasive Rectal Cancer Surgery, Florida Hospital, Orlando
- Areas of Clinical Practice:
- Colorectal surgery
- General surgery
- Minimally invasive surgery
- Endoscopy

Areas of Special interest:

- Cancer of the colon and rectum
- Inflammatory bowel disease
- Anorectal disease
- General surgery: laparoscopic cholecystectomy & hernia surgery

Dr Colin Howden
Gastroenterologist Specialist,
University of Tennessee, Memphis

MB, ChB University of Glasgow, 1978; MD, University of Glasgow, 1985
Trained in Internal Medicine, Gastroenterology and Clinical Pharmacology in University of Glasgow and at McMaster University, Canada
Professor of Medicine, University of South Carolina, Columbia, SC, USA 1991 – 98
Professor of Medicine, Rush University, Chicago, IL, USA 1998 – 99
Professor of Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL, USA 1999 – 2014
Hyman Professor of Medicine and Chief, Division of Gastroenterology, University of Tennessee Health Science Center, Memphis, TN, USA 2014 – present
Accredited by Joint Committee on Higher Medical Training (U.K.) in General (Internal) Medicine, Gastroenterology and Clinical Pharmacology & Therapeutics, 1991
Diploma in Gastroenterology, European Board of Gastroenterology / European Union of Medical Specialists, 1997
U.S. Board certification (American Board of Internal Medicine)
Internal Medicine, 1995
Gastroenterology, 2005, 2015
Professional Societies
American Gastroenterological Association (Fellow)
American College of Gastroenterology (Fellow)
American College of Physicians (Fellow)
British Society of Gastroenterology (Member)
American College of Clinical Pharmacology (Fellow)
Royal College of Physicians and Surgeons of Glasgow (Fellow)
Editor-in-Chief, GI & Hepatology News, 2011 – 16
Associate Editor, American Journal of Gastroenterology, 2009 – 13
Associate Editor, Alimentary Pharmacology and Therapeutics, 2014 – 16
Co-Editor, Alimentary Pharmacology and Therapeutics, 2016 - present
Chair, Scientific Advisory Board, American Gastroenterological Association (AGA) Center for Diagnostics and Therapeutics, 2014 – 18

Dr David Patch
Consultant Hepatologist,
The Royal Free Hospital, London.

Dr David Patch was appointed at the Royal Free Hospital as a Registrar in 1993 and completed his gastroenterology/ general hepatology specialist training in 1998, accredited in General Internal Medicine and Gastroenterology. He was appointed to a substantive consultant post at the Royal Free Hospital in 1998 in the Department of Hepatology and Liver Transplantation.

Dr Patch's clinical role is as a Hepatologist and Liver Transplant Physician and his specialist interests include management of portal hypertension and complications of chronic liver disease. He performs upper endoscopies including variceal banding/gastric variceal gluing. He also performs a number of radiological procedures including trans-jugular liver biopsies, hepatic wedge pressure measurements and TIPS procedures. These have comprised his principal areas of research and he has lectured nationally and internationally on

variceal bleeding and complications of portal hypertension. Furthermore he has been on the transplant rota at the Royal Free for nearly twenty years and has published within the field of rejection, and pre- and post-operative management. He was recently Secretary of BASL (British Association for the Study of Liver disease).
Specialises in Hepatobiliary
Areas of interest: Liver transplantation; Portal hypertension; Chronic liver disease and cirrhosis; Vascular disorders of the liver.

Dr Michael Heneghan
Consultant Hepatologist.
Medical Advisor to the
Primary Biliary Cirhosis (PBC)
Foundation. UK

Qualifications:
MB., BCh, BAO (N.U.I.), MRCPI, M MED Sc, MD, USMLE, FRCPI
Year qualified: 1992
Primary speciality: Hepatology
Specialist interests: Liver transplantation
Autoimmune liver disease
Professional memberships:
British Association for the Study of the Liver (BASL)
Royal Academy of Medicine of Ireland (RAMI)
American Association for the Study of Liver Disease (AASLD)
International Liver Transplantation Society (ILTS)
American Gastroenterological Association (AGA)
European Association for the Study of the Liver
Biography
Dr Heneghan is a Consultant Hepatologist with specialist interest in liver transplantation and autoimmune liver disease. He trained at the University College of Dublin and qualified in 1992. After his Residency in Internal Medicine at the University College Hospital Galway, he trained in Gastroenterology and Hepatology between 1995 and 2001 in Ireland, London and the U.S.A. Dr Heneghan worked at Duke University Medical Centre in the U.S.A before starting at King's as Senior Lecturer and Consultant Hepatologist. He is the Clinical Lead for Hepatology and Liver Outpatient Services for King's.

Dr Anthony O'Connor
Consultant Gastroenterologist
Tallaght University Hospital, Dublin.

Dr Anthony O'Connor graduated in medicine from University College Cork in his hometown in 2004. He completed SHO training in Limerick before undertaking higher specialist training in Gastroenterology in Tallaght and St. James's Hospitals in Dublin. He was awarded an MD by Trinity College Dublin in 2012 for a thesis on the management of Helicobacter pylori infection and gastric intestinal metaplasia with regard to gastric cancer prevention supervised by Professor Colm O'Morain.

Upon completion of his training in Ireland he worked as a fellow in IBD at Beth Israel Deaconess Medical Center/ Harvard Medical School in Boston, USA before taking up an appointment as Consultant Gastroenterologist at Leeds Teaching Hospitals NHS Trust in June 2014 and returning to Ireland in 2016 to an appointment as Consultant Gastroenterologist at Tallaght Hospital where he leads the IBD service. He has published more than 40 peer-reviewed journal articles and has given invited lectures and oral presentations at many national and international meetings. His interests are Inflammatory Bowel Diseases especially Post-operative prophylaxis of Crohn's disease and Quality of Life for patients with IBD, the GI complications of cancer therapies, Upper Gastrointestinal Tract Bleeding, Helicobacter pylori infection and Gastric Cancer prevention. Away from work he lives in south Dublin with his wife and small twins and unsuccessfully juggles the conflicting demands of work and family life with several lowbrow interests which mainly revolve around supporting hopelessly lost causes in the worlds of sport and politics.

Dr Casper Steenholdt
Dept of Gastroenterology,
Herlev University Hospital, Denmark.

Born 4th of June, 1980
2007 Medical Doctor (MD) at University of Copenhagen, Denmark (DK)
2013 PhD at Faculty of Health and Medical Sciences at the University of Copenhagen, DK
2014-Resident in Internal Medicine: Gastroenterology & Hepatology, Copenhagen, DK
2016 Doctor of Medical Science (DMSc) at the University of Copenhagen, DK

ISG Board Members

Professor Laurence Egan,
President ISG
NUI Galway

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

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.

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

Glen grew up in Northern Ireland and graduated in Medicine at Trinity College Dublin in 1998. He was awarded his PhD by NUI in 2006 and completed his gastroenterology training in Ireland followed by an advanced IBD fellowship at Beth Israel Deaconess Medical Center and Harvard Medical School, Boston. Since 2010 he has worked as a consultant gastroenterologist at St Vincent's University Hospital in Dublin and as a senior clinical lecturer in the School of Medicine and Medical Science at University College Dublin. His research interests are in the role of innate and adaptive immunity in inflammatory bowel disease (Ulcerative Colitis and 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 is a Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast.. He has more than 70 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" which has been published as a 3rd edition and translated into Polish and Chinese. He has contributed to several other book chapters. He has been co-author of guidelines on ERCP, Barretts

oesophagus, perianal Crohns, non medical endoscopy workforce and UK gastroenterology services. He was the Guidelines Editor for Gut. He is on the International Editorial Board of the journal Gastrointestinal Endoscopy; Associate Editor of the World Journal of Gastrointestinal Endoscopy; Diagnostic and Therapeutic Endoscopy. He has received several awards for being a top reviewer for Gastrointestinal Endoscopy.

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

Mr Jürgen Mulsow
Consultant General and Colorectal Surgery
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

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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Professor of Pharmacology

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Consultant Gastroenterologist

Professor Glen Doherty, Hon. Treasurer, ISG
Consultant Gastroenterologist

Dr Susanne O'Reilly
Gastroenterology SpR

Dr Paul Lynch,
Consultant Gastroenterologist

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Dr Tony Tham,
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Mr Jurgen Mulsow
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Dr Manus Moloney
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Oral Presentations - ISG Winter Meeting

Ref:	Name	Title of Paper	Time
18W200	Ciaran Judge	Vedolizumab is a Safe and Effective Choice in the Treatment of Ulcerative Colitis: An Irish Perspective	9.00
18W149	Tim Ryan	Sustained Remission in Inflammatory Bowel Disease Patients after Discontinuing Infliximab; are we too reluctant to stop biologics?	9.12
18W177	Rita Douglas	Shared Angiogenic Drivers of Intestinal Vascular Disorders	9.24
18W164	Fintan O'Hara	Implementation of the Performance Indicator of Colonic Intubation: How useful is this new measure in clinical practice?	9.36
18W147	Mairead McNally	The use of Fatty Liver Index and Fibroscan to determine the prevalence of Non alcoholic Fatty Liver Disease in an Irish Population	9.48
18W144	Stephanie Denieffe	The Impact of Different Assay Methodologies in Prognostic Liver Scoring Systems	12.00
18W170	Laksman Kumar	Composite Scores for Quality in Endoscopy: Are we being PICI enough with our KPIs?	12.12
18W202	Erin Sullivan	Loss of adipose tissue mass during systemic chemotherapy predicts poor survival in patients with colorectal cancer	12.24
18W182	Syafiq Ismail	Colon Capsule Endoscopy with or without biomarkers as a viable alternative to colonoscopy in unselected patients with lower GI symptoms:Pilot study	12.36
18W151	Cathy Rowan	Mucosal Hypoxia and altered HIF pathway signalling is a hallmark of disease activity in severe UC	12.48

ORAL PRESENTATIONS

ABSTRACT 1 (18W200)

Vedolizumab is a Safe and Effective Choice in the Treatment of Ulcerative Colitis: An Irish Perspective

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Introduction
Vedolizumab (VDZ) is a monoclonal antibody designed to inhibit α4β7 integrin and result in gut-selective anti-inflammatory activity. Randomised control trials have shown VDZ to be safe and effective in treating patients with ulcerative colitis (UC). However, real-world data describing the outcome of VDZ therapy in routine clinical practice are limited.

Aims/Background
We aimed to evaluate the safety and efficacy of VDZ in routine clinical practice.

Method
A multi-centre, retrospective study was conducted across 10 Irish academic hospitals. Patients receiving VDZ for UC were evaluated. N=86 patients were identified, with n=64 patients having at least 6 months follow-up included in the final cohort. Primary study endpoint was therapy success as defined by duration of time patients remained free of VDZ discontinuation. Secondary endpoints included 3-month clinical response, 6-month corticosteroid-free remission, and adverse events. Clinical response was defined as ongoing receipt of VDZ with a reduction in partial Mayo subscore of ≥3 points, or a Mayo score of ≤2. 6-month clinical remission was defined as ongoing steroid-free receipt of VDZ with a Mayo score of ≤1 point.

Results
64 patients were identified (male 66.7%; median [range] age 39 years [19 – 80 years]; median follow up 15 months [7 – 28 months]. Disease characteristics included; UC extent (50.0% extensive; 41.1% left-sided; 8.9% proctitis); previous anti-TNF exposure (21.9% anti-TNF naïve; 39.1% ≥2 previous anti-TNF medications); partial Mayo subscore at baseline 7 [0 – 9]. 26.6% of patients discontinued VDZ during follow up, median time to VDZ discontinuation 5 months [5 – 22 months]. 3-month clinical response and 6-month corticosteroid-free remission rates were 40.6% and 31.3%, respectively. A subset analysis of 29 patients with follow up at 1 year revealed a 1-year corticosteroid-free remission rate of 26.6%. Adverse events occurred in 1.6% of subjects (n=1), which was minor and self-limiting.

Conclusions
These data support vedolizumab as a safe and effective induction and maintenance agent in the treatment of ulcerative colitis in a refractory cohort. The improvement in clinical disease activity suggests utility of VDZ in treating patients with significant previous exposure to anti-TNF.

ABSTRACT 2 (18W149)

Sustained Remission in Inflammatory Bowel Disease Patients after Discontinuing Infliximab; are we too reluctant to stop biologics?

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Introduction
Biologic therapy, including Infliximab is the current gold standard treatment of both Crohn's Disease (CD) and Ulcerative Colitis (UC). Long term treatment is associated with adverse effects and significant healthcare budget burden. Previous studies into the discontinuation of biologic treatment for patients in clinical remission have shown 40-49% relapse rates by 24 month follow up.

Aims/Background
To critically evaluate the clinical/biomarker/financial outcome of biologic discontinuation in IBD patients from 2006 to 2018.

Method
A single centre retrospective analysis of all patients discontinuing Infliximab treatment due to disease remission defined by clinical, endoscopic and biomarker (CRP or FCP) criteria. The mean length of infliximab received before discontinuation was 38.5 months. Data was gathered on patients' biomarkers, endoscopy scores and clinical status at baseline, 3, 6, 12 and 24 months. Combination drug therapies and changes in medications were documented and a cost analysis performed.

Results
The study identified 30 patients discontinuing Infliximab due to disease sustained remission. Data on 22/30 patients was available at 24 months, 91% (20/22) remained in clinical remission. Of the original cohort, 13.3% (4/30) patients had relapsed, resulting in restarting biologic treatment Of the relapse patients, 75% had CD, 25% UC. After discontinuation 50% (n=2) took no other medications for IBD. Cost analysis showed €379,351.56 per annum saving from discontinuation of Infliximab.

Conclusions
This study showed low relapse rates compared with other studies. Demographics were similar in relapse patients versus the sustained remission cohort. Discontinuation of Infliximab for patients in remission was safe and offered substantial savings to the healthcare budget.

ABSTRACT 3 (18W177)

Shared Angiogenic Drivers of Intestinal Vascular Disorders

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Introduction
Telangiectasias are common to a variety of GI disorders with differing etiologies and presentations. Shared angiogenic factors modulated by disease specific elements could be a common denominator and represent novel diagnostic and therapeutic targets. As yet, assessment of angiogenic factors across common GI vascular disorders has not been reported.

Aims/Background
To assess serum levels of angiogenic factors in intestinal vascular disorders.

Method
Serum from patients with sporadic angiodysplasia (SBA), Portal hypertensive gastropathy (PHG), Gastric Antral Vascular Ectasia (GAVE) and non-bleeding, non-anaemic controls were collected. Using ELISA, concentrations (pg/ml) of Angiopoietin 1 (Ang-1), Angiopoietin 2 (Ang-2) and Vascular Endothelial Growth Factor (VEGF) were measured and compared between groups using a T-test.

Results
To date 39 samples were tested: 10 SBA, 11PHG, 8 GAVE and 10 Controls. Mean age 65 (range 33-86) years and 20 (51%) were males. Controls were significantly younger (41 vs 63yrs). SBA, PHG and GAVE Ang-1 levels were similar and were significantly lower than controls: 35695, 23111, 30753, V's 57900, (P=0.0001, 95%CI 313.7 to 820), while their Ang- 2 levels were higher: 2803, 4297, 4231, V's 1676 (P=0.02, 95%CI -776.7 to -58.2). There was no difference in their VEGF levels, 443, 316, 435 V's 403 (P=0.86).

Conclusions
Our novel study of intestinal vascular disorders has shown a reduction in Ang-1 levels, a vascular factor associated with vessel stabilization and maturation, with associated elevation of its competitive inhibitor Ang-2. Angiopoietin factor disturbance may represent a common pathophysiological pathway modified by as yet unknown disease specific factors.

ABSTRACT 4 (18W164)

Implementation of the Performance Indicator of Colonic Intubation: How useful is this new measure in clinical practice?

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Introduction
Poor quality colonoscopy is associated with more frequent adverse outcomes such as missed cancers and higher complication rates. Traditional quality measures like the Caecal intubation rate (CIR) fail to take into account variables that might reflect safety and patient experience, such as patient comfort and sedation. A recent study has proposed the Performance Indicator of Colonic Intubation (PICI), which combines three key parameters of colonoscopy: Caecal Intubation, sedation dosage and Patient comfort score. It has been proposed to use this indicator to benchmark endoscopy units and to identify, support and monitor individuals in need of improvement.

Aims/Background
To investigate the potential usefulness of the PICI as a tool for quality improvement in colonoscopy.

Method
A retrospective analysis of all colonoscopies performed in our unit over a period 12 months was performed. Anonymised data from colonoscopies performed between July 2017 - July 2018 was collated. PICI rate was defined as the percentage of procedures achieving cecal intubation with midazolam dose

Results
2990 colonoscopies by a total of 26 endoscopists were recorded. A PICI rate was 54.9% was achieved overall. 71.2% by Gastroenterologists vs 48.4% Surgeons (OR = 2.64, P <0.001) Colonoscopies achieving the PICI had a significantly higher PDR 32.7% vs 21.4% (OR = 1.78, P <0.001). PDR also varied between Gastroenterologists and Surgeons (36.6% vs 22.5%, OR = 1.99, P <0.001)

Conclusions
Endoscopists with a higher PICI rate have a significantly higher PDR. PICI provides a useful composite performance indicator for quality improvement in colonoscopy.

ABSTRACT 5 (18W147)

The use of Fatty Liver Index and Fibroscan to determine the prevalence of Non alcoholic Fatty Liver Disease in an Irish Population

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Introduction
Rates of non-alcoholic fatty liver (NAFLD) and non alcoholic steatohepatitis (NASH) are increasing worldwide with NASH now being the second commonest indication for liver transplant in the US.

Aims/Background
To use the Fatty Liver Index (FLI) to identify those at risk of having NAFLD amongst all comers presenting to the Acute Medical Unit (AMU). To use this data as an indicator of prevalence of NAFLD in Ireland and to subsequently perform fibroscan on those with a high FLI score.

Method
All patients attending AMU in a six month period were invited to participate. A FLI score was then calculated and those with a score > 60 were invited back for fibrsoscan and NAFLD fibrosis score.

Results
Data was completed on 504 participants, 89 were excluded, due to alcohol excess or pre-existing liver disease. Of the remaining 415; 134 had a FLI score 60 (high risk). Male sex ($p<0.0001$) and increasing age ($p< 0.0001$) were associated with higher risk. Those with FLI score > 60 were invited back for fibroscan; 121 accepted, 13 of which had an elevated fibroscan score > 7. The mean fibroscan score of these 13 was 9.92 and 61.5% were male, 50% were diabetic vs 24.7% in those with a normal fibroscan score.

Conclusions
In this study 45% of participants were found to be at high risk of NAFLD, with age and male sex being significant risk factors. Reassuringly of those with a high FLI score only 11% had an elevated fibroscan score.

ABSTRACT 6 (18W144)

The Impact of Different Assay Methodologies in Prognostic Liver Scoring Systems

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Introduction
The use of biochemical tests and their incorporation into liver scoring systems forms a major part of patient management and appraising prognosis. There is no gold standard laboratory method for aminotransferases and albumin analyses and two different methods for each analyte are commonly used by diagnostic laboratories.

Aims/Background
This research examined the extent of variation in the biochemical methodologies of alanine, aspartate aminotransferase and albumin and their consequent impact on results obtained in FIB-4 and Child-Pugh calculations.

Method
Cohorts of patients referred to GI/Hepatology specialists had plasma samples tested using both International Federation of Clinical Chemistry (IFCC) and non-IFCC methodologies for the aminotransferases (n=174) and 2 commonly used complexometric methods, bromocresol green (BCG) and bromocresol purple (BCP), for albumin (n=118). The biomarker values were then incorporated into FIB-4 and Child-Pugh scores.

Results
There was discordance in FIB-4 classifications in 18% of patients when aminotransferases were analysed by IFCC versus non-IFCC. BCG methodology gave significantly higher results for albumin. The Child-Pugh cut-offs of 28g/l and 35g/l derived using BCG equate to values of 23.6g/l and 31.4g/l using BCP. Child-Pugh score varied according to methodology ($p <0.001$), with 11% of patients showing classification differences, particularly when albumin levels were between 28g/l and 35g/l.

Conclusions
Our results have provided insight into the degree of discordance in commonly utilised laboratory assays and their translation into prognostic scores.

ABSTRACT 7 (18W170)

Composite Scores for Quality in Endoscopy: Are we being PICI enough with our KPIs?

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Introduction
The Performance Indicator of Colonic Intubation (PICI) score was developed in 2017 as a composite score of 3 key performance indicators (KPI); caecal intubation, Gloucester comfort score (≤ 3) and sedation administered (Midazolam dose $\leq$2mg). Colonoscopies achieving PICI are considered of high quality. It is proposed that PICI becomes the KPI in colonoscopy quality improvement initiatives.

Aims/Background
To measure the standard of colonoscopies performed in an Irish teaching hospital using the PICI score.

Method
Retrospective analysis of data from colonoscopies performed from January 2014 to September 2018. PICI scores were correlated with polyp detection, patient demographics, indication, endoscopist and quality of bowel preparation.

Results
15010 colonoscopies from 2014 to 2018 were reviewed. Caecal Intubation Rate (CIR) was 93.64%. The median dose of midazolam used was 4mg and the mean comfort score was 1.62. PICI was achieved in 2479 (16.52%) colonoscopies. Achievement of PICI was associated with a higher polyp detection rate (46.72% vs 35.92%, $p<0.00001$). Male gender and specific indications (previous polyps, anaemia) were found to have significantly higher PICI rates. Quality of bowel preparation did not make a significant difference to PICI achievement ($p=0.082$). Independent endoscopists had better PICI rates than trainees (17.6% vs 15.8%, $p=0.039$). The highest CIR (94.74%) and lowest average comfort score (1.42) was achieved when 3mg Midazolam was used.

Conclusions
The PICI score is a useful tool to measure endoscopic quality, correlating with higher polyp detection rates. Overall, PICI achievement rates were low due to Midazolam usage > 2 mg primarily. Independent endoscopists performed better than trainees supporting the need for dedicated training lists.

ABSTRACT 8 (18W202)

Loss of adipose tissue mass during systemic chemotherapy predicts poor survival in patients with colorectal cancer

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Introduction
Obesity is an established risk factor for colorectal cancer (CRC), however little is known about changes in adiposity during chemotherapy and its impact on survival.

Aims/Background
A prospective study of adult CRC patients undergoing chemotherapy between 2012-2016 was conducted.

Method
Longitudinal changes in body composition were examined using computed tomography (CT) images at two timepoints (interval 7 months IQR:4-9 months) using paired t-tests. Sarcopenia and low muscle attenuation (MA) were defined using published cut-points. Cox proportional-hazards models were used to estimate mortality hazard ratios.

Results
227 patients were recruited (67% male, mean age 63 years) and 53% were treated with curative intent. At baseline, 4% were underweight (BMI<20kg/m2) and 60% were overweight/obese. However, 47% had cancer cachexia, 45% were sarcopenic and 43% had low MA. Neither baseline BMI, sarcopenia, sarcopenic obesity, low MA nor cachexia predicted survival. Longitudinal analysis (over 200 days) revealed significant muscle loss (2.8%, p=0.01) in patients treated with palliative intent, while the curative group lost 1.9% muscle mass (p=0.018) and gained total and subcutaneous fat (4.4%, p=0.038 and 6.3%, p=0.009 respectively). Adjusting for known prognostic covariates, loss of subcutaneous fat (Q1) was independently associated with poorer survival compared to those who remained stable or gained subcutaneous fat (Q2-Q4) [HR:2.04 (95%CI:1.31–3.19), p=0.002]. Patients who were muscle and fat stable survived significantly longer than those losing >2% fat [HR:2.15 (95%CI:1.16–4.01), p=0.016].

Conclusions
Loss of fat mass (specifically subcutaneous fat) during chemotherapy is prognostic of reduced survival, while a gain of fat mass was associated with better survival. Further work is required to elucidate the impact of concurrent changes in muscle and adipose tissue masses and the potential role of nutrition support in these changes.

ABSTRACT 9 (18W182)

Colon Capsule Endoscopy with or without biomarkers as a viable alternative to colonoscopy in unselected patients with lower GI symptoms: results of a pilot study.

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Introduction
Lower-gastrointestinal symptoms (LGS) are poor at predicting significant disease despite being the main way of prioritising referrals. Alternative diagnostic pathways are needed, biomarkers and/or colon capsule endoscopy (CCE) may be helpful.

Aims/Background
To evaluate the use of stool biomarkers and CCE in diagnosing lower-GI disease compared to colonoscopy.

Method
A prospective comparative single-centre study. Following ethical approval, patients 18-80 years referred with LGS were recruited. Participants had FC, FIT, CCE and a standard colonoscopy. FIT>10ug/g and FC>50ug/g was considered positive. Colonoscopy was considered the gold-standard. Diagnostic accuracy of biomarkers and CCE was determined and Pearson-coefficients calculated.

Results
So far, 69 patients recruited; 8 excluded. Mean age 47(20-79) years, 46%(n=32) males. To date, 40/61(66%) have undergone colonoscopy. Colonoscopy diagnostic yield 58%(n=23), caecal intubation 95%(n=38). Findings; diverticulosis, polyps, high-risk adenoma and IBD 6(15%), 10(25%), 3(7.5%) and 5(13%) respectively. 37(92.5%) FIT and 37(92.5%) FC are available; 43%(n=13/37) and 35%(n=13) were positive respectively. Mean FIT and FC; 70.5ug/g (range 0-2345) and 119.9ug/g (range <19.5->1250). FIT and FC performed poorly with a weak correlation with colonoscopy(r=0.17,-0.08); sensitivity 50%&29%, specificity 67%&56%, PPV 69%&46%, NPV 48%&38% respectively. CCE excretion rate 78%(n=31/40) and reached left colon in 100%. Diagnostic yield for CCE was 58% (n=23). CCE had a strong correlation with colonoscopy (R=0.8); sensitivity=96%, specificity=82%, PPV=88%, NPV=93%.

Conclusions
Biomarkers performed poorly and should not be considered a reliable screening tool for significant disease in patients with LGS. However, CCE had excellent correlation with colonoscopy in our unselected symptomatic cohort and warrants further investigation as a filter test.

ABSTRACT 10 (18W151)

Mucosal Hypoxia and altered HIF pathway signalling is a hallmark of disease activity in severe UC

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Introduction
Tissue hypoxia and its effect on Hypoxia-inducible Factor (HIF) is known to be a key microenvironmental regulator of mucosal barrier-function and inflammation in pre-clinical colitis models. Its role in the pathogenesis of UC has yet to be extensively studied.

Aims/Background
The aim of this study was to measure mucosal oxygen saturations and HIF pathway proteins in patients with UC and assess relationship with disease activity.

Method
Patients undergoing colonoscopy/sigmoidoscopy (CO2 insufflation) were prospectively recruited in a single academic centre, with >3800 IBD patients. Mucosal Hb saturations (%) were recorded using an endoscopic probe (applied to intact mucosa) and tissue-oximeter (T-Stat System, Spectros). Mucosal biopsies were obtained to grade histologic activity and for PCR/Western Blot analysis of HIF-1α and hydroxylases.

Results
N=49 patients were recruited (n=41 UC; median age 39.8yrs;63.4% male). Mucosal saturations recorded in the sigmoid in Mayo 3 disease were significantly lower compared with Mayo 0-2(p=0.001). Saturations from "inflamed" segments were significantly lower compared to normal adjacent mucosa. (p=0.001) HIF-1α expression was significantly higher in patients with mucosal saturations below the median in the sigmoid colon.Patients with endoscopically active disease had significantly higher expression of the hydroxylases PHD-1, PHD-2 and FIH compared with Mayo 0 disease.

Conclusions
This is the first study to measure mucosal Hb saturations in UC patients. Severe disease is associated with mucosal hypoxia. This effect is localised only to inflamed mucosa. Significant differences in the expression of hydroxylases confirms the involvement of the HIF pathway in the mucosal inflammatory response, making this a potential therapeutic target.

POSTER ABSTRACTS ISG WINTER 2018

ABSTRACT 11 (18W101)

Eosinophilic Oesophagitis, rarely seen or rarely looked for? Are we investigating Eosinophilic Oesophagitis correctly?

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Introduction
Eosinophilic Oesophagitis is an inflammatory condition of the oesophagus that is the second most common cause of chronic oesophagitis and dysphagia in adults. Giving its prevalence there has been an increasing importance for optimizing diagnosis of this condition.

Aims/Background
Our aim was to audit our current practice of the work up of patients presenting with symptoms of dysphagia against the recommendations outlines in UEG for the diagnosis of Eosinophilic Oesophagitis. UEG guidelines 2017 suggest "At least six biopsies should be taken from at least two different locations, focusing on areas with endoscopic mucosal abnormalities."

Method
Retrospective analysis of medical records to collect information on the work up of a cohort of 99 patients who underwent endoscopy investigation for dysphagia over a 6 month period with no obvious pathology identified on direct visualization.

Results
Median age 55, range 19-89 years. 43 patients (43.4%) with grossly normal OGD findings had oesophageal biopsies taken for further assessment of their symptoms. Of these 43 patients 30% of them had their biopsies obtained from just 1 location on the oesophagus and only 2% had the recommended 6 or more biopsies taken for analysis. Of the 99 patient cohort, no patient was diagnosed with Eosinophilic Oesophagitis on histology

Conclusions
Eosinophilic Oesophagitis appears to be a condition that is overlooked in this cohort of patients despite its increasing prevalence. Our low pick up rate of the condition may be secondary to suboptimal work up as opposed to low incidence of the disease.

ABSTRACT 12 (18W102)

Attitudes and experiences of individuals with Irritable Bowel Syndrome (IBS) attending a tertiary Irish hospital

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Introduction
IBS affects approximately 20% of Irish people. There is no data on the Irish individual's experience of IBS

Aims/Background
To investigate the attitudes and experiences of individuals with IBS attending a tertiary Irish hospital (n=93)

Method
The authors conducted an anonymous survey online and via post between Mar-Sept 2018.

Results
81% of respondents were female, 53% were over 45. 41% are not at all satisfied with current services for IBS. On a scale of 0-10, quality of life was rated ≥5 in 73% while severity of IBS was rated ≥5 in 92%. Bloating was the most prevalent symptom (82%) followed by abdominal pain and cramping (78%), wind (67%), diarrhoea (55%), constipation (47%) and others (20%). The healthcare professional respondents would most like access to is a dietitian (75%). 60% would like access to a doctor and 12% a psychologist. Respondents mostly get their information about IBS from the internet (37%) and their doctors (28%). However 28% receive no information and only 4% report receiving information from a dietitian despite 74% feeling their symptoms are affected by what they eat. Other comments made centered around 3 themes; frustration and anger at waiting times and lack of services, the impact of IBS on their life, and doubt or confusion over their diagnosis.

Conclusions
The results suggest that individuals with IBS are unhappy with current services for their condition and want increased access to a dietitian. Reliable sources of information are low due to lack of appropriate services in hospital or primary care.

ABSTRACT 13 (18W105)

Continuing Education of NCHDs Improves the Appropriateness of PPI Prescribing in Surgical Patients

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Introduction
Proton pump inhibitors (PPIs) are the mainstay in treatment of acid-related disorders. However, the prescribing rate is out of proportion to the known prevalence of acid-related disorders.

Aims/Background
The aim of this study was to assess the impact of Non-consultant Hospital Doctors (NCHDs) education on PPI prescribing practice in Wexford General Hospital.

Method
A prospective review of the clinical notes and drug kardex of surgical inpatients was carried out over a four-month period. Admitting diagnosis, comorbidities and concurrent medications were documented, along with whether a PPI was prescribed. weekly teaching sessions were used to educate NCHDs on the PPI prescribing guidelines. One year later, a re-audit was carried out over a three-month period for comparison. Standards published by Scarpignato et al (2016) were used to identify whether a PPI was appropriately prescribed.

Results
Our results showed a marked decrease in the rate of inappropriate PPI prescribing over a one-year interval (70% inappropriate in 2017 vs 23% in 2018). Of those patients prescribed a PPI de novo on admission, the decrease was even more marked (72% vs 29%). Biliary pathologies were the most common diagnoses among those inappropriately prescribed a PPI. Esomeprazole was the most commonly prescribed PPI.

Conclusions
The rate of inappropriate PPI prescribing in Wexford General Hospital has decreased following ongoing NCHD education.

ABSTRACT 14 (18W106)

Bowel Screen polyp MDT audit 2018 – Are you any better?

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Introduction
Patient X attended for index colonoscopy on 25/05/2015; a 3cm tubulovillous adenoma (TVA) in proximal ascending (A/)colon was removed by endoscopic mucosal resection (EMR). At MDT the case was deemed intermediate risk and surveillance was scheduled for 3 years. The Endoraad report had stated the polyp may not be fully removed and recommended follow up colonoscopy at 6/12. This did not take place. At surveillance colonoscopy on 13/05/2018 patient X had a large sessile polyp 3-4cm in the proximal A/colon. To assess whether further errors had been made, 25 random MDT decisions from 2015 and 25 from 2016 were reviewed. The number of errors was a concern and the decision was made to extend the review to all MDTs 2015-1017 inclusive

Aims/Background
The purpose of the Audit was to review polyp MDT decisions and their entry on the bowel screen COR database.

Method
741 patients who attended STGH through BowelScreen Jan 2015-Dec 2017 were included. o The recorded MDT decision was correlated with the COR system. o A single consultant reviewed all patients' histopathology and Endoraad reports.

Results
17 patients had their MDT decision altered. 7/17 suffered no delay/impact; 10/17 were delayed by >2yr: These 10 patients have now all had their surveillance procedure performed: - o 2 had normal colonoscopies o 6 had tubular adenomas o 1 had recurrence of a caecal TVA, low grade dysplasia (LGD) o 1 had a recto sigmoid cancer

Conclusions
Busy clinicians must realise that the polyp MDT meeting has a vital role in the BowelScreen program. Dedicated time to ensure all relevant information is both available and reviewed is essential. Recommendations following audit: 1. New MDT recording sheet has been developed 2. Paperwork reviewed at MDT must include the Electronic endoscopy report 3. MDT decision should be signed off by both the clinician and bowel screen nurse (CNS) 4. Two people to enter the MDT decision on the COR system. 5. All BowelScreen procedure reports to be followed up by the CNS.

ABSTRACT 15 (18W108)

Complementary and Alternative Therapies for Inflammatory Bowel Disease

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Introduction
Use of complementary and alternative medicines is common in patients with inflammatory bowel disease (IBD); with previous studies showing rates between 21-60%. To date, few studies have evaluated their role for symptoms associated with IBD.

Aims/Background
To evaluate the use of non-prescribed complementary therapies in patients with IBD.

Method
IBD patients were recruited from out-patient gastroenterology clinics at Tallaght University Hospital during September 2018. They completed a self-administered survey. Participants were asked about supplement use (prescribed and non-prescribed) and the impact of these on their symptoms, including abdominal pain, diarrhea, nausea and vomiting.

Results
We recruited prospectively 43 IBD patients. The response rate was 97.7%. Thirty-four percent of patients were prescribed dietary or vitamin supplements. Nineteen patients (44.2%) reported use of non-prescribed therapies. Eleven of these patients (57.9%) described a positive impact on IBD symptoms. 30.2% of all patients had taken probiotics; seven of these patients had improved symptoms (53%), most commonly reporting reduced abdominal pain. Two

patients had previously used cannabis-based products to treat their symptoms with only one patient reporting a benefit. Fish oils were the second most commonly used non-prescribed supplement (27.9%). While most patients were taking these for their general well-being, five patients (41.7%) reported beneficial effects for their IBD symptoms. Respondents also reported use of turmeric (20.9%), aloe vera (18.6%), acupuncture (13.95%), aromatherapy (13.95%) and hypnosis (2.3%).

Conclusions
These results support previous studies which have shown that complementary therapy use is prevalent among IBD patients. Further studies are crucial to determine their role in IBD.

ABSTRACT 16 (18W109)

Nutritional Management of an Ehlers-Danlos Patient

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Introduction
Ehlers-Danlos syndromes (EDS) are a group of rare inherited conditions that affect connective tissue. Gastrointestinal symptoms in EDS are common in that some patients rely on total parenteral nutrition (TPN) to meet nutritional requirements. This case study explores the successful transition from TPN back to enteral and oral nutrition

Aims/Background
Aim: To discontinue TPN and to meet nutritional requirements through enteral and oral feeding. Long term management aims to place PEJ which would significantly improve quality of life

Method
22 year old female student presented for nutritional management with hypermobile Ehlers-Danlos syndrome (hEDS). At this time patient was on home TPN for three years as all other means of meeting nutritional requirements had previously failed. Patient was admitted to ascertain possibility of discontinuing TPN. Several feeding regimes trialled through the preferred post pyloric NJ feeding route

Results
After a trial of several feeding regimes through NJ feeding route a semi-elemental tube feed was successfully tolerated resulting in patient being able to meet nutritional requirements through combination of NJ and oral nutrition. TPN was discontinued.

Conclusions
There are no specific evidence based management guidelines for the management of GI symptoms in EDS patients and further studies are required. We have shown that intensive dietetic intervention is an integral part of long term MDT management of EDS patients resulting in cost effective and improved quality of life outcomes

ABSTRACT 17 (18W110)

Missed opportunities in those who died as a result of alcohol related morbidity

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Introduction
The 2013 National Confidential Enquiry into patient outcome and death of patients with alcohol related liver disease (ARLD) found that less than half of these patients received good care and avoidable deaths were identified. The majority had prior hospital attendances where there was a failure to screen for alcohol misuse. The Belfast Health and Social Care Trust (BHSCT) introduced mandatory screening with AUDIT-C of all medical admissions in 2015.

Aims/Background
To review deaths in 2016 resulting from alcohol related morbidity in the BHSCT and determine how many had admissions/ED attendances in the preceding 12 months and were referred to alcohol liaison services.

Method
Retrospective study analysing those patients who had alcohol related morbidity coded on their death certificate in the BHSCT in 2016 and how many had attendances to hospital in the year prior to their death. The alcohol liaison service database was used to identify referrals.

Results
There were 74 patients in 2016 as a result of alcohol related morbidity. 31 of these patients were coded as ARLD on their death certificate and 51 (68%) had a hospital attendance in the year prior to their death. Of these patients 17 (33.34%) were referred to ALN and 34 (66.67%) were not. The majority of deaths were male 59/74 (79.7%) and in the age range of 51-60 years.

Conclusions
This study demonstrates that patients with ARLD often present on multiple occasions. Two thirds of these patients were not referred to support services representing a missed opportunity to potentially change the outcome of the final admission.

ABSTRACT 18 (18W111)

To Assess The Appropriate Use Of Proton Pump Inhibitors Among Inpatients At University Hospital Kerry

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Introduction
Proton Pump Inhibitors (PPIs) are one of the most commonly prescribed medications globally. As per NICE guidelines, there are indications for their use including gastro-oesophageal reflux disease, peptic ulcer disease and dyspepsia. Patients who are inappropriately prescribed PPIs can develop avoidable side effects such as

constipation, depression, flatulence, myopathies, hyponatraemia and hypocalcemia. Recent evidence also suggests a correlation between PPI usage and nosocomial C.Difficile infection.

Aims/Background
Establishing whether PPIs have been appropriately prescribed among patients admitted to University Hospital Kerry.

Method
This prospective study was conducted in 1 month. Patient demographics and PPI indication were obtained from drug charts, medical records and endoscopic reports to determine; PPI indication, PPI duration and if gastroscopy was performed.

Results
Data was obtained from 196 patients admitted in April 2018. 128 patients were using PPIs with 46% (n=58) of these patients having no documented valid indication for PPI use. 54% (n=70) of patients had a valid indication and were taking PPIs for more than 2 years. However, only 31% (n=22) of these patients underwent gastroscopy which showed oesophagitis/gastritis as an indication for PPI use. All patients were H.pylori negative.

Conclusions
PPIs are over prescribed in healthcare. Their overuse has a significant impact on healthcare costs and can lead to adverse side effects. The risk of using long term PPIs must be weighed against the benefits. The following measures may ameliorate this issue; educating doctors regarding evidence based NICE guidelines recommendations when prescribing PPIs and having a dedicated pharmacist monitoring PPI usage during hospital admission and reviewing discharge prescriptions.

ABSTRACT 19 (18W112)

Examining The Incidence Of Symptomatic CMV Infection Requiring Antiviral Treatment Following Liver Transplantation – The Scottish Experience 2010-2017

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Introduction
Presence of CMV IgG is tested in all transplant donors and recipients. In case of donor positive / recipient negative mismatch (D+ve/R-ve), it is recommended that 100 days of valganciclovir prophylaxis is prescribed.

Aims/Background
To determine rates of CMV viraemia, and if this differs with immunosuppression choice or CMV recipient status.

Method
This was a retrospective audit of all liver transplant recipients in Edinburgh between 2010 and 2017. Electronic records were used for data collection.

Results
Between 2010 and 2017, 736 liver transplants were performed on 708 patients. CMV status was available for all recipients. All CMV D+ve/R-ve mismatches (205) received appropriate prophylaxis. 110/708 patients required oral or parenteral treatment for CMV viraemia or disease. 62 viraemic episodes occurred in the mismatch group, with mean time from transplant to viraemia of 6.2 months. 36/62 mismatch patients required parenteral antiviral treatment, with 6/62 having biopsy-proven end-organ damage. 48 CMV IgG R+ve patients developed CMV viraemia or disease. Mean time to viraemia post-transplant was 2.3 months, with 22/48 requiring parenteral treatment, and 13/48 having evidence of biopsy-proven end-organ damage. In both mismatch and reactivation groups, patients were more likely to have MMF (61) than azathioprine (46) as second immunosuppressive agent, in spite of higher azathioprine use (417 versus 255 at discharge).

Conclusions
43.6% of infections in our cohort occurred in the CMV R +ve group, and suggests that consideration should be given to prophylaxis. In view of higher rates of CMV viraemia amongst MMF patients, Edinburgh now prescribes six months of prophylaxis.

ABSTRACT 20 (18W113)

The growth of alcohol related liver disease: A decade of admissions to Irish hospitals.

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Introduction
Ireland has the second highest rate of binge drinking globally and 7% of Irish adults are alcohol dependent. Heavy consumption can lead to alcoholic liver disease (ALD), liver failure, cirrhosis and hepatocellular carcinoma (HCC).

Aims/Background
This study examined a decade of ALD admissions to all Irish public acute hospitals with particular attention paid to mortality, sex, co-morbidities and specialty care.

Method
A retrospective study of ICD-10 AM discharge codes from the Hospital Inpatient Enquiry (HIPE) database. All discharges 2006 -2016 with ALD (K701-K709) were identified. Demographic information and associated diagnosis were examined.

Results
ALD admissions increased by 23% over the period. HCC admissions increased 300% (48% ALD). In 2016, there were 3,532 ALD discharges and 40,482 inpatient days. Mean length of stay was 13 days. 71% were men and 29% female. 57% had cirrhosis, 27% ascites and 10% acute kidney failure. Overall mortality was 9%, 15% if ascites present and 37% with a diagnosis of acute kidney failure. Only 30% of patients were under a gastroenterologist at discharge.

Conclusions
ALD related hospital admissions increased by 23% over the study period. There are 111 patients with ALD admitted daily to Irish Public hospitals. Mortality rates are high and less than a third are under a gastroenterologist or hepatologist. This study focused solely on inpatients with ALD. The number of emergency department attendances and admissions with other alcohol complications is exponentially greater. There is an immediate need for public health measures to reduce alcohol related harm.

ABSTRACT 21 (18W117)

An Exploratory Study On The Prevalence Of Anal Human Papillomavirus In Patients With Inflammatory Bowel Disease

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Introduction
Treatment related immunosuppression for inflammatory bowel disease (IBD) could increase the risk of chronic human papillomavirus (HPV) infection, potentially elevating the risk of anal dysplasia and cancer. This is especially relevant as higher incidence of cancer in IBD patients has been demonstrated.

Aims/Background
To investigate the prevalence of anal HPV infection in IBD patients and evaluate its association with immunosuppressive medications.

Method
This study recruited 66 IBD patients and matched controls undergoing clinically indicated colonoscopy in June and July 2018. Data was collected via questionnaire before a swab was taken from the anal verge of each participant. Samples were analysed using the Roche Cobas HPV test.

Results
Of the IBD patients, 18 (55%) had ulcerative colitis (UC) and 15 (45%) had Crohn's disease (CD). The mean current age of the IBD patients was 47 ± 12 and controls was 48 ± 12. The prevalence of anal HPV infection was 9% (n=6), with no significant association between HPV and IBD (p=1) or immunomodulator use (p=1). The 3 HPV positive IBD patients were on immunosuppressive therapies; corticosteroids, azathioprine, or biologic therapy adalimumab. Both HPV positive females with IBD also had irregular pap smear results in the past, as did one of the HPV positive women in the control group.

Conclusions
Chronic anal HPV infection could be a risk for cancer development, especially in immunosuppressed IBD patients and those with perianal disease who are at risk for HPV-associated cancers. Further research is needed to address this question.

ABSTRACT 22 (18W118)

A Cross-Sectional Study On Prevalence Of Dysphagia Precipitated By Eosinophilic Esophagitis In Secondary Care Settings

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Introduction
Eosinophilic esophagitis (EoE) is a chronic immune-mediated condition that is more frequently identified in recent years.Diagnosis is made by the endoscopic findings and the presence of eosinophils in the esophageal biopsy with no other apparent cause of eosinophilia.

Aims/Background
Recent reports suggests EoE is increasing in incidence but still a rare disorder and more data needs to be evaluated in this field.The purpose of this study is to evaluate the prevalence of EoE in patients presenting with dysphagia as their primary complaint.

Method
This is a cross-sectional study performed with data collected from two hospital sites from July 2015 to June 2018.The histological reports of esophageal biopsy samples evaluated for the presence of eosinophils were analysed.EoE was considered in the samples in which at least 15 eosinophils/HPF were present.

Results
Between July 2015 and June 2018, a total of 277 patients with symptoms of dysphagia had esophageal biopsies taken for histological examination.Among the 277 patients, 7 (2.52%) were diagnosed with EoE based on the accepted standard. Out of these 7 patients, only 2 had endoscopic findings suggestive of EoE. In 6 patients (2.16%) EoE was included in the differential diagnosis but they did not meet the criteria of at least 15 eosinophils/HPF.

Conclusions
Based on our findings, esophageal biopsy should be considered in patients presenting with dysphagia even in the absence of typical endoscopic findings of EoE.

ABSTRACT 23 (18W119)

Compliance with surveillance guidelines for Barrett's oesophagus

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Introduction
Inappropriate booking of interval surveillance endoscopy in patients with Barrett's oesophagus adds to the already large burden that exists of outpatient endoscopy. A specialised ordering form (with guidelines printed on form) for Barrett's surveillance has been introduced in our hospital.

Aims/Background
Primary Outcome: To assess adherence to guidelines for surveillance intervals of patients with Barrett's oesophagus. Gastroscopy reports performed (before booking of surveillance) were appraised to determine the use of Prague Classification in describing endoscopic findings, use of chromoendoscopy and patient age at time of endoscopy.

Method
Surveillance booking cards for Barrett's surveillance (before 25th May 2018 to comply with GDPR) and corresponding gastroscopy reports were reviewed manually. Guidelines from the British Society of Gastroenterology were utilised to assess suitability of surveillance interval. Chi-squared test was used to assess categorical variables.

Results
199 cards reviewed. 14% (28/199) of bookings were not adherent to guidelines. 29% (57/199) had no documented Prague classification.

Chromoendoscopy was used in 54% (107/199) of procedures. Use of chromoendoscopy increased overtime significantly, 21% (4/19) for 2015 versus 62% (27/43) in 2018, p=0.002. The mean age at time of gastroscopy was sixty years, 11% (22/199) were aged greater than 75 years at time of gastroscopy. Endoscopist use of Prague classification was associated with increased adherence to recommended surveillance intervals {87% (127/142) vs 77% (44/57), p=0.02}

Conclusions
There was good compliance with recommended surveillance intervals, this was increased in procedures where Prague classification was documented.

ABSTRACT 24 (18W120)

An Audit Investigating If Current Practice In The Diagnosis Of Coeliac Disease Is In Keeping With Current Guidelines

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Introduction
Coeliac disease (CD) is an autoimmune condition triggered by exposure to gluten in the diet, resulting in crypt hyperplasia and intestinal villous atrophy of the small intestine. In the diagnosis of CD, the NICE guidelines backed up by studies, state that serological testing should be offered before referral for endoscopy, and if serological result present negative, biopsy should only be offered with significant clinical suspicion. However, the Northern trust has seen an increase in the number of referrals made without prior serological testing, potentially incurring cost to patient and the health service, warranting an audit.

Aims/Background
To assess whether the NICE guidelines were adhered to in the diagnosis of CD and the potential additional direct cost amongst patients attending Antrim Area Hospital.

Method
350 patients undergoing gastroscopy as part of evaluation for anaemia, weight loss and atypical dyspepsia with a single endoscopist from 2015-2017 had their data recorded from endoscopy reports and the Electronic Health Care Record. Data collected included demographics, presenting complaint, if sedation was administered, and the histopathological and, serological result preceding or following each biopsy.

Results
Results show that 178 (51.1%) of patients did not receive serological testing prior to endoscopy and 92.4% of these patients underwent a biopsy. Based on these results, and the Northern trust tariff, the current trust practice incurred an excess of £22,480 on the HSC.

Conclusions
Patients attending the Northern trust are not routinely offered serological testing prior to endoscopy. Patients with negative serological test are also being biopsied, which does not comply with recommended guidelines.

ABSTRACT 25 (18W122)

Dysplasia In Short Segment Barrett's, Five Year Interval Too Long?

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Introduction
Barrett's oesophagus (BO) is a clear identifiable premalignant condition which can lead to adenocarcinoma. As per American College of Gastroenterology guidelines, for patients without dysplasia, surveillance is advocated every 3-5 years.

Aims/Background
The aim of this audit was to explore the correlation between the length of Barrett's oesophagus (BO) and incidence of dysplasia in patients attending for gastroscopy during a single year (Jan 2017 to Dec 2017) in our centre.

Method
The data was collected from the Endoscopy and histopathology database in our hospital. Out of the 171 patients selected for the study, 50.8 %(87) had both microscopic and macroscopic evidence of BO.

Results
Of the 48 patients with short segment BO, 2 (4.2%) patients had confirmed dysplasia. Both patients were known to have non-dysplastic Barrett's since 4 years before. In the 3-6 cm group (n=26), 30% (7) had dysplasia and (1)3.5% had established adenocarcinoma. In the 6-10 cm group (12), (3)25 % had dysplasia and (1)8.3% had adenocarcinoma. In the single patient with 10-15 cm BO, there was no dysplasia. In the two patients who had high grade dysplasia, one underwent Endomucosal resection and the other had Radiofrequency ablation.

Conclusions
As per our study, Progression from non-dysplastic to dysplastic Barrett's occurred in a relatively short space of time, approximately four years, and therefore diagnosis would have been delayed if a five year surveillance guideline was adhered to. This warrants a larger cohort study to clarify the risk of dysplasia in short segment Barrett's and determine whether we need to stratify these patients according to additional risk factors.

ABSTRACT 26 (18W123)

Therapeutic drug monitoring of infliximab in Inflammatory Bowel Disease Patients: a single centre experience.

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Introduction
Therapeutic Drug monitoring for infliximab in the treatment in IBD patients is becoming commonplace. It offers information in non-responders or patients failing anti-TNF treatment.

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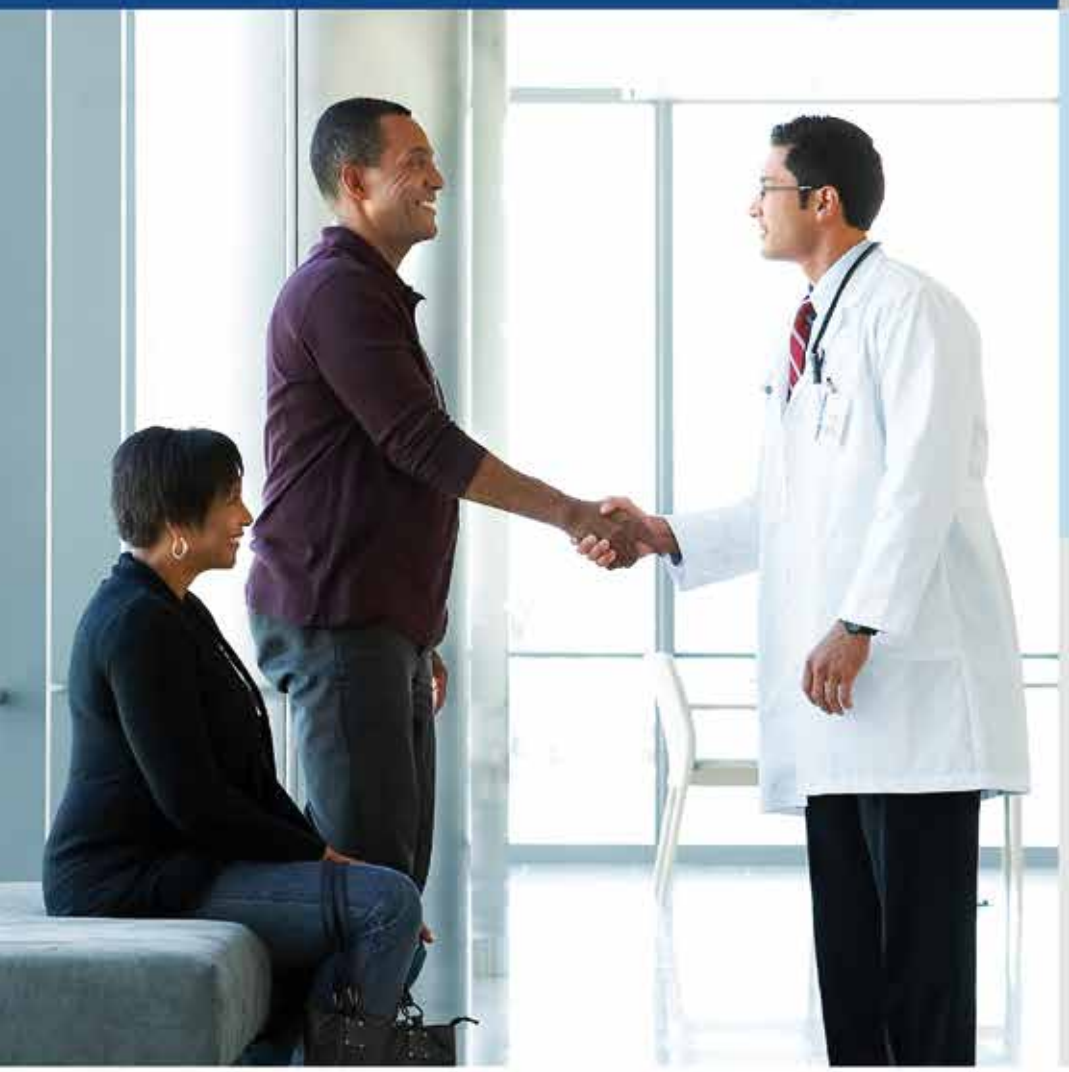

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Aims/Background
The aim of the audit is to review the use of infliximab drug levels and antibody levels of IBD patients in Naas Hospital.

Method
Retrospective analysis of therapeutic drug monitoring of IBD patients on infliximab. Chart review was performed to obtain:1) Patient demographics; 2) To assess disease activity at the time of drug monitoring; 3) Documentation of Infliximab levels and antibodies 4) If the doses of infliximab were adjusted according to AGA and/or Australian guidelines 5) Concomitant use immunomodulators.

Results
Of the 83 completed bloods tests at a cost of €13,074.16, only 32% of results were documented in the chart or outpatient letters. Of the infliximab levels only 26.5%,43.3%,50.6% of patients had therapeutic levels in accordance with the AGA, Australian and Manufacturers guidelines respectively; Of those patients with low infliximab levels only 3 had their dose increased. 13 patients (43%) had detectable infliximab antibodies, 4 patients had their therapy adjusted by switching biologic therapy or stopping their infliximab infusions.

Conclusions
The results demonstrated a disjointed application of drug monitoring to justify the significant costs. 1) Generate a guideline for the use of TDM 2) Team NCHD teaching about the use of TDM 3) Revieww of the use of immunomulators in this patient cohort. 4) Perform an Audit of TDM of Adalimumab patients 5) Assess cost effectiveness of a proactive versus reactive TDM

ABSTRACT 27 (18W124)

Are We Missing By Speeding ?A Retrospective Study Of Colonoscopy withdrawal time and polyp detection rate.

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Introduction
As per American society of gastroenterology (ASGE)guidelines (2015)on quality indicators for colonoscopy , Withdrawal time should be measured in all colonoscopy examinations, with the performance target being a 6 minute average withdrawal time in negative result screening colonoscopies.

Aims/Background
The aim of our study was to establish the relationship between Normal colonoscopy average withdrawal time (NCWT) and polyp detection rate (PDR) in all colonoscopies done by experienced Endoscopists during the year 2017 in the Endoscopy unit in Author's hospital

Method
Retrospective study analyzing electronic endoscopy database records from an academic teaching hospital from January 1st, to December 31st, 2017. A snap shot study of percentage of adenoma among the polyps detected was done by randomly selecting and checking the histology report from the hospital histopathology data base.

Results
2870 colonoscopies were done by 28 endoscopists including consultants and trainees. For the purpose of this study, we included only experienced endoscopists those who have done at least 90 procedures during the selected year (n=1819). Five out of the seven endoscopists met the criteria of at least 6 minutes NCWT. The PDR ranged from 38.6 to 51.7% among the five endoscopists who were compliant. Noticeably, two endoscopists with their NCWT >8 minutes had a high PDR (46.68 and 47.8 % respectively). The endoscopist with the lowest NCWT (3:48 minutes) have the lowest PDR (17.2%).

Conclusions
Withdrawal time is an important quality indicator that can affect polyp detection rate significantly. However, there can be other factors like experience level, bowel preparation etc. that can influence as well.

ABSTRACT 28 (18W125)

Lidocaine Spray: Help or Hindrance

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Introduction
Oesophagogastroduodenoscopy(OGD) is mostly performed under conscious sedation. A key quality standard for sedation states that the combination of intravenous sedation and pharyngeal anaesthesia can be used. Several studies have demonstrated the effectiveness of combining topical pharyngeal anaesthesia to improve the tolerance of gastroscopy. Despite this, anecdotal experience is mixed. Many endoscopists choose not to use lidocaine due to a concern that the sensation it induces often adds to patient anxiety.

Aims/Background
To investigate whether topical lidocaine benefits OGD by reducing midazolam dose and patient's tolerance.

Method
A retrospective single centre study was conducted in 2018 between July and September. Patients undergoing their first diagnostic OGD who received conscious sedation for various clinical indications were assigned into two groups; Lidocaine spray and Midazolam or Midazolam only. Their procedure times, Midazolam dose and demographics were taken from a local endoscopy database. Patients were called after their procedure and asked to assign comfort scores ranging from: 1-No discomfort, 2-Mild discomfort, 3-Moderate discomfort, and 4-Severe discomfort.

Results
128 patients were studied. 67% (n=86) in the combination, and 33% (n=42) in the Midazolam only group. The two groups had a similar age profile (Mean = 56 years, SD= 19.5 vs Mean= 58 years, SD= 17). An independent samples t-test was conducted and showed no significant difference in terms of the Midazolam dose used (M= 3mg, SD= 0.97 vs M=3mg, SD= 0.86; p= 0.71), Procedure time (M= 13mins, SD=4.2 vs M=12mins, SD=4.8; p=0.12) and comfort scores (M= 1, SD= 0.62 vs M=1, SD= 0.5; p=0.26) between the Lidocaine/ Midazolam and Midazolam only group respectively.

Conclusions
There appears to be no significant benefit with the addition of lidocaine spray in the use of conscious sedation and patient's tolerance in our institution. Gastroscopy equipment and practice have improved over the years, such that oesophageal intubation is now rapid, controlled and well tolerated. This might account for the minimal role lidocaine spray play in combination with midazolam.

ABSTRACT 29 (18W126)

Incidence Of Autoimmune Hepatitis In Co.Mayo A Population Based Study

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Introduction
Autoimmune hepatitis is a form of chronic inflammatory disease of the liver that starts as an acute hepatitis and may progresses to chronic liver disease, cirrhosis and HCC, this usually requires long term immunosuppressive treatment, surveillance program and possible liver transplantation.

Aims/Background
Our aim was to assess the incidence of autoimmune hepatitis in County Mayo (population of 130,638) in the last 10 years.

Method
We did a retrospective study on all the liver biopsies performed in Mayo University Hospital between march 2007 until march 2018 (992 biopsies), all histology reports which showed probable AIH were examined together with the autoantibody profile and the final diagnosis made.

Results
17 patients were diagnosed with autoimmune hepatitis in the period between March 2007 and March 2018 with an incidence rate of 1.3/100,000 persons. The female-to-male ratio was 5.6:1 The lowest age at diagnosis was 25 and the highest age was 77.

Conclusions
The incidence of autoimmune hepatitis diagnosed in County Mayo is in accordance with the data available which estimates the incidence rate in Western Europe of 1-2 per 100,000 population. Although the incidence rate is quite low for AIH it remains a high disease burden as it needs a high suspicion for diagnosis and swift decision to treat with multiple possible complications. This data can be used as part of national data collection to estimate the incidence and prevalence of autoimmune hepatitis in Ireland.

ABSTRACT 30 (18W127)

A review of treatment decisions for all hepatocellular cancers (HCC) presented at the Northern Ireland regional HPB MDM in 2017

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Introduction
HCC usually arises in patients with liver cirrhosis. Although some treatments (transplantation, resection and RFA) can achieve cure, the majority of HCC patients are treated with palliative measures. In September 2017, NICE approved the use of sorafenib for advanced stage HCC although only for those with Child-Pugh A liver impairment.

Aims/Background
To retrospectively review the treatment option that was selected for patients with HCC who were discussed in the NI regional HPB MDM.

Method
The regional HPB MDM database was reviewed to identify all HCC cases during a 12 month period from 1 Jan 2017 and how many were detected through HCC screening. NICE TA474 criteria were applied to determine those eligible for sorafenib.

Results
70 patients with HCC were identifed. Only 15 (21%) were detected via HCC screening programme. Palliative care was recommended for 32 (45.7%) patients. For those offered treatment, the treatments were TACE in 16 (22.9%) patients, hepatic resection in 11 (15.8%), RFA in 4 (5.75%), SIRT in 6 (8.6%) and liver transplant for 1 (1.4%) who also had TACE. 13 (40%) of the 32 patients recommended for palliative care were Child Pugh A of whom 7 would have been eligible for sorafenib. No patients received sorafenib as it was not available or by the time funding was approved they had deteriorated.

Conclusions
Almost half (46%) of all HCCs in this cohort of patients were only suitable for palliative care rather than a treatment intervention. The introduction of sorafenib could provide an option for up to 40% of those offered palliation.

ABSTRACT 31 (18W128)

CLOVES Syndrome

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Introduction
CLOVES Syndrome is a rare disorder characterised by Congenital Lipomatous Overgrowth, Vascular malformations, Epidermal naevi and Skeletal anomalies. A sporadically occurring genetic mutation, 50 cases reported worldwide.

Aims/Background
CLOVES Syndrome belongs to a spectrum of conditions caused by mosaic mutations in the PIK3CA gene. This activates a cellular signalling pathway causing overgrowth predominantly in adipose tissue.

Method
A 48 year old lady was referred to Gastroenterology with severe bloating and chronic constipation. Past history included excision of lymphangiomatous masses in her feet with subsequent bilateral below knee amputation, truncal masses, multiple osteochondromata, haemangiomata of the rectum, colon, pelvis, liver and diverticulosis.

Results
The PIK3CA gene was identified on biopsy of fibroblasts from lower limb. The mutation was not detected in unaffected tissue or saliva. Her symptoms of constipation and bloating improved with a combination of laxatives, probiotics and dietary changes. Endoscopy identified sigmoid diverticulosis, large vascular lesions in the colon and inflammatory fibroid colonic polyps. Recent CT abdomen

identified progressive intraperitoneal lipomatosis and low-grade haemangiomatosis with calcification of rectum and colon. Symptoms have deteriorated in line with the macroscopic progression seen.

Conclusions
CLOVES Syndrome is a complex condition with a distinct phenotype. Early diagnosis is desirable to detect complications. To date there have been no formal guidelines for surveillance but regular abdominal ultrasound to screen for Wilms' tumour in childhood is suggested. Patients are considered to be at increased risk of thrombosis and may benefit from pre-operative anticoagulation. There is a possible role for immunosuppressant therapy. Current research suggests a role for specific gene-inhibitor therapy.

ABSTRACT 32 (18W129)

Acute Severe Refractory Coeliac Disease

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Introduction
Refractory Coeliac Disease is defined as malabsorptive symptoms and villous atrophy persisting after one year on a strict gluten free diet when other causes have been excluded.

Aims/Background
Types 1 and 2 described, the latter a poorer prognosis with increased risk of lymphoma.

Method
A 68 year old male presented with a two month history of acute diarrhoea and weight loss; background of Coeliac Disease. Bowel habit of six unformed stools per day and 33% loss of total body weight in this time period. Stool cultures negative, compliant with diet, tTG normal. Commenced on Creon and Rifaximin but weight loss and diarrhoea continued. Previous D2 histology in keeping with treated Coeliac disease. History included a small bowel resection eleven years earlier for ulcerating jejunal/ileal disease with stricture.

Results
CT TAP - stable small bowel lymphadenopathy. PET scan negative. Diagnostic laparoscopy- multiple adhesions from prior surgery. D2 biopsy now showed sub-epithelial collagen deposition, refractory sprue. Commenced on semi-elemental diet. Electrolytes monitored daily. Started on intravenous Hydrocortisone, improved clinically. Bowel motions decreased from six to two per day, improved consistency. Albumin increased from 9 to 16. Switched to uncoated Budesonide 9mg OD with steady improvement

Conclusions
The management of Refractory Coeliac Disease requires intensive dietetic support in conjunction with pharmacological treatment. Treatment guidelines are limited but steroids are often used as first line therapy, with a role for immunosuppressant agents also identified. There is anecdotal evidence that the addition of Leukotriene receptor antagonists may also assist in reducing steroid dependence.

ABSTRACT 33 (18W130)

Real world experience using Maviret® for treatment of chronic hepatitis C in Northern Ireland

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Introduction
Maviret® (glecaprevir/pibrentasvir) is a pangenotypic direct acting antiviral agent used in the treatment of chronic hepatitis C virus (HCV) infection. Maviret® was licensed in the UK in August 2017 and became available in Northern Ireland (NI) in October 2017. The once daily short duration of therapy makes Maviret® suitable for those with compliance issues.

Aims/Background
To determine the effectiveness of Maviret® in treating patients with chronic HCV in NI.

Method
Consecutive patients treated with Maviret® from Oct 17 to Apr 18 were included. All HCV treatments in NI are approved through the The Regional Liver Unit HCV MDM. From October 2017, Maviret® was selected for patients with compliance issues (including homeless, PWIDs, prisoners) and otherwise used in equal measure along with other approved treatments. Response to treatment was determined by HCV PCR, 12 weeks after completion of therapy (SVR-12).

Results
Fifty-six patients (47 male) were treated with Maviret®. Seven (12.5%) were cirrhotic. Genotype distribution was 33 (58.9%) genotype 3, 21(37.5%) genotype 1 and 2 (3.6%) genotype 2. Fifty-five (98%) patients were treatment naïve and 1 had a prior treatment failure. 49 patients received 8 weeks Maviret® (including 22 (39.3%) with compliance issues), 6 received 12 weeks and 1 patient received 16 weeks. Fifty (89.3%) patients achieved SVR-12. Six patients completed treatment but failed to return for follow up. There were no recorded failures. No major ADRs occurred during treatment.

Conclusions
Maviret® is a safe, efficacious and well-tolerated treatment for chronic HCV. Targeting those with compliance issues can result in difficulty obtaining SVR-12 results.

ABSTRACT 34 (18W131)

The Impact of the Irish H. Pylori Working Group (IHPWG) Guidelines on Eradication Rates

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Introduction
In response to falling eradication rates the IHPWG proposed changes to standard empirical triple therapy. Despite increasing resistance,

clarithromycin remains the mainstay of increased duration (14 days) empirical therapy. Levofloxacin is recommended in 2nd line treatment and targeted therapy is reserved for rescue.

Aims/Background
To assess the effectiveness of new recommendations on eradication rates.

Method
Post-eradication patients pre and post IHPWG guidelines were identified from a UBT database. Demographics, regimen (including antibiotics and duration), treatment type (1st, 2nd line or rescue) and UBT results were compiled. Eradication rates were compared using a chi2 test, p value <0.05 was considered significant.

Results
232 subjects were included, mean age 46 and 45% male. 84 and 148 received 14 and 7-day treatments. In 14 and 7-day treatment groups, 70 (83%) and 131 (89%) received 1st line, 14 (17%) and 3 (2%) received 2nd line and 0 (0%) and 14 (9%) rescue therapy. 14-day duration didn't significantly improve eradication rates, 77% (54/70) Vs 72% (94/131), 100% received clarithromycin. 2nd Vs 1st line eradication was lower 65% (11/17) vs 74% (148/201), p=0.45. Longer duration improved 2nd line success, 71% (10/14) vs 33% (1/3) p=0.47. Targeted rescue therapy achieved similar eradication to 1st line 71% (10/14) vs 72% (94/131).

Conclusions
Enhanced duration of clarithromycin-based therapy does not improve eradication which remains suboptimal, likely reflecting high primary resistance. Suggesting alternative first line antibiotics warrant investigation.

ABSTRACT 35 (18W132)

Superior High-Quality Colon Cleansing With 1L NER1006 vs Sodium Picosulfate + Magnesium Citrate, 2L Polyethylene Glycol + Ascorbate, Or Oral Sulfate Solution: A Post-hoc Pooled Analysis

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Introduction
NER1006, a 1L-polyethylene glycol (PEG)-based bowel preparation, was evaluated in three randomised trials.

Aims/Background
A post-hoc pooled analysis comparing high-quality segmental cleansing with NER1006 versus comparators: Sodium Picosulfate + Mg Citrate (SPMC), 2L-PEG + Ascorbate (2LPEG) and Oral Sulfate Solution (OSS).

Method
Dosing regimens varied by trial. All trials had similar recruitment criteria. Alternative primary endpoints were overall and right colon cleansing using the Harefield Cleansing Scale (HCS); all trials had treatment-blinded central reader assessed cleansing scores. The number of high-quality segments (HCS score 3-4) attained by NER1006 versus its comparator were analysed (Populations: Full analysis set (FAS), modified FAS (mFAS), Per-protocol set (PP)).

Results
1,985 patients were included. In each of the populations (FAS, mFAS, PP), day before dosing with NER1006 attained significantly more high-quality segments than with SPMC (16.9% vs 10.4%; P< 0.001, 17.4% vs 10.7%; P< 0.001, 18.4% vs 10.7%; P< 0.001). Overnight split dosing with NER1006 showed more high-quality segments than with 2LPEG (46.1% vs 29.0%; P< 0.001, 47.5% vs 30.2%; P< 0.001, 48.7% vs 32.5%; P< 0.001). Morning only dosing with NER1006 also achieved more high-quality segments than overnight split dosing with 2LPEG (46.8% vs 29.0%; P< 0.001, 48.1% vs 30.2%; P< 0.001, 50.6% vs 32.5%; P< 0.001). Finally, overnight split dosing with NER1006 delivered more high-quality segments than with OSS (40.1% vs 36.2%; P=0.013, 45.0% vs 40.2%; P=0.005, 48.8% vs 44.0%; P=0.011). No serious adverse events were reported.

Conclusions
In all three analysis sets, NER1006 delivered more colon segments with high-quality cleansing scores than SPMC, 2LPEG, or OSS.

ABSTRACT 36 (18W133)

Higher Harefield Cleansing Scale Scores Are Associated With Improved Lesion Detection: Post-hoc Analysis Of Three Randomised And Central Reader-Assessed Phase 3 Clinical Trials

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Introduction
Effective colonoscopy requires successful bowel cleansing. The bowel preparation NER1006 was assessed in three identically designed randomised phase 3 clinical trials. These trials used validated cleansing scales and treatment-blinded central readers for a standardised cleansing quality assessment.

Aims/Background
This post-hoc analysis assessed the relationship between colon cleansing quality using the Harefield Cleansing Scale (HCS), and overall colon detection rates for adenomas (ADR) and polyps (PDR).

Method
Patients aged 18-85 years were included if they had fully reported HCS scores, adenoma and polyp counts, and also identical segmental HCS scores (range 0-4) in all five HCS colon segments. A logistic regression analysis examined the odds ratio (OR), 95% confidence interval (CI) and P-value (P) for the resulting trend in lesion detection, when segmental HCS scores increased incrementally from zero to four.

Results
469 patients were included in this analysis. When uniform segmental HCS scores were increased from 0, 1, 2, 3, and 4, the resulting ADRs increased continuously (0%, 10.0%, 25.6%, 32.4% and 53.8%) as did the PDRs (0%, 30%, 43.3%, 51.4%, and 61.5%). The corresponding

OR (CI) and [P] were, for ADR 1.61 (1.182 - 2.199) [0.0026], and for PDR 1.38 (1.021 - 1.863) [0.0361].

Conclusions
ADR and PDR increased continuously with improved colon cleansing quality. There was a strong association between uniform segmental HCS scores and both ADR and PDR.

ABSTRACT 37 (18W134)

Screening For Coeliac Disease In Type 1 Diabetics

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Introduction
Coeliac disease is an autoimmune condition that can co-exist with type 1 diabetics with an increased frequency compared to the general population.

Aims/Background
An audit was carried out of the type 1 diabetics attending our outpatient department We examined whether patients with type 1 diabetes were being tested for coeliac disease (serum tissue transglutaminase) and IgA antibodies. The audit cycle was completed 1 year later. We followed standards from the American Diabetic Association, NICE guidance and American College of Gastroenterology.

Method
A list of patients attending the diabetic clinic over the two 3 months periods 1 year apart were generated. Laboratory tests taken from the patients at that visit were collected and analysed. A database was gathered and the results were compared to each other and the audit standard

Results
Compared to the first audit cycle, screening for coeliac disease at diagnosis improved from 2% to 22% at diagnosis. Screening for coeliac disease after diagnosis of type 1 diabetes had improved from 26% to nearly 70%. Screening for IgA antibodies was low despite the overall improvement in screening for coeliac disease, 38% in year 1 and only 5% in year 2.

Conclusions
We would encourage to continue with the progress made in terms of screening for coeliac disease at outpatient visits after diagnosis of type 1 diabetes. We would hope for improvement in the areas of screening for coeliac disease at the point of initial diagnosis and especially in requesting for IgA antibody testing

ABSTRACT 38 (18W135)

Does Serum Ferritin predict Hepatic Iron Concentration as measured via Magnetic Resonance Imaging?

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Introduction
The measurement of iron overload is a diagnostic dilemma. Liver biopsy is considered the gold standard however use is limited due to its invasive nature. The improvements in MRI modalities have meant that Hepatic Iron Concentration can be reliably measured using various techniques. However, limited access to MRI in most centres means this cannot be performed routinely. Therefore, serum ferritin remains the most common and efficient way to assess iron burden in susceptible patients.

Aims/Background
Our aim was to determine if serum ferritin accurately reflects Hepatic Iron Concentration as measured by MRI and remains a reliable surrogate measurement of iron burden.

Method
A retrospective analysis of all MRIs Liver and Spleen performed in Our Lady of Lourdes Hospital, Drogheda between 2012-2018 was performed. The Hepatic Iron Concentration was measured using MRQuantIF and compared to the contemporaneous serum ferritin measurement in relevant patients. A subgroup analysis was then performed based on sex, haemochromatosis status and further divided based on HFE genotype. The data was analysed using R using a linear regression model, with serum ferritin as the explanatory variable and HIC as the outcome variable.

Results
There were a total of 33 patients (26 male, 7 female). The regression model of liver results explained by serum ferritin provided a statistically significant slope co-efficient of 0.04 ($p = 0.02$) with an R2 value of 0.14. Serum ferritin was therefore positively correlated with HIC and explained 14% of the change in liver iron. A subgroup analysis that considered male and female patients separately, found that, for men, the slope co-efficient was 0.08 ($p<0.001$) with serum levels explaining 46% of liver iron levels and for women a negative slope co-efficient of – 0.008 that was not statistically significant ($p = 0.7$). As a diagnostic indicator in this dataset, serum ferritin has a sensitivity of 86%, a specificity of 75%, a positive predictive value of 96% and negative predictive value of 43%.

Conclusions
While this is a limited, single-centre study with a small sample size, the results suggest that serum ferritin is positively correlated with Hepatic Iron Concentration as measured by MRI. While this holds true for men, the relationship is not true in the female population. As such, serum ferritin can be considered a reliable surrogate of iron burden, however this may need to be further evaluated in a larger study, especially considering the disparity between sex.

ABSTRACT 39 (18W136)

The incidence of Helicobacter Pylori colonisation in newly diagnosed coeliac patients : A single centre analysis

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Introduction
A surge in the prevalence of coeliac disease(CD) cannot be attributed to better detection rate alone. It has been hypothesized that environmental factors such as Helicobacter pylori(H. pylori) colonisation triggers autoimmunity.

Aims/Background
The aim of this study was to evaluate if our newly diagnosed cohort of coeliac patients have a higher incidence of H. pylori than a control group. In doing so we aim to assess if there is a correlation between CD & H. pylori infection.

Method
A retrospective observational comparative study was performed. Data was collected from Dec 2016 to Dec 2017. All patients with newly positive serology.i.e. those with a positive anti-tissue transglutaminase(TTG) and/or endomysial antibody(EMA), were included in the study. Biopsy results were analysed looking for the presence of H. pylori. Results were compared to a control group. The control group consisted of patients undergoing routine upper GI endoscopy who were tested for H. pylori.

Results
121 new cases of CD were diagnosed between December 2016 - 2017 out of a geographical population of approx 80,000. 70% of positive serology was sent by family physicians(n=85) and 30% from hospital admissions or outpatient clinics(n=36). Diagnosis typically occured between the ages of 11-21 accounting for 26% of all new diagnosis (n=32), furthermore there was a later surge for those aged 43-53. 44% of these new cases had upper GI endoscopy performed(n=53). 8% had H. pylori on biopsy(n=4). In the control group 13% of patients tested positive for H. pylori. In those diagnosed at or after the surge in the 5th decade who had a biopsy(n=17), the prevalence of H. pylori positivity increased to 18%.

Conclusions
Overall the rate of detection of H. pylori was low in both controls and coeliac disease patients. Furthermore, H pylori detection was overall lower in newly diagnosed CD v's control. This inverse relationship raises the question that perhaps Helicobacter pylori colonisation is protective against coeliac disease. This would account for the reduced detection of H pylori and the increasing prevalence of coeliac disease.

ABSTRACT 40 (18W137)

Tissue Elastography In Patients With Primary Biliary Cholangitis

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Introduction
Primary Biliary Cholangitis (PBC) is an autoimmune liver disease characterised by progressive damage to interlobular bile ducts which can lead to cirrhosis. Tissue elastography (Fibroscan) is a noninvasive means of assessing liver fibrosis in chronic liver disease. Data on fibroscan for patients with PBC is scarce and there is a growing need for non-invasive methods to measure disease progression, particularly as we now have other medical options available to us for Ursodeoxycholic acid non-responders.

Aims/Background
To determine whether or not fibroscan scores on patients with PBC correlated with clinical and biochemical parameters

Method
From a database of patients with PBC attending our outpatient department, a list of 21 patients who had had a fibroscan was generated. The results from the fibroscan were clinically correlated with biochemical results

Results
21 patients were identified, 76% of which were female with an average age of 60.38 (age range 34-75 years). Using Pearson's correlation coefficient, it was found that patients who had an abnormal fibroscan result (>7Kpa), were statistically more likely to have an elevated alkaline phosphatase greater than twice the upper limit of normal, r=-0.05359, 95% CI -0.7859 to -0.1355 (p=0.0123).

Conclusions
Fibroscan is a useful, noninvasive bedside test that can be used to identify progressive disease in fibrosis in patients with PBC. We are currently performing fibroscan on our total cohort of over 100 patients with PBC and will present further findings at the ISG.

ABSTRACT 41 (18W138)

Evaluation of the Ridagene Helicobacter pylori real-time PCR assay compared to culture for the detection of clarithromycin resistance.

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Introduction
Molecular methods provide a more rapid alternative than culture for the detection of clarithromycin-resistant H. pylori infection.

Aims/Background
to evaluate the Ridagene H. pylori real-time PCR assay compared to culture-based methods for the detection of clarithromycin resistance.

Method
Gastric biopsies were processed for clarithromycin susceptibility testing using Etest strips (Biomerieux, France) and DNA was analysed for the 3 most common clarithromycin-mediating point mutations (A2146C, A2146G and A2147G) using the Ridagene H. pylori real-time PCR assay (R-Biopharm AG, Germany).

Results
In all, samples from 131 rapid urease test- and culture-positive patients (mean age 47.4 ± 14.2 years; 46.6% female) were analysed. The Ridagene assay detected H. pylori DNA in 96.9% (N=127/131) of samples. Using biopsies that were both culture- and H. pylori DNA-positive, the clarithromycin resistance rate was significantly higher by culture than the Ridagene assay (51.2% (N=65/127) vs 38.6% (N=49/127), respectively; X2=4.1; P=0.04). Results were concordant from both methods in 80.3% (N=102/127) of cases. The sensitivity and specificity of the Ridagene assay compared to culture for the detection of clarithromycin resistance were 67.7% (95% CI: 55.0-78.8%) and 91.9% (95% CI: 82.2-97.3%), respectively. The positive predictive value was 89.8% (95% CI: 78.9-95.4%) and the negative predictive value was 73.1% (95% CI: 65.5-79.5%).

Conclusions
Although quick and easy to use, the low sensitivity compared to culture for the detection of clarithromycin resistance in our cohort limits its use to cases where culture-based methods are unsuccessful.

Further studies are required to characterise the full spectrum of clarithromycin resistance-mediating mutations present in our patients.

ABSTRACT 42 (18W140)

Threading The Needle: Diagnostic Yield EUS Guided FNA In Real World Clinical Practice

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Introduction
EUS tissue sampling is integral to diagnosing suspicious pancreatic lesions. Guidelines recommend target rate of >85% for diagnostic rate of adequate sample in all solid lesions undergoing EUS-FNA.
Aims/Background
Primary aim was to assess diagnostic yield of solid pancreatic lesions. Secondary outcomes include: assessing number of passes performed and presence of trainees on diagnostic yield.

Method
Electronic endoscopy recording system (EndoRad) identified patients that underwent EUS in 2017. Endoscopy reports were examined manually to identify if EUS guided sampling of solid pancreatic lesions was performed. Patient demographics, presence of trainee and number of passes with sampling needle recorded from endoscopy reports. Pathology reports examined to assess whether an adequate sample was received from EUS guided sampling.

Results
388 EUS procedures were performed in 2017. 48 patients with solid pancreatic lesions underwent EUS guided tissue sampling. 77% (37/48) of procedures yielded an adequate tissue sample as per histology report. The higher number of passes, the higher the proportion of samples that had an adequate sample for diagnostic purposes, 89% (16/18) for 3 passes compared to 72% (13/18) and 67% (8/12) for two and one passes respectively. The presence of a trainee was associated with an increased diagnostic yield, 85% (23/27) versus 67% (14/21).

Conclusions
This retrospective study demonstrates that higher number of passes is associated with higher diagnostic yield, mirroring published clinical trials. A standardised protocol for number of passes and needle type used may warrant repeat audit in the future.

ABSTRACT 43 (18W141)

Appropriateness of OGD referrals and follow up in a single centre

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Introduction
The volume of referrals for endoscopy procedures in the developing world is increasing exponentially and currently healthcare systems are under extreme pressure to meet this demand. There are often questions raised about the appropriateness of referrals for these invasive procedures.

Aims/Background
To categorise OGD outcomes based on the reason for referral and follow up and assess whether the indications were appropriate.

Method
Data of 366 patients was collected. All outpatient OGD's performed by a single surgeon carried out between Feb 2017 and Nov 2017 were recorded. Data collected included gender, age, reason for referral antiplatelet/anti coagulant medication, ability to complete procedure and scope outcomes.

Results
The most common reason for referral was reflux symptoms (34.4%), followed by epigastric pain (10.38%). There 31 referrals coded as 'other', these included; chest pain, nausea, family history gastric/esophageal cancer, incidental CT findings and previous unequivocal celiac biopsy. Based on NICE guidelines for suspected upper GI cancer, Barretts surveillnace and dyspepsia management, ESMO recommendation for surveillance of gastric cancer and clinical judgement all referrals of dysphagia, epigastric pain, reflux, surveillance for celiac, Barretts, post cancer, post upper GI bleed were all deemed appropriate (73.04%). In the absence of more detailed information it was uncertain if anemia, weight loss, stricture surveillance, surveillance post inflammation, and indications in the 'other' category were appropriate (22.32%). The remaining 4.64% that included hiatus hernia surveillance were deemed inappropriate due to lack of data supporting their follow up.

Conclusions
More detailed referrals including clinical examination findings are necessary to stratify patients more efficiently into risk categories so that those with significant pathology such as cancers are reviewed and scoped promptly

ABSTRACT 44 (18W142)

A Picture Paints A Thousand Words: Disability In IBD Using The IBD Disk

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Introduction
Inflammatory bowel disease (IBD) impacts on the physical and mental wellbeing of patients. Quantifying disability as part of Patient Reported Outcomes (PROs) is included among the therapeutic targets to reach in IBD.

Aims/Background
Primary aim was to assess for any correlation between disability reported by patients with IBD, their endoscopy findings and IBD therapy using the IBD Disk, a visual self administered tool for assessing disability in IBD.

Method
A prospective study was conducted over 3 months between July to September 2018. Patients attending the IBD clinic were invited to complete the 10 item self-administered IBD Disk questionnaire. Patient demographics, IBD therapy and endoscopy findings were recorded.

Results
58 patients completed the questionnaire. 34 (59%) were male, age range was 19-85. 34(59%) had ulcerative colitis (UC), 24 (41%) crohn's disease. 19 (33%) scored >50/100 signifying higher levels of disability. Low energy levels was the commonest disability reported at 57% (33), followed by difficulty sleeping at 53% (31). Body image dissatisfaction and sexual dysfunction were the lowest disabilities reported at 24%(14) and 22%(13) respectively. 6 patients (10%) had no disability and were receiving either 5- aminosalicylate (5-ASA) monotherapy or combination with an immunomodulator. 40%(23) used 5-ASA therapy alone, 31%(18) used immunomodulators and 26%(15) used biologics. 2 patients had a Mayo Endoscopic score of 3, while 10(17%) patients with UC scored >50/100 on the questionnaire.

Conclusions
No correlation was shown between the degree of disability, endoscopic scores and IBD treatments. Disabilities reported were variable and the IBD Disk has the potential to highlight patients' concerns.

ABSTRACT 45 (18W143)

Is transient elastrography CAP more effective than traditional imaging modalities at diagnosing non-alcoholic fatty liver disease A Retrospective Analysis

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Introduction
Non-alcoholic fatty liver disease NAFLD is now considered one of the main caues of chronic liver disease globally. A diagnosis of NAFLD necessitates that there is evidence of hepatic steatosis on imaging or histology, along with exclusion of other causes of liver disease or steatosis. Blood tests, ultrasound or CT imaging have typically been used to diagnose NAFLD in the past. Diagnositic yield is limited by the sensitivity of imaging modalities necessitating liver biopsy in selected cases. Transient elastrography (fibroscan) with Controlled Attenuation Parameter (CAP) is a useful non-invasive adjunct in the diagnostic algorithm of NAFLD

Aims/Background
To compare Fibroscan CAP assessment to that of conventional ultrasound or CT imaging in identifying hepatic steatosis.

Method
Retrospective analysis of all Fibroscan with CAP readings from September 2017 to April 2018 in the Royal Victoria Hospital, Belfast. We used the electronic care records to collect data. We included patients with CAP scores of >280. This provided us with 132 patients in total. We took these patients and inspected their previous imaging to check if evidence of steatosis had been picked up on US/CT imaging. Other parameters analysed included indication for Fibroscan and liver stiffness.

Results
Our results revealed that 42 (32%) patients had US/CT imaging which did not reveal evidence of steatosis that was present on CAP readings.

Conclusions
Fibroscan CAP is a more sensitive modality for identifying steatosis in comparison to US/CT imaging. If widely available could help identify patients at risk of progressing to Non-alcoholic steatohepatitis and intervene at an earlier stage.

ABSTRACT 46 (18W145)

Diagnosis And Management Of Eosinophilic Oesophagitis

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Introduction
Eosinophilic oesophagitis (EoE) is a chronic, immune/antigen-mediated oesophageal disease characterized clinically by symptoms related to oesophageal dysfunction and histologically by eosinophil-predominant inflammation.

Aims/Background
The aim was to audit current diagnostic and management practice for patients with EoE and identify areas for improvement. Salient points from international guidelines are as follows. Symptoms unreliably reflect the histologic disease activity of EoE, so histology currently continues to be necessary to monitor disease. The utility of allergy tests in the identification of food triggers in EoE is consistently low in adults and should not be used to identify causative food triggers. The effect of any pharmacological/dietary therapy should be checked by means of a follow-up endoscopy after 6-12 weeks

Method
A retrospective audit of medical records from patients diagnosed with eosinophilic oesophagitis between 2008 and 2018 was carried out. Patients were identified by interrogation of coded histology diagnoses and charts were obtained for review. International (UEGJ) standards were identified and compared with practice in St. James's Hospital.

Results
19.14% of patients underwent a reassessment endoscopy within 8 weeks of their initial OGD. Full data regarding follow-up endoscopy within 12 weeks, 6 months and 1 year are awaited at this time. It is clear from provisional data that many patients do not undergo short term follow-up endoscopy to assess for histological remission after commencement or change of therapy. Specific IgE testing was carried out in 36% of patients (n = 17). Most commonly, specific IgE to milk, wheat, egg, nuts, soya and fish were tested. Occasionally, specific IgE to house dust mite, tree and grass were measured as well as IgG and IgE to Aspergillus. Skin prick testing was arranged in 8.5% of patients (n=4). Tryptase levels (a specific marker for mast cell activation) was measured in 8.5% of patients (n=4). 27.66% of patients were referred to Immunology services. 21.27% of patients (n=10) had a form of dietary management. In keeping with guidelines, the vast majority of patients were commenced on appropriate doses of PPI or swallowed corticosteroid prior to commencing dietary therapy.

Conclusions
Follow-up endoscopy for patients with EoE to assess histological response to commencement or change of therapy should optimally

occur within 6 to 12 weeks. This reflects the knowledge that patients can remain asymptomatic in the context of histological eosinophilic inflammation. Most patients in St. James's have repeat endoscopy outside of this recommended window. Therapeutic response in many patients is based on symptoms alone. Many patients underwent skin prick and specific IgE testing. These poorly predict food triggers, and current data supports a non-IgE mediated inflammatory process. Their use in the assessment of EoE is not recommended. In keeping with current guidelines, dietary management is being utilised as a therapeutic option as well as PPI and corticosteroid therapy. The data from this audit could be utilised to inform a management pathway for patients with eosinophilic oesophagitis.

ABSTRACT 47 (18W148)

Impact Of Direct Access Referral Pathway On Waiting Times For Venesection In Haemochromatosis And Patient Satisfaction

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Introduction
Hereditary Haemochromatosis (HH) is the most common genetic disorder in Ireland. The mainstay of treatment is therapeutic venesection. Guidelines recommend early pre-emptive treatment. Delays in treatment can result in premature death secondary to diabetes, cirrhosis, cardiomyopathy and hepatocellular carcinoma. A direct access referral pathway was established in 2011 to address the 8 month wait for venesection. This is a nurse led service with support from consultants.

Aims/Background
To study the impact of the new direct access referral pathway for venesection on waiting time and patient satisfaction within a model 2 hospital.

Method
A retrospective study of all patients referred to a venesection clinic between 2015- 2017. Patient demographics, referral dates and dates of venesection were recorded from a designated register. An anonymous questionnaire was distributed in clinic to assess satisfaction with the service.

Results
380 patients were referred over a 3 Year period, 240 (63%) males and 140 (37%) females. Mean age was 49 (range 19-86). Average referral to venesection time was 51 days. 80 patients completed the questionnaire. 85%(68) waited <6 weeks from referral to first phone contact from the venesection nurse. 96% (77) described the service as either excellent or very good. 95% (76) waited <15 minutes in clinic for venesection, 96% (77) found the service accessible by phone and 100% had confidence in the care and management they were receiving.

Conclusions
Direct access referral pathway to venesection has allowed timely, earlier treatment of patients with HH with a very high satisfaction level.

ABSTRACT 48 (18W150)

Portal hypertensive complications and long term outcome in paediatric/adolescent patients with portal vein thrombosis

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Introduction
Portal vein thrombosis (PVT) has multiple aetiologies, leading to the development of portal hypertension (PHT) and variceal bleeding (VB). Data on VB and the long-term sequelae of PVT in paediatric and adolescent patients is limited.

Aims/Background
To study the long-term outcomes and incidence of variceal bleeding in paediatric and adolescent patients with PVT.

Method
Patients included were diagnosed with PVT between January 2000 and December 2014. Data collected included episodes of VB, mortality, shunt surgery and liver transplantation.

Results
108 patients (59 male) were identified. Median age at presentation was 5 years. Overall survival was 97.3%. Median follow up was 63 months. No cause for PVT was identified in 68 cases (63%). Twenty-two (21.1%) patients had VB after presentation which was not associated with increased mortality compared to non-recurrent VB (median follow up 86 months, p=0.09). Multivariate analysis suggested sclerotherapy and pancytopaenia were associated with recurrent VB. Thrombocytopaenia, a clinical indicator of PHT, was more prevalent at follow up and in recurrent VB. Spleen size Z-score was higher in recurrent VB (median 1.77 vs 1.31, p=0.027). Eighteen patients had shunt surgery (meso-Rex bypass (MRB), n=11) with 4/18 patients (27.2%) experiencing VB post-surgery. Nearly all patients (95.8%) attended school (up to age 16) however 21.1% of eligible patients were not in higher education or employment.

Conclusions
Recurrent VB post index presentation is common in patients with PVT with evidence of evolving PHT however survival is not affected. Development of pancytopaenia is associated with recurrent VB that may benefit from enhanced endoscopic surveillance or MRB surgery.

ABSTRACT 49 (18W152)

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

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Introduction
Endoscopic scores of local severity do not reflect disease extent, or disease burden. . The DUBLIN score is a simple bedside clinical score that estimates inflammatory burden using both disease severity and extent. As the need to personalise therapy for UC patients increases, a score to accurately assess disease burden will be of great relevance. The aim of this study was to assess the clinical utility of the DUBLIN score by comparing its performance with objective biomarkers.
Aims/Background

The aim of this study was to assess the clinical utility of the DUBLIN score by comparing its performance with objective biomarkers.

Method
DUBLIN score was calculated as a product of Mayo Endoscopic Score (0-3) and disease extent (E1-E3). Correlation with objective biomarkers was performed in a retrospective 'discovery cohort'. A 'validation cohort was recruited from a single centre,where clinical outcomes, colectomy rate and biochemical data were collected prospectively.

Results
The discovery cohort included 70 patients with UC. DUBLIN score correlated significantly with faecal calprotectin levels. (r= 0.394; p50µg/g showed a higher AUC with DUBLIN score (AUC=0.76) than Mayo Score (AUC 0.73). The validation cohort included 41 patients. Patients with high inflammatory burden (DUBLIN >3) had higher C-reactive protein and faecal calprotectin, and lower albumin than low inflammtory burden patients. High DUBLIN score was associated with an increased risk of treatment failure. (HR 2.98 95% CI 1.002-8.87; p=0.049)

Conclusions
The DUBLIN score is a simple measure of inflammatory burden which correlates with objective inflammatory markers and is associated with clinical outcomes such treatment failure. DUBLIN score has the potential to assist in personalising therapy for patients with UC.

ABSTRACT 50 (18W153)

Trough Ustekinumab Concentrations and Clinical and Biochemical Outcomes at 24 weeks in a prospective cohort

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Introduction
Ustekinumab is licensed for use in moderate-severe Crohn's disease. Data regarding the optimum trough-concentration is limited. 23 patients were recruited. The median age was 38.1years (IQR 28.3-53.5 years); median disease duration was 18.9 years (IQR 7.5-23.9 years). 16 patients (66.7%) had previously undergone a surgical resection and all patients were previously treated with anti-TNF agents. HBI improved significantly from median 5 to 0 by week 24. (p=0.004) 69.6% (n=16) patients were in clinical remission. FCP, Albumin and CRP improved by Week 24. Ustekinumab trough-concentrations at week 8 were median 6.1 microg/ml. 80% patients in the lowest Week 8 quartile required treatment escalation. Week 24 median trough-concentrations were 4.2 microg/ml. Trough levels were significantly higher in patients on 4-weekly intervals compared to 8-weekly doses. (7.8 microg/ml vs 2.9 microg/ml) In terms of clinical remission, trough-concentration of 2.95 microg/ml had a 71.4% sensitivity and 50% specificity.

Aims/Background
The aim of this study was to analyse the relationship between ustekinumab trough-concentrations and clinical/biochemical outcomes.

Method
A prospective cohort study was performed in a single academic centre. At induction patients received 360mg ustekinumab subcutaneously (3 divided doses). Clinical, biochemical and demographic data were collected. Serum was collected prior to ustekinumab administration to measure ustekinumab trough-concentrations.

Results
23 patients were recruited. The median age was 38.1years (IQR 28.3-53.5 years); median disease duration was 18.9 years (IQR 7.5-23.9 years). 16 patients (66.7%) had previously undergone a surgical resection and all patients were previously treated with anti-TNF agents. HBI improved significantly from median 5 to 0 by week 24. (p=0.004) 69.6% (n=16) patients were in clinical remission. FCP, Albumin and CRP improved by Week 24. Ustekinumab trough-concentrations at week 8 were median 6.1 microg/ml. 80% patients in the lowest Week 8 quartile required treatment escalation. Week 24 median trough-concentrations were 4.2 microg/ml. Trough levels were significantly higher in patients on 4-weekly intervals compared to 8-weekly doses. (7.8 microg/ml vs 2.9 microg/ml) In terms of clinical remission, trough-concentration of 2.95 microg/ml had a 71.4% sensitivity and 50% specificity.

Conclusions
Ustekinumab therapy using subcutaneous induction and intensive maintenance therapy was effective in achieving clinical remission and improved biochemical profiles. Off-label use of ustekinumab resulted in trough-concentrations above those published to date from trial data. Further exploration of optimal ustekinumab trough concentrations will be key to enhancing patient outcomes.

ABSTRACT 51 (18W154)

A nine year retrospective cohort study of nucleoside/nucleotide analogue outcomes in the treatment of chronic hepatitis B in Northern Ireland.

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Introduction
New nucleoside/nucleotide analogues were approved for treatment of chronic Hepatitis B by NICE and introduced to practice in 2008/9.

Aims/Background
Our aim is to review outcomes for patients with chronic hepatitis B virus (HBV) infection who have been treated with oral antiviral therapy since 2009.

Method
The HBV database and treatment database for the Regional Liver Unit, RVH were cross referenced, identifying all HBV patients treated since 2009. Patients treated during pregnancy and co-infected patients were excluded. Demographic details, clinical and virological outcomes were recorded.

Results
138 patients were identified as being treated for HBV in this period (47 cirrhotic). 118 (86%) were treated with tenofovir, 11 (8%) with entecavir, 3 (2%) with adefovir, 5 (3%) with Lamivudine, 1 (1%) with lamivudine and adefovir. Of 138 patients, 58 (42%) were HBeAg positive on commencing treatment. 28 (48%) of these achieved HBeAg seroconversion, all of whom were on tenofovir. This gives a tenofovir seroconversion rate of 20%. 15 (11%) of the 138 patients achieved HBsAg seroconversion all of whom were on tenofovir. 1 patient had viral breakthrough on tenofovir (switched to entecavir) and 1 had viral breakthrough on entecavir. 25 (18%) patients of 138 experienced adverse outcomes. 3 (2%) underwent liver transplantation, two for HCC and one of decompensated cirrhosis. In total, 13 (9%) patients developed HCC (9 cirrhotic) 2 of whom had co-factors. 7 (5%) died from conditions unrelated to their HBV.

Conclusions
This 9 year review of nucleoside/nucleotide analogues shows good viral control and a serocoversion rate of 20% for tenofovir. Despite viral control there was a 9% incidence of HCC.

ABSTRACT 52 (18W155)

Imaging in Hereditary Haemochromatosis: Establishing a Local Guideline for Cardiac and Hepatic Surveillance

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Introduction
Hereditary Haemochromatosis (HH) is an autosomal recessive condition, most commonly caused by HFE gene mutations. The prevalence of HH in Ireland is 1 in 83 per head of population. Untreated HH may lead to cirrhosis, hepatocellular carcinoma (HCC), diabetes and non-dilated cardiomyopathy. Hepatic and myocardial iron deposition can be reproducibly quantified using T2* MRI. Echocardiography can identify early pathophysiology due to iron overload. Iron overload cardiomyopathy can be effectively managed with conventional heart failure treatment along with venesection or iron chelation.

Aims/Background
There are no definitive guidelines in HH for the frequency of liver or cardiac imaging to assess for complications of iron overload. Our aim was to assess our patient cohort in order to establish a local guideline for interval surveillance.

Method
Data were collated for those attending for venesection at Connolly Hospital. Our laboratory system was used to attain genotype, ferritin at diagnosis and liver function tests. NIMIS was used to determine if patients had undergone liver or cardiac imaging. Chi-squared analyses were employed to evaluate a correlation between ferritin at diagnosis and evidence of hepatic or cardiac dysfunction.

Results
279 patients were included, 80 female and 199 male with a median age of 52 years. 264 ferritin results were recorded. 155 patients had ferritin levels over 500 at diagnosis and 109 less than 500. Of the ferritin <500 group, 32 had normal liver imaging, with 38 abnormal results. In the ferritin >500 cohort, 105 underwent liver imaging, with 34 normal and 71 abnormal results. Ferritin >500 at diagnosis is not indicative of end stage liver dysfunction (p=0.08). Ferritin >500 at diagnosis is associated with abnormal liver imaging, most commonly hepatosteatosis. Four patients had radiological signs consistent with cirrhosis (p=ns). No patients were diagnosed with HCC. 42 patients had cardiac imaging. 19 had structural abnormalities, while 23 had normal studies. Left ventricular diastolic dysfunction was reported in 17 of the 19 abnormal studies. Ferritin >500 showed a statistically insignificant correlation with cardiac structural abnormality (p=ns), likely due to low patient numbers with imaging. Males were more likely to undergo echocardiography.

Conclusions
Ferritin level >500 at diagnosis is not associated with an increased risk for liver dysfunction and, therefore, interval for liver screening may be decreased to 18-monthly, yielding cost savings. Although numbers are small, there appears to be a correlation between high ferritin levels and cardiac structural abnormality. Therefore, we recommend that all patients undergo echocardiography at diagnosis and every 1-2 years thereafter. Patients who demonstrate abnormalities should be referred to specialist cardiac services and undergo cardiac MRI with T2*.

ABSTRACT 53 (18W156)

A Review of Current Medical Therapy in IBD between patients diagnosed Pre and Post Introduction of Biologics

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Introduction
Diagnosis and management of inflammatory bowel disease (IBD) has changed dramatically over the two decades especially since the introduction of biologics for management of IBD.

Aims/Background
We sought to review differences in current treatment in our centre between patients with IBD diagnosed pre and post introduction of biologics.

Method
We studied 119 patients. 14 patients were excluded as date of

Prescribing Information

Humira (adalimumab) 20mg and 40mg solution for injection in pre-filled syringe, Humira 40mg solution for injection in pre-filled pen, Humira 40mg/0.8ml solution for injection (vial) and Humira 80mg solution for injection in pre-filled pen. Refer to Summary of Product Characteristics (SmPC) for full information.

Presentation and method of administration: Each single dose 0.2 ml pre-filled syringe contains 20 mg of adalimumab for subcutaneous injection. Each single dose 0.4 ml pre-filled pen, 0.4 ml pre-filled syringe or 0.8 ml vial contains 40mg of adalimumab for subcutaneous injection. Each single dose 0.8 ml pre-filled pen contains 80 mg of adalimumab for subcutaneous injection. **Indications and Dosage:** Humira 20mg pre-filled syringe, Humira 40 mg vial and Humira 80 mg pen are only approved for use in specific indications with a therapeutic requirement, **please refer to SmPCs for full information**. Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of conditions for which Humira is indicated. Ophthalmologists are advised to consult with an appropriate specialist before initiation of treatment with Humira. Patients treated with Humira should be given the special alert card. After proper training in injection technique, patients may self-inject with Humira if their physician determines that it is appropriate and with medical follow-up as necessary. During treatment with Humira, other concomitant therapies (e.g., corticosteroids and/or immunomodulatory agents) should be optimised. **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. Dosage: 40 mg single dose every other week (EOW). Concomitant MTX should be continued. In monotherapy, patients may require 40 mg every week or 80mg EOW 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. Reintroduction of Humira after discontinuation for 70 days or longer gave same magnitudes of clinical response and similar safety profile as before dose interruption. **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. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Dosage: ≥ 10 kg to ≤ 30 kg: 20 mg EOW. If > 30 kg: 40 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Enthesitis-related arthritis (ERA), paediatrics 6 years and above:** For active ERA with inadequate response or intolerance to conventional therapy. Dosage: 15 kg to < 30 kg: 20 mg EOW. If ≥ 30 kg: 40 mg EOW. **Ankylosing spondylitis (AS), adults:** For severe active AS with inadequate response to conventional therapy. Dosage: adults: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **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. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **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. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Psoriasis (Ps), adults:** For moderate to severe chronic plaque psoriasis in candidates for systemic therapy. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW 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 dosage to 40 mg every week or 80mg EOW (refer to SmPC). If adequate response is achieved with 40mg every week or 80mg EOW, dosage may subsequently be reduced to 40 mg every other week. **Psoriasis, paediatrics 4 years and above:** For severe chronic plaque psoriasis with inadequate response to or if topical therapy and phototherapies are inappropriate. Dosage: 15 kg to < 30 kg: 20 mg dose initially followed by 20 mg EOW starting one week after initial dose. If ≥ 30 kg: 40 mg dose initially followed by 40 mg EOW starting one week after initial dose. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. **Hidradenitis suppurativa (HS), adults and adolescents from 12 years of age:** For active moderate to severe HS (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Dosage: HS, adults: 160 mg dose initially at Day 1, followed by 80 mg two weeks later at Day 15. Two weeks later (Day 29) continue with a dose of 40 mg every week or 80mg EOW. Reintroduction after treatment interruption: 40 mg every week or 80 mg EOW. Dosage: HS, adolescents from 12 years and ≥ 30 kg: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. If there is inadequate response to 40 mg EOW, an increase in dosage to 40 mg every week or 80mg EOW may be considered. Treatment interruption: Humira may be re-introduced as appropriate. Adults and adolescents from 12 years of age: Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions is recommended to be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no improvement in that time. Evaluate periodically the benefit and risk of continued long-term treatment. **Crohn's disease (CD), adults:** For moderately to severely active CD in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or are intolerant to or have medical contraindications for such therapies. Dosage: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If decrease in clinical response, can increase dosage to 40 mg every week or 80mg EOW. Patients with no response by Week 4 may benefit from continued maintenance therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Paediatric Crohn's disease (CD), 6 years and above:** For moderately to severely active CD with inadequate response to, intolerance to or contraindication for conventional therapy including primary nutrition therapy and a corticosteroid, and/or an immunomodulator. Dosage: < 40 kg: Induction: 40 mg dose at Week 0, followed by 20 mg at Week 2. For a more rapid response: 80 mg at Week 0, followed by 40 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 20 mg dose EOW. If insufficient response, consider an increase in dosage to 20 mg every week. If ≥ 40 kg: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg dose at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. If insufficient response, consider an increase in dosage to 40 mg every week or 80 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Ulcerative colitis (UC), adults:** For moderately to severely active UC with inadequate response to, intolerance to or contraindication for conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Dosage: Induction: 160 mg dose at Week 0, followed by 80 mg at Week 2. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If insufficient response, consider an increase in dosage to 40 mg every week or 80mg EOW. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time. **Uveitis, adults:** For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be

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received in accordance with clinical practice starting two weeks after completing treatment with Humira. Evaluate on a yearly basis the benefit and risk of continued long-term treatment. **Paediatric Uveitis, Psoriasis and above:** For chronic non-infectious anterior uveitis with inadequate response or intolerance to conventional therapy, or in whom conventional therapy is inappropriate. Dosage: ≥ 30 kg: 20 mg dose EOW in combination with MTX. Optional 40 mg loading dose one week prior to start of maintenance therapy. No clinical data in use of loading dose < 6 years of age (see SmPC). If ≥ 30 kg: 40 mg dose EOW in combination with MTX. Optional 80 mg loading dose one week prior to start of maintenance therapy. Evaluate on a yearly basis the benefit and risk of continued long-term treatment. **Contraindications:** Hypersensitivity to the active substance or any of the excipients (see SmPC). Active tuberculosis (TB) or other severe infections such as sepsis and opportunistic infections. Moderate to severe heart failure (NYHA class III/IV). **Warnings and precautions:** Clearly record trade name and batch number of administered product to improve traceability of biological medicinal products. ***Infections:*** Patients taking Tumour Necrosis Factor (TNF)-antagonists 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 who have travelled in areas of 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, including the use of concomitant immunosuppressive medications. **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. Appropriate screening tests (i.e. tuberculin skin test and chest X-ray) should be performed in all patients. 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 of HBV has occurred in chronic carriers (surface antigen positive). Patients should be 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. Discontinuation of treatment should be considered if any of these disorders develop. Neurological evaluation should be performed in 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. Examine all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment for non-melanoma skin cancer prior to and during treatment, 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 of developing malignancy or acute leukaemia unknown. Patients with no history of malignancy or ulcers, particularly to be screened for dysplasia before 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 develop while on treatment. **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 with Humira. 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 which had a fatal outcome. Consider risk of infections in these patients. **Interactions:** Antibody formation was lower when Humira was given together with MTX in comparison with use as monotherapy. Combination of Humira with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Fertility, pregnancy and lactation:** Humira should only be used during pregnancy if needed. Women of childbearing potential should consider the use of adequate contraception and continue its use for at least five months after the last Humira treatment. No administration of live vaccines (e.g. BCG) to infants exposed to Humira in utero for 5 months following mother's last Humira treatment during pregnancy. Humira can be used during breast-feeding. **Adverse Reactions:** *Very common ≥ 1/10:* Respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leukopenia (including neutropenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema). **Serious, including fatal, adverse reactions have been reported**, including infections/sepsis, TB, opportunistic infections, allergic reactions (including anaphylaxis), HBV reactivation and malignancies (including leukaemia, lymphoma and hepatosplenic T-cell lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia, aplastic anaemia, central and peripheral demyelinating events and reports of lupus, lupus-related conditions and Stevens-Johnson syndrome. **Prescribers should consult the SmPC for the complete list of reported side effects. Legal Category:** POM **Marketing Authorisation Numbers:** EU/1/03/256/022, EU/1/03/256/013, EU/1/03/256/017, EU/1/03/256/001, EU/1/03/256/021. **Further information:** available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24. **HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Date of revision of PI:** June 2018, PI/256/023.

* Treatment escalation/de-escalation based on pre-specified criteria for clinical symptoms (CDAI and prednisone use) and biomarkers of inflammation (FCP and CRP).[1]

† Treatment escalation/de-escalation based on pre-specified criteria for clinical symptoms (CDAI and prednisone use).[1]

References: 1. Colombel JF, Panaccione R, Bossuyt P et al. Effect of tight control management on Crohn's disease (CALM): A multicentre, randomised, controlled phase 3 trial. Lancet. 2017;390(10114):2779-2789. doi: 10.1016/S0140-6736(17)32641-7. **2.** HUMIRA® Summary of Product Characteristics. Available on www.medicines.ie

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diagnosis was not available. Patients completed a self-administered questionnaire collecting data on IBD phenotype, date of diagnosis, current medications and surgical history.

Results
104 patients were included. 30 were included in our pre-biologic cohort (diagnosis before 2000) (Group 1). 74 were included in our post-biologic cohort (diagnosis after 2000) (Group 2). Group 1: Median age 52(22-74). 48.39% male (n = 15). 54.84% (n = 17) had Crohn's Disease (CD). 16.13% (n=5) were on no medications for their IBD. 41.94% (n = 5) were taking a 5ASA. 19.35% (n=13) were on immunomodulators. 51.61% (n = 16) were on biologic therapy. 41.94% (n= 13) of patients had previous bowel surgery. Group 2: Median age 36(18-91). 54.04% male (n = 40). 52.70% (n = 40) had CD. 20.27% (n=15) were on no medications. 44.59% (n = 33) were taking a 5ASA. 22.97% (n=17) were on immunomodulators. 35.13% (n = 26) were on biologic therapy. 20.27% (n= 15) had previous bowel surgery.

Conclusions
Our review shows current treatment of patients diagnosed pre and post biologics is similar. However, there is an increased use of biologics in patients diagnosed in the pre-biologic era. One could hypothesise this is secondary to a more aggressive form of disease inadequately treated pre-biologics. Reassuringly surgical rates have reduced in our centre since introduction of biologics.

ABSTRACT 54 (18W157)

The effectiveness of using Infliximab in treating IBD in Naas General Hospital

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Introduction
The use of therapeutic drug monitoring (TDM) for infliximab in the treatment of inflammatory bowel disease (IBD) is becoming increasingly commonplace. In cases of non-response (primary or secondary), TDM can provide information about the cause of treatment failure and offer a rationale for steps to recapture response. Gastroenterologists should consider target trough concentrations of at least 5 mcg/mL for infliximab.

Aims/Background
To assess the effectiveness of Infliximab use in treating IBD patients on NGH in comparison to International standards

Method
Patients database in the day ward was used, and verbal consent from all patients obtained by the team prospectively. Samples were collected from patients of trough infliximab levels, infliximab antibodies and fecal calprotectin levels. Data were, from July 2017 to March 2018.

Results
Of 23 patients receiving infliximab at day ward in NGH 10 (44%) of them Group A, their infliximab levels (IL) are within a therapeutic level and having normal, calprotectin. 5 (22%) Group B has above therapeutic IL with normal FCP. 4 (17%) of patients Group C below therapeutic IL with high FCP. 4 (17%) were receiving ineffectively Infliximab, one of them Group D has high IL and high Antibody level, the other 3 patients (12%) Group E have below therapeutic IL and high Antibody level.

Conclusions
Only 44% of patients in Infliximab infusion in NGH can continue of the same dose, however, 66% of patients need a dose adjustment or changing medication.

ABSTRACT 55 (18W158)

Evaluating The PICI Score In A Single Irish Endoscopy Unit

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Introduction
The PICI (Performance Indicator of Colonic Intubation) score has been proposed as a new key performance indicator in colonoscopy quality improvement initiatives by Valori et al. A completed PICI score requires all of: Midazolam use of 2mg or less, Caecal intubation rate (CIR) of 100% and nurse recorded comfort score <4.

Aims/Background
The Mater GI Unit performs approximately 3,300 colonoscopies annually, comprising Colorectal Cancer screening, non-screening endoscopy and inpatient endoscopic services. We sought to establish the PICI score for the unit and also a modified PICI (mPICI) with ≤3mg midazolam cut off.

Method
All colonoscopies completed between January and June 2018 were analysed for midazolam use, caecal intubation rate and recorded comfort score. The PICI score was compared to standard KPIs for the subset of colonoscopies performed by the Gastroenterology service.

Results
1618 colonoscopies were completed between January and June 2018. 30% (n=489) fulfilled PICI criteria. Using the modified PICI criteria (≤3mg midazolam), this increased to 55% (n=893), consistent with the results of the original Endoscopy paper. Individual endoscopist PICI scores ranged from 4% to 53% and mPICI scores from 4% to 85%. The primary differential of achieving PICI score vs standard KPIs was sedation usage.

Conclusions
Using a slightly modified PICI score, colonoscopy performance in our Unit was similar to that of the original PICI paper. These results suggest that PICI is a comparable binary indicator of colonoscopic performance to standard KPIs. Further analysis of the proposed PICI score nationally is necessary before determining its utility and applicability in the Irish context .

ABSTRACT 56 (18W159)

Review of Eus Workload in A Tertiary Referral Centre: 2016-2018

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Introduction
The Mater GI unit performs approximately 570 EUS procedures annually. A significant proportion of these patients are referred from external hospital sites, both inside and outside the IEHG (Ireland East Healthcare Group). The Mater GI Unit can facilitate same day EUS and ERCP procedures.

Aims/Background
We sought to audit the EUS workload and its impact of the general endoscopy workload and capacity. Demand for the external EUS service has been increasing on an annual basis. EUS is only performed in one the unit's endoscopy rooms (currently 3.5 rooms available).

Method
All EUS procedures completed between July 2016 and June 2018 were reviewed. Data was collated detailing age, indication, sedation, procedure duration, procedural interventions and success rates.

Results
1137 procedures were recorded over the 2 year period. Only 33% (n=371) were on Mater patients. Non-IEHG patients accounted for 57% (n=644) of the total EUS workload. Annually, EUS procedures account for 24% procedures performed but 32% of the total procedure time for that room. 26% (n=297) of patients underwent combined EUS/ERCP on the same date.

Conclusions
Providing the EUS diagnostic service has a significant effect on the general endoscopic service provision of the GI Unit. The majority of patients are from non-IEHG sites. This increased workload is associated with increased GI Unit and Hospital resource utilisation without any increase in GI Unit capacity or funding.

ABSTRACT 57 (18W160)

Review of Ercp Workload and Resource Utilisation in a Single Tertiary Referral Centre: 2016-2018

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Introduction
The Mater GI unit performs approximately 650 ERCP procedures annually. A significant proportion of these patients are referred from external hospital sites, both inside and outside the IEHG (Ireland East Healthcare Group).

Aims/Background
We sought to audit the ERCP workload in the Mater GI Unit. The financial cost of providing this service was investigated to estimate an average referral cost. This would provide an estimation of the projected future requirements to both maintain current unit standards and anticipate future growth.

Method
All ERCP procedures between July 2016 and June 2018 were reviewed. Data was collated detailing referral site, procedure duration, interventions and admission rates. Stent deployment was recorded and costs for stent usage acquired from purchasing department.

Results
1288 procedures were recorded over the 2 year period. This represents 32% of procedures performed in the ERCP room, one of 3.5 endoscopy rooms in Unit, but 46% of procedure time. 69% (n=885) were performed on patients from outside the Mater. 58% of patients originated outside the IEHG with the largest number from the Saolta Hospital Group at 32% (n=407). 30 non-elective admissions from external hospitals were recorded. Over 2 years, 491 stents were deployed, with a total stent cost of €126,689. External patients accounted for €89,928 of total stent expenditure.

Conclusions
Demand for ERCP has increased over the past number of years, with the majority of procedures being referred from external hospital sites. This increased workload is associated with increased GI Unit and Hospital resource utilisation without any increase in GI Unit capacity or funding.

ABSTRACT 58 (18W161)

Future Key Performance Indices for Device Assisted Enterosocpy, what we can learn from current practice.

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Introduction
ESGE recommends device-assisted-enteroscopy(DAE) to confirm and treat small bowel(SB) lesions. DAE lacks Key Performance Indices(KPI) compared to other endoscopy procedures. Assessment of current practice could highlight important future KPIs.

Aims/Background
To identify potential KPIs for DAE through assessment of current practice at a single university-affiliated-centre.

Method
DAEs from 2014-2017 were included. Electronic records were reviewed including SB capsule-endoscopy(SBCE) reporting system. Demographics, indications, findings, interventions and complication rates were documented. Data was analysed according to potential KPI and compared using a chi2 test, a $p<0.05$ was significant.

Results
251 cases were reviewed; 146(58%) male; mean age 59+/-17years. 186(74%) were anterograde. Average depth of insertion was significantly longer for anterograde versus retrograde, 2.37+/-0.97m versus 1.06+/-0.66m[$p<0.0001$(95% CI 1.05-1.58)]. 83%(n=206) had prior SB imaging. The overall diagnostic yield was 58%(n=145); 30%(n=74) involved a therapeutic procedure, and tattooing was undertaken in 36%(n=99). Complication rate was 0.8%(n=2); one

post-polypectomy bleed and one mild pancreatitis. Diagnostic yield was significantly higher for patients with prior SBCE(64%, n=103/162) compared to both those with prior radiology(51%, n=21/47) or with no imaging (47%, n=42/89), p=0.02, OR-1.9(95% CI 1.15-3.3). Therapeutic intent was achieved in 98%(n=74/75). Independent trainees, trainees under supervision or a consultant performed 21%, 49% and 30% of procedures respectively. Reporting of positive findings was significantly higher 66% vs 49%(p=0.02) by independent trainees.

Conclusions
DAE in our practice was effective and associated with few complications. Our data suggests that pre-screening with SBCE could be a future KPI, enhancing diagnostic yield and targeting approach, along with complication, and trainee supervision rates.

ABSTRACT 59 (18W165)

Assessing the burden of NAFLD in primary care

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Introduction
The prevalence of NAFLD in the general population of Western countries is 20-30%. About 2-3% of the general population is estimated to have non-alcoholic steatohepatitis (NASH), which may progress to liver cirrhosis and hepatocellular carcinoma. Determining those at risk of progressive disease in primary care is challenging and waiting lists to access secondary care are currently lengthy

Aims/Background
To assess the burden of NAFLD in primary care and need for a streamlined referral pathway direct to fibroscan.
Method

Patients at risk of NAFLD in a single primary care centre were identified using electronic records. A sample of those identified were selected to calculate MAYO-NAFLD scores and those with a score >-1.455 were offered fibroscan.

Results
167 patients in a practice of 10,000 were identified with possible NAFLD. A subset of 31 patients were selected (those who had been offered lifestyle advice with no improvement) and invited for venepuncture to facilitate MAYO NAFLD score calculation. 9/31 ((%) attended and 8/9 had MAYO NAFLD scores in the indeterminate or high risk group. These 8 were invited for fibroscan. 5/8 attended for fibroscan and of these 3 (10%) had a fibroscan in the cirrhotic range, 1 (3%) with fibrosis and 1 normal. All patients undergoing fibroscan had a CAP score consistent with steatosis (>280).

Conclusions
This study confirms NAFLD patients are challenging to engage. Nonetheless, it appears NAFLD is prevalent in primary care and there is a significant disease burden not yet identified. It also confirms the need for a discussion about primary care access to fibroscan.

ABSTRACT 60 (18W166)

Association between Trough Vedolizumab Concentrations and Therapy Outcome in a Cohort of Patients with Inflammatory Bowel Disease

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Introduction
Vedolizumab(VDZ) is an α4β7 integrin antagonist for the treatment of IBD. The role of VDZ therapeutic drug monitoring has not been clearly defined.

Aims/Background
We aimed to investigate the association between VDZ trough levels and therapy outcome in an IBD cohort.

Method
IBD patients receiving VDZ were identified in a cross-sectional study where serum samples were not collected at a pre-specified time point. Ulcerative colitis(UC) and Crohn's disease(CD) clinical activity were quantified using partial Mayo score (PMS, remission ≤ 1) and Harvey Bradshaw Index (HBI, remission < 5). VDZ and antibody-to-vedolizumab (AVA) concentrations were determined. P values < 0.05 were considered significant.

Results
N=35 IBD patients included (57% UC, 54% male, median age(range) 44.3 years(17.7 – 76.2), 9% receiving immunomodulators, 83% prior anti-TNF. 34/35 patients had trough VDZ level performed during maintenance therapy. Median(range) trough VDZ concentration 9.5 µg / mL(0 – 25). 0/35 subjects had detectable AVAs. No association between PMS or HBI defined remission and trough VDZ concentrations was observed p=0.38 and p=0.83 respectively. No difference in trough VDZ concentrations was observed comparing subjects by IBD phenotype(p=0.50); prior biologic exposure(n=0.37); or concomitant immunomodulator use(p=0.68). CRP and albumin concentrations were not correlated with trough VDZ concentrations, correlation coefficient -2.2(p=0.36) and 0.21(p=0.36) respectively.

Conclusions
In a real-world study of IBD patients receiving VDZ no association between VDZ trough concentrations and therapy outcome was observed. Significant immunogenicity was not observed supporting the use of VDZ monotherapy in uncomplicated patients. Further study is required to determine the utility of therapeutic drug monitoring in VDZ-treated patients.

ABSTRACT 61 (18W167)

Seasonal Variations in Acute Hospital Admissions with Inflammatory Bowel Disease

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Introduction
Several environmental factors have been reported to play a significant role in both the aetiology and exacerbation of Inflammatory Bowel Disease (IBD). However, there is scarce and conflicting data assessing the role of seasonal variations on exacerbations of IBD.

Aims/Background
The aim of this study was to determine the relationship between seasonal variation and hospital admissions with IBD, and correlation between environmental factors (temperature and rainfall) and acute hospital admissions for IBD.

Method
This single center retrospective cohort study included patients admitted acutely to our hospital with Crohn's Disease (CD) or Ulcerative colitis (UC) between September 1st 2015 and August 31st 2018. Patient data was collected from Hospital In-Patients Enquiry (HIPE) system and temperature and rainfall data was accessed from the MET Èireann website.

Results
A total of 227 patients were included in the study. CD: 142 (M: 65, F: 77, Mean age: 42 ±14.9 years), UC: 85 (M: 35, F: 50, Mean age: 51 ± 21 years). There were significantly more CD admissions in summer and spring (44, 44) compared to autumn and winter (28, 26), (p=0.04 chi-square). By contrast, while there were low numbers of UC admissions in the summer (16) there was no significant seasonal variation when compared with spring (26), autumn (21) or winter (22); (p=0.49). There was a significant negative correlation between CD admissions and mean monthly rainfall (p-value: 0.02) and a significant negative correlation between UC admissions and mean monthly temperature (p-value: 0.04). There was no significant correlation observed between temperature and CD admissions or between rainfall and UC admissions.

Conclusions
Our data indicates a high incidence of CD admissions in spring and summer with a low incidence of UC admissions in summer. Seasonal changes as well as changes in temperature and rainfall appear to have a dichotomous relationship with CD and UC. Seasonal factors may be responsible for triggering IBD exacerbations in addition to other environmental factors such as infections, smoking, NSAIDs and use of other medications.

ABSTRACT 62 (18W168)

Bowel Screen – Does it reach its target audience?

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Introduction
BowelScreen, the National Colon Cancer Screening programme, began in 2012; the second screening round will be completed in December 2018. Offered to people aged 60-69 via invitation letter and follow-up Faecal Immunochemical Test (FIT); if FIT positive offered colonoscopy.

Aims/Background
To assess factors affecting BowelScreen awareness, offers and uptake.

Method
Interviews with patients born 1942-1958, attending SMH August-September 2018. Questions included awareness of BowelScreen; invitation to participate; uptake; FIT result; offer of colonoscopy; reason for declining.

Results
44/54 were aware of BowelScreen (81%). 36/54 were offered screening (67%). 32/54 were invited to screening by letter (60 %) The remaining 4/54 (7%) contacted the service themselves. 27/36 submitted a sample for FIT (75%). 5/27 (19%) were FIT positive; all had a colonoscopy, demonstrating polyps in 4 and colon cancer in 1 patient. Reasons for declining screening included regular or planned colonoscopies, busy lives, separate health issues, avoidance of doctors, fear of results and forgetfulness. 30/54 had previously had a colonoscopy (56%), including 7/9 who declined screening (78%). Positive FIT occurred in 1/30 (3 %) versus 4/24 without prior colonoscopy (17%).

Conclusions
This small survey found good awareness of Bowelscreen. However, only 60% of the target population (32/54) was contacted. BowelScreen reported 40% uptake after its first round, the uptake in our patients was 75%. Improving the 'contact rate' and uptake would enhance an excellent screening tool but would also have implications for service provision.

ABSTRACT 63 (18W169)

Schistosomiasis as a weird cause of deranged LFTs in an Irish patient

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Introduction
Schistosomiasis is Parasitic disease caused by several species of flatworm that Affects many in developing countries, Can contract it by wading or swimming in lakes, ponds and other bodies of water infested with the parasite's snail host. First described by German pathologist Theodore Bilharz who performed autopsies on Egyptian patients who had died from the disease and found male & female parasite eggs in the liver portal system, bladder.
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Method
52 years old male patient , referred to NGH with sudden onset of severe Rt. Loin pain and persistent deranged LFTS, with no previous

history of similar episodes, fever, surgical operations, haematuria, haematochezia. He is a farmer and lives with his wife, non-smoker, nor drinker. Travelled to north Africa 13 years ago and was exposed to rivers. Labs showed thrombocytopenia, hyperbilirubinemia over the last few years, CT reported as ureteric stone, splenomegaly with dilatation hepatic portal veins suggestive of Portal HTN. Marked dilatation of the IVC , multiple small rounded liver lesions each measuring less than 2 cm. Triphasic CT showed Multiple focal liver lesions with differential includes nodular regenerative hyperplasia and regenerative liver nodules, however, liver metastases cannot be excluded.
Results

Negative results to viral hepatitis and HIV, auto-immune hepatitis. Normal Iron and coper studies. Liver biopsy showed irregular fibrosis, fibroscan reported as fibrosis (11.7 Kpa). OGD showed large oesophageal varices that were banded Anti-Schistosomiasis Ab titre +ve (1.7).

Conclusions
parasitic infection should be considered investigated as a possible rare cause of deranged LFTs.

ABSTRACT 64 (18W171)

Patient Reported Outcome Measures, How useful are they for monitoring IBD?

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Introduction
The use of Patient Reported Outcome Measures (PROMs) is gaining popularity in Inflammatory Bowel Disease. The IBD control questionnaire uses a simple set of items to capture disease control from the patient's perspective. It has been hypothesized that it can be used as a screening tool to identify patients with quiescent disease. The IBD control Visual Analogue Scale, using a cut off of ≥85, has a sensitivity of 64.3% and specificity of 90% for identifying quiescent patients.

Aims/Background
To assess the utility of a validated PROM for monitoring IBD patients on maintenance therapy.

Method
We performed a cross sectional study over a 2 month period. 150 IBD patients attending for infliximab infusions were studied. Patients completed the IBD control questionnaire and we assessed how it correlates with disease activity and therapeutic drug monitoring.

Results
Patients who reported remission (n-99) according to the IBD control visual analogue scale were equally likely to have a CRP >5 as those who reported non-remission (n=51) and there was no difference in median CRP between the two groups. Patients who reported remission were equally likely to have therapeutic (65%), sub-therapeutic (38%) and undetectable drug levels (11%) as those who reported non remission (62%, 35%and 12% respectively).

Conclusions
In our patient cohort the administration of the IBD control questionnaire did not discriminate patients requiring treatment optimisation. This suggests PROM may have limited clinical utility in monitoring IBD.

ABSTRACT 65 (18W172)

Is proactive TDM worthwhile in the real world?

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Introduction
Proactive versus reactive therapeutic drug monitoring is a hot topic in IBD patient management. The current data would suggest reactive TDM is more valuable in patient management.

Aims/Background
We aimed to assess whether our patient population would benefit from proactive TDM by capturing a snapshot of levels and anti drug antibodies in our patient population.
Method
Over a 2 month period we assessed infliximab levels and anti drug antibodies on all our patients receiving Infliximab infusions

Results
150 patients were included in the study. 11% had undetectable infliximab levels. 5% had both undetectable infliximab as well as antibodies >280. In those with therapeutic levels no patients had anti-drug antibodies >280, compared to 18% in the sub-therapeutic group. Median MAYO scores were higher in the sub-therapeutic group versus the therapeutic group but there was no difference in HBI. When a validated patient reported outcome measure visual analogue scale was applied there was no difference between the two groups in the proportion reporting remission. Those with sub-therapeutic levels were twice as likely to have a raised CRP as those with therapeutic levels.

Conclusions
Using proactive TDM in our patient cohort has identified patients who are being sub optimally managed on infliximab. We have reacted by changing doses or dosing interval or by adding immunomodulator therapy and we plan to follow up over the coming months to assess response to treatment changes.

ABSTRACT 66 (18W173)

Faecal calprotectin in Inflammatory Bowel Disease (IBD). 100% accurate or potential red herring?

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Introduction
Faecal calprotectin (FC) is increasingly being used in clinical practice as surrogate marker for intestinal inflammation. A meta-analysis of prospective studies using suspected IBD patients found the pooled FC sensitivity and specificity to be 93% and 96% respectively. Previous

studies showed that several medications, dietary supplements, sampling time, pregnancy and body mass index (BMI) have been mentioned as confounding variables affecting FC results.

Aims/Background
There were reports among endoscopists that with raised FC leading to endoscopic examination, the findings were negative for presence of colitis. The primary aim of our study is to assess the prevalence of this subgroup cohort and assess sensitivity and specificity of FC in our department. This subgroup identification may have clinical impact on provision of colonoscopy service if statistically significant.

Method
This retrospective analysis study involved obtaining results of FC samples taken and correlate with colonoscopic and histological findings. The FC samples in our institution were processed in two external labs (Biomnis, Ireland and Birmingham, UK).

Results
Our study cohort involved 70 patients (32 males, 38 females). The median age was 44. There were 34 patients with Crohn's disease, 29 with ulcerative colitis, 5 indeterminate and 2 newly diagnosed IBD. The FC range in our external lab (Biomnis) are subdivided into 3 - ie. negative for level < 50ug/g, between 50 – 200 gray zone and >200 is positive for inflammation whilst the lab in Birmingham used the cut off FC level <60ug/g as being negative. There were 54 patients (77%) who had raised FC results. Of these, 45 (83%) had findings of colitis on histology and 9 (17%) showed negative histology (p-value 0.01). There were 13 (18.5%) patients who had normal FC and had colonoscopy performed which showed colitis findings and confirmed histologically. There were 3 patients (4.5%) who had normal FC with no colitis evident endoscopically and histologically.

Conclusions
Faecal calprotectin is utilized in IBD centres as surrogate markers and initial non-invasive screening for intestinal inflammation. The FC specificity and sensitivity is variable and the possibility of confounding variables and patients' factors should be taken into account when interpreting results.

ABSTRACT 67 (18W174)

Azathioprine Initiation In IBD treatment. Step Up Increment or High Dose Commencement ?

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Introduction
Thiopurines (TPs) are commonly used medication in treatment of Inflammatory Bowel Disease (IBD). The need for regular bloods monitoring especially in the early treatment phase is crucial due to possible bone marrow suppression.

Aims/Background
There has been a different practice approaches to Azathioprine (AZA) initiation regime amongst gastroenterologists. The conventional approach is to initiate AZA at a low dose with subsequent dose increment at weeks interval if tolerated well with regular bloods monitoring. The other alternative approach is to start AZA at a high dose with subsequent bloods monitoring. The aim of this study is to compare these two different approaches and assess impact on clinical outcome and response in our IBD patients. Disease activity indices were assessed with Harvey Bradshaw Index (HBI) for Crohn's disease and partial MAYO score for ulcerative colitis.

Method
Data was obtained from our IBD database. Patients were contacted to obtain the relevant information.

Results
We managed to make phone contact with 70 of 100 patients (30 patients did not answer the phone call). We specifically looked into two study arm groups with 35 on each arm ie. started on high AZA dose (100mg) and the other arm, incremental dose increase. For the group started on high dose, the mean partial MAYO score was 0.8 after 3 months initiating AZA and HBI was 1.7. Six patients (17%) described transient side effects of nausea and vomiting, 2 (5.7%) described flu-like symptoms. For the incremental AZA dose subgroup, the partial MAYO score was 0.9 at 3 months initiation and HBI was 1.5. There were 5 patients (14%) describing nausea and vomiting and 1 other patient described initial rise in liver blood test. There was no reported serious AZA side effects ie. bone marrow suppression or pancreatitis after 3 months initiation in both study arms.

Conclusions
In our study cohort, both the different approaches of AZA commencement showed good initial outcome as shown by the low disease activity indices. Incremental dose approach involve more attention in terms of more frequent bloods monitoring prior to dose increase and perhaps the workload can be reduced with high dose commencement approach and at the same time, still achieving the same treatment target without serious adverse outcomes.

ABSTRACT 68 (18W175)

Smoking Remains A Major Contributor To The Burden Of Crohn's Disease In Ireland And Warrants The Development Of A Specific Targeted Smoking Cessation Intervention

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Introduction
In Ireland, 15,000 people have Crohn's disease (CD) and active CD smokers have a higher risk of relapse and surgery. However, many Irish CD patients co
ntinue to smoke perhaps due to lack of awareness.

Aims/Background
To determine current smoking rates, the impact of smoking on CD severity and to assess patient awareness of the risks associated with smoking.

Method
A self-assessment questionnaire was employed to assess smoking habits, demographics, disease characteristics and awareness of the impact of smoking in the CD cohort.

Results
139 questionnaires have been returned, 56 CD patients and 83 Controls. The mean age was 47 years (range 19-80 and 62 (47%) were males. Disappointingly 52% (n=72) overall reported having ever smoked with similar rates in CD and control patients, 57% (n=32) and 48% (n= 40). Within the CD cohort 52% (n=29) had previous surgery. HBI results were available for 31 (55%) CD patients. Current smokers reported higher HBIs 13 vs 5, P=0.01 (95% CI= 1.91-13.6). In all active smokers were twice as likely (88% vs 38%) to have an elevated HBI >7, RR= 2.1, P= 0.03. Only 41% (13/32) and 28% (9/32) of our CD cohort thought smoking was a significant risk factor for IBD and surgery while just 25% (8/32) thought smoking cessation could significantly decrease the severity of their disease.

Conclusions
Smoking rates remain high in our Irish CD population, with a negative impact on disease severity and need for surgery. Few CD patients were aware of the negative impacts of smoking and the potential benefit of cessation.

ABSTRACT 69 (18W176)

Outcomes of an Outpatient Gastroenterology Service Survey

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Introduction
Outpatient waiting lists are a major issue. Nationally 10,261 patients are awaiting gastroenterology review, 1461 waiting >1 year. Healthcare strategy favors devolving care to the community. Patient's opinions are important and should influence policy and future services.

Aims/Background
To collect patient feedback and recommendations on our outpatient service.

Method
Over a 6-week period, a voluntary self-assessment questionnaire was distributed covering demographics, key indices, overall satisfaction and recommendations. For each question, non-responders were excluded.

Results
150 outpatients, 57(38%) male, mean-age 53 years participated. Referral source; 49% (70) GP, 34% (49) intra-hospital, 3% (4) inter-hospital, 11% (16) combined, other 3% (5). Waiting times; 30% (43) <3months, 34% (48) 3-6 months, 15% (21) 7-9 months, 21% (30) >1year. 122(88%), 14(10%) and 3(2%) attended for new, review or second opinions. 26% (39) received a repeat prescription, 59% (88) had further follow up scheduled; 65% (57) clinic appointment, 35% (31) a procedure. Overall 79% (82) were satisfied, 15% (16) undetermined and 6% (6) unsatisfied with their clinic visit. Regarding patient recommendations, 66.3% (69) preferred a physical appointment compared to 11.5% (12) a virtual clinic. Only 18.3% (19) preferred follow up with their GP. Regarding appointments, 43.3% (62) still preferred a notification letter, 17.5% (25) a text-message, 2.8% (4) an email, whereas 36.4% (52) preferred more than two methods.

Conclusions
A significant proportion of GI referrals are from other specialists. The majority attend outpatients for chronic disease management. Despite clinic waiting times, overall satisfaction was good. Patients prefer attending a specialist clinic.

ABSTRACT 70 (18W178)

Balloon sphincteroplasty is a safe and reliable method to achieve biliary clearance in an at risk choedocholithiasis cohort.

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Introduction
Endoscopic balloon sphincteroplasty (EBP) has been recommended by ESGE as an alternative to Endoscopic Sphincterotomy (ES) in patients with coagulopathy or alternated anatomy.

Aims/Background
To investigate the effectiveness of EBP versus ES in managing selected patients with choledocholithiasis at TUH.

Method
Over one year, patients with untreated coagulopathy or abnormal anatomy, with choledocholithiasis were recruited. Indication, demographics, diagnosis, duct clearance rates, sedation and complications were recorded. EBP was performed with an 8mm Hurricane Biliary Balloon for ≥ 4 minutes under direct and fluoroscopic control, with subsequent stone extraction using standard techniques. Outcomes were compared to age and sex matched ES choledocholithiasis patients.

Results
Of 577 ERCPs, 19 EBPs were performed and compared to 57 matched ES cases. Mean age 62 (21-91), 29 (38%) males. Indications: gallstone pancreatitis 4(5%), choledocholithiasis alone 72(95%). Findings: Confirmed choledocholithiasis, 15/19 (79%) and 42/57 (74%), normal balloon trawl, 3/19 (16%) and 15/57(26%) in EBP and ES groups respectively and 1/19 (5%) EPB stricture. While failure of duct clearance was less common in EBP patients (OR 0.65), the difference was not significant; 87% (13/15) EBP vs 81% (34/42) ES, p=0.47. Despite EBP patients being coagulopathic, ES intra-procedural bleeding rates were higher (OR 3.3), again non-significant; EBP 1/19 (5%) vs ES 9/57 (67), p=0.4. There were no significant post-procedure complications. Procedure duration and mean sedation were comparable.
Conclusions
EBP was not inferior to ES in selected patients with choledocholithiasis. A low bleeding rate despite coagulopathy, with effective duct clearance suggests EBP warrants further investigation.

ABSTRACT 71 (18W179)

Comparing Colon Capsule Endoscopy To Colonoscopy; A Patient's Perspective

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Introduction
Colonoscopy is the gold standard lower-GI investigation. Patients can be reluctant to undergo this invasive procedure due to embarrassment, inconvenience or discomfort. ESGE recommends Colon Capsule endoscopy (CCE) as a safe alternative to colonoscopy. Few studies have focused on patient preference.

Aims/Background
To identify comfort scores and patient preferences between CCE and colonoscopy.

Method
Patients from our centre who had both CCE and colonoscopy within the last 12 months were identified. We performed over-the-phone interviews focused on satisfaction, comfort and overall preference. A 10-point scale was used to assess comfort and satisfaction. Electronic records were also reviewed. Student t-test was used to compare parametric data and a $p<0.05$ was significant.

Results
In all, 40 patients were identified. 57.5%(23/40) female and mean age 48(24-78). There was a statistically significant difference in mean comfort (9.2 vs 6.7, $p<0.0001$) but not satisfaction scores (8.3 vs 7.7, $p=0.28$) between CCE and colonoscopy. Bowel preparation as the main cause of dissatisfaction with CCE. The correlation between intra-procedural Modified-Gloucester-Comfort-Scale and patient reported values was weak ($R=0.28$). Overall, 77.5%(31/40) of patients would prefer CCE if they required further investigation. Of these, 77.4%(24/31) preferred CCE despite the potential need for follow-up colonoscopy.

Conclusions
CCE has a high satisfaction rating and has a higher comfort rating than colonoscopy. Studies have confirmed CCE and colonoscopy have equivalent diagnostic yields. The majority of patients in our cohort prefer CCE to colonoscopy. CCE should be considered as an alternative to colonoscopy in selected individuals.

ABSTRACT 72 (18W180)

Oesophageal biopsies for all? The diagnostic yield of oesophageal biopsies in detecting significant eosinophilia for patients referred for OGD to investigate dysphagia

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Introduction
Eosinophilic oesophagitis (EoE) is characterised by symptoms such as dysphagia and eosinophil-predominant inflammation histologically. Although there are associated endoscopic features, 10-25% of endoscopies may be normal. The UK quality standard in OGD states that two different regions in the oesophagus should be biopsied to exclude EoE if there is dysphagia or food bolus obstruction (FBO) if no alternate cause is found. ACG guidance states 2–4 biopsies should be obtained from both the proximal and distal oesophagus.

Aims/Background
We sought to evaluate the diagnostic yield of performing oesophageal biopsies in patients referred for OGD with dysphagia, with no apparent cause, in detecting significant eosinophilia (≥15 eosinophils/hpf).

Method
A retrospective analysis of patients undergoing OGD in a National Health Service hospital in England for investigation of dysphagia was performed. Electronic medical records were reviewed for cases between 21/05/17 to 21/05/18. In cases where there was no obvious cause, an analysis was made on the number and site of oesophageal biopsies and of each pathology report. The presence of endoscopic features to suggest EoE was noted.

Results
In total, 312 records were reviewed. 147 had a clear endoscopic diagnosis. In the remaining 165 patients there was no clear diagnosis. Only 85 (51.5%) of these patients had oesophageal biopsies taken as per guidance. 130 patients (78.7%) had some oesophageal biopsies taken but there was large variation in practice. 35 patients had no biopsies. Only 6 cases of significant oesophageal eosinophilia were detected. 83% had endoscopic features of EoE. The average age of these patients was 41.6 years. 66.6% with significant oesophageal eosinophilia were male. With adherence to the biopsy protocol, there was a diagnostic yield of 7% for significant oesophageal eosinophilia, and approximately 5% irrespective of this.

Conclusions
There was a low yield in detecting significant oesophageal eosinophilia in this cohort of patients, albeit with the biopsy protocol not rigorously followed. Some have suggested age, sex and FBO as strong predictors for the presence of EoE. Current guidance leaves significant room for interpretation on whom to biopsy and perhaps the aforementioned factors could be incorporated into future guidance. Oesophageal biopsies have a significant time and cost impact, and a reduction in the number of low yield biopsies could result in greater savings. Future prospective studies should look at improving the diagnostic yield in suspected EoE.

ABSTRACT 73 (18W183)

Enteropathy and Colopathy Associated with Olmesartan: a Pan-GI disorder?

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Introduction
Olmesartan is an angiotensin II receptor blocker (ARB) antihypertensive medication. Olmesartan-induced enteropathy (OIE) is being increasingly recognised, typically presenting with diarrhoea and weight loss. The mechanism is unclear. It is known that A II induced enhanced gene expression of TGF-β is involved in damage to various organs.

Aims/Background
We report our experience with 3 patients presenting with OIE as a refractory aggressive enteropathy mimicking coeliac disease with additional features of colopathy.

Method
Three patients, 2 female, aged 62-70 presented to our institution in one year with severe diarrhoea, weight loss, malaise ranging from 1 week to 12 months.

Results
In patients 1 & 2 duodenal biopsies (D2 Bx) revealed villous atrophy presumed coeliac and commenced on a GFD with no response. OIE was suspected on medication review and an immediate clinical response occurred on withdrawal. Patient 3 with T1DM had presumed diabetic gastropathy. OIE was suspected before D2 Bx, and rapid response was noted following withdrawal. D2 Bx revealed villous atrophy with associated colitis and ileitis on histology. Full resolution of villous architecture was observed on repeat D2Bx following > 3 months of GFD.

Conclusions
OIE needs to be recognised as a mimic of coeliac disease in whom coeliac serology is negative with no clinical response to GFD. It can involve the colon as a pan-GI disorder. Early review of anti-hypertensives is essential. The mechanism of SB toxicity is unclear. The rapid clinical response to drug withdrawal predates the macroscopic response. Investigation of TGF-β expression in the enterocytes may clarify the underlying pathophysiology.

ABSTRACT 74 (18W184)

Colorectal Polyp Burden in Hnpcc: Time To Modify Surveillance Strategy?

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Introduction
HNPCC (Lynch Syndrome) is associated with increased risk of colorectal cancer and extra-GI malignancies. Surveillance from 25yo has been recommended to reduce cancer mortality. Our initial experience in a High Risk Family Cancer clinic with > 2900 participants has demonstrated that a significant polyp yield does not emerge until after age 50.

Aims/Background
To re- evaluate the neoplasia yield in a HNPCC cohort undergoing surveillance colonoscopy (F/C) followed up to 20 years and to characterise polyp morphology, age, mismatch repair (MMR) and surveillance intervals.

Method
Cohort comprised 265 patients meeting HNPCC Amsterdam criteria, with MMR confirmation in 90. Mean age of 52, 113 male, 152 female, gene status -MSH2 = 42, MSH6 = 12, PMS2 =7, MLH = 20, Mixed = 3. Between 1- 6 F/C were performed in each patient with a total of 756. Other surveillance, including uterine continued in parallel.

Results
Of 218 index F/C, 6 cancers (2.3%) were detected, mean age 56 (range 33-71), with 52 polyps (Tubular adenomas (TAs), including serrated lesions n= 34). In the MMR cohort, 6 TAs were observed in MSH1&2 genotype, mean age 42. In HNPCC remainder, 27 TAs were detected, mean age 47. Surveillance from round 2-6 (Mean 11 years) showed reduced TA yield from 20-17-11-4-3 respectively.

Conclusions
Overall polyp yield for both gene positive and unconfirmed, is concentrated in individuals >45yo, including the index diagnosed cancers. Although early (40yo would optimise the clinical yield without compromising overall outcomes.

ABSTRACT 75 (18W185)

Positive impact of switching from BSG to ESGE post polypectomy guidelines on a colonoscopy surveillance waiting list

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Introduction
Estimates suggest ≥ 20% of endoscopy capacity is occupied by surveillance colonoscopy. Compliance with post-polypectomy guidelines is advised to maximise effectiveness. The impact of switching between guidelines is unclear.

Aims/Background
Assess current compliance and the impact of switching surveillance recommendations.

Method
A consecutive sample of surveillance patients was identified. Indication, surveillance interval, index endoscopy and histology findings were documented. Compliance with BSG and impact of switching to ESGE guidelines was determined.

Results
To date, 261 cases have been reviewed, 93 were excluded (86 (33%) non-polyp surveillance and 7 (3%) insufficient data). Of 168 post polypectomy cases, 60% were men and mean age 67 (35-89) years, compliance with BSG recommendations was 62% (n=104). Of the 64 (38%) with inappropriate intervals, 31(18%) did not require surveillance, 8 (5%) should have had a longer interval (median 18 months), and 25 (15%) a shorter interval (median 24 months). Of the 137 requiring surveillance, in 108 (79%) the interval would be extended by a median of 60 months by switching from BSG to ESGE recommendations, only 14 (10%) would be shorter, median 24 months and 15 (11%) remain unchanged. In those requiring surveillance, if compliance with BSG guidelines was 100%, our surveillance intervals would actually have been reduced by 456 months. Conversely, switching to ESGE recommendations would extend intervals by 6,144 months and 3,809 months assuming 100% and 62% compliance.

Conclusions
Our data confirms surveillance guideline compliance remains an issue. While optimising compliance is important, adopting ESGE intervals would have a greater impact on colonoscopy demand.

ABSTRACT 76 (18W186)

Management of Phlegmon with Anti-TNFs?; A "Mass-ive" dilemma or straight-forward treatment?

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Introduction
A phlegmon is an inflammatory mass that can occur in the setting of Crohn's Disease (CD). Phlegmons can be further complicated by abscess formation. Historically, patients with CD related phlegmons were often managed surgically. With the emergence of anti-TNF medications and increasing access to interventional Radiology (IR) less invasive techniques can be used for the management of IBD associated phlegmons.

Aims/Background
To assess outcomes of patients with Crohn's related phlegmon formation who were managed with Anti-TNF.

Method
We retrospectively reviewed the records of all patients with a diagnosis of Crohn's disease and phlegmon who were being managed with Infliximab. The primary outcome of time to surgery was assessed.

Results
21 Crohn's related phlegmons were identified. 13 of which were managed with antibiotics and early infliximab. 11 of 13 (84.61%) patients did not require surgery after the initiation of anti-TNF therapy at a median follow-up of 39 (0-89) months. 2 patients (15.39%) required surgery at a median interval of 6.5 (6-7) months after the initiation of Infliximab. 1 had an associated stricture and total mid-gut rotation. The other patient developed a small bowel obstruction. The phlegmon was complicated by an abscess in 6 patients. Of the 11 that did not require surgery, 3 had IR drainage of an abscess before the commencement of Infliximab. There was no reported cases of intra-abdominal sepsis or mortality in any of the patients after the initiation of Infliximab.

Conclusions
Crohn's disease complicated by phlegmon with or without abscess formation can be safely managed in selected patients with infliximab and anti-microbial cover.

ABSTRACT 77 (18W187)

A patient-centred evaluation of midazolam versus propofol based sedation for complex HPB endoscopy

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Introduction
Midazolam based sedation for complex endoscopy maylead to poor patient tolerance, with failed technical outcome and poor patient experience.

Aims/Background
We evaluated patient satisfaction and comfort for midazolam/opiate (M) and anaesthetist-administered propofol (P) sedation, as well as collating data on adverse outcomes.

Method
Patient questionnaires were issued to all patients post-ERCP/EUS between January and June 2016 to evaluate levels of comfort and awareness during the procedure. Patients were also questioned whether they would consider having the same procedure with the same sedation and whether they would want to be offered propofol sedation.

Results
A total of 325 patients were included (82% responded). Patients receiving P were younger (mean age 55.5 vs 60.8 years, p=0.006) and ERCP was more frequently performed compared with EUS (66.2 vs 54.9%, p=0.038). In the P group a significant proportion had also previously experienced PB endoscopies (73.8 vs 59%, p=0.006). No difference was observed for inpatient admission or procedural complications. The P group experienced high rates of comfort (96.9%). Comfort and awareness were variable for the M group without a correlation between scores for individual patients (R2=0.304). In the M group, 73.8% of patients would consider the same sedation for a repeat procedure, compared with 96.9% in P group (p=0.001). In the M group, 45.6% responded "yes" to wanting P sedation and of these patients 46.1% had previously experienced ERCP.

Conclusions
High rates of patient satisfaction were achieved in patients experiencing propofol sedation without an increase in complications or inpatient admissions. Satisfaction with sedation experience was much higher for propofol than midazolam group. Previous experience of ERCP with midazolam sedation, higher midazolam and fentanyl requirements as well as lower reported patient awareness and comfort scores were associated with patients requesting propofol sedation. These findings may help select patient that may benefit from propofol sedation for subsequent PB endoscopy.

ABSTRACT 78 (18W188)

Smoking Trends in Inflammatory Bowel Disease – Have we improved?

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Introduction
The relationship between smoking and inflammatory bowel disease (IBD) has been exhaustingly demonstrated by numerous studies that expand across decades. Current data has supported the fact that smokers are more likely to develop Crohn's Disease and smoking increases the severity of the disease. In contrast, protective properties of smoking have been observed in Ulcerative Colitis (UC) – seemingly decreasing the severity of disease.

Aims/Background
This cross-sectional study aims to establish smoking trends in the IBD population in Cork University Hospital - specifically questioning the importance of previous smoking history on severity of disease.

Method
Data was acquired on patients seen in our IBD clinic over a two week period. We appreciated patient demographics, smoking history, reasons for smoking cessation and surgical history.

Results
This cross sectional study consisted of 30 patients. 56.67% (n=17) were male. 53.3% patients were characterised by Crohns disease, 43.3% UC and 3.33% IBD-U. Only 1 (3.33%) patient was actively smoking at the time of data collection. 50% (n= 15) of patients were ex smokers. 20% (n=6) had ceased smoking when diagnosed with IBD. 40% (n=6) stopped following increased awareness of the detrimental effects on their health. 46.67% (n=7) of ex-smokers had disease so severe that it required surgery at some interval of their clinical care pathway. 57.14% (n=4) of these patients had surgery prior to cessation.

Conclusions
The most recent Healthy Ireland Survey reported that 22% of people aged 15 years and older were people who currently smoke. This cross-sectional study, of 30 patients, showed only 3.33% of our patients were actively smoking – however, a previous smoking history dictated a more injurious clinical care pathway.

ABSTRACT 79 (18W189)

Compliance with EASL guidelines for Hepatocellular carcinoma surveillance in St Luke's Hospital Kilkenny in 2016 and 2017.

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Introduction
Hepatocellular Carcinoma (HCC) is the fifth most common tumour worldwide. Cirrhosis is a key risk factor for the development of HCC. For patients with cirrhosis, surveillance should be offered when HCC risk is 1.5% a year or greater. Currently patients with cirrhosis and other high risk groups are recommended to undergo US every 6 months. This demand contributes to waiting lists for all patients, including symptomatic patients.

Aims/Background
To assess the proportion of US performed for HCC surveillance that comply with guidelines. Secondary outcomes were to assess what proportion of patients underwent screening with serum biomarker alpha-feta protein.

Method
All US performed in 2016 and 2017 at St. Luke's Hospital for the indication of HCC surveillance in our cohort of patients who attend our tertiary hepatology service were analysed to assess compliance with European Association for the Study of Liver disease (EASL) HCC surveillance guidelines.

Results
164 US were performed at SLK for the indication of HCC surveillance during study period. Of these, 36% of patients were compliant with EASL guidelines for enrolment in screening. However, only 5% of patients had US performed regularly at recommended 6 month intervals due to long waiting lists. 57% of patients underwent yearly US. 88% of patients had a AFP along with their US.

Conclusions
We believe that by closely adhering to guidelines for patient selection it may be possible to decrease the screening interval and decrease waiting lists for those patients at high risk of developing HCC.

ABSTRACT 80 (18W190)

Association Between Tissue Oncostatin M Expression and Infliximab Response in Corticosteroid Refractory Acute Severe Ulcerative Colitis

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Introduction
Infliximab(IFX) is a rescue therapy for corticosteroid refractory acute severe ulcerative colitis(ASUC). A significant proportion of ASUC patients fail to respond to IFX or require accelerated dosing. High pre-treatment expression of the cytokine oncostatinM(OSM) has been associated with anti-TNF therapy failure.

Aims/Background
We aimed to evaluate whether OSM had utility as a tissue biomarker of IFX response in a cohort of patients with ASUC.

Method
Patients attending SJH with ASUC who received rescue IFX for IV corticosteroid refractory disease were selected for inclusion. Included patients had an endoscopic assessment prior to IFX initiation. Colonic tissue slides from biopsies collected during this procedure were retrieved. Immunohistochemistry for OSM was performed on slides and scoring performed to quantify epithelial and stromal immunostaining. The association between OSM immunostaining and colectomy and requirement for accelerated IFX dosing was assessed. P values <0.05 were considered significant.

Results
N=21 patients were included [median age 38.3 years (21.1 – 28.8), median endoscopic Mayo score 3(2 – 3). Median follow up 47.2 weeks (0.6 – 117.1). 65% received standard IFX induction. 7/21 (33%) required colectomy. There was no association between epithelial or stromal OSM staining and requirement for colectomy or accelerated dosing($p>0.6$ for all comparisons). Neither epithelial nor stromal OSM staining were associated with time to colectomy, $p=0.99$ and 0.44 respectively.

Conclusions
Tissue OSM expression was not associated with IFX response or requirement for accelerated IFX dosing in a small cohort of corticosteroid refractory ASUC patients. Further studies are required to definitively assess the utility of this biomarker in ASUC.

ABSTRACT 81 (18W191)

Cost-effectiveness of Utilising Proactive Infliximab Therapeutic Drug Monitoring for Inflammatory Bowel Disease in Routine Clinical Practice

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Introduction
Therapeutic drug monitoring(TDM) is increasingly utilised in IBD practice to guide dosing of anti-TNFs. TDM assessment has not, however, been clearly shown to improve clinical outcomes compared with empiric dose optimisation. The use of TDM may provide cost savings.

Aims/Background
To assess whether a proactive-TDM strategy, with the aim of dosing patients to an IFX-level in the therapeutic range, is a cost-effective strategy in routine practice.

Method
IFX TDM has been available at SJH for a 1-year period. On a pilot basis IBD patients receiving IFX had a single trough sample collected. IFX-levels and antibody-to-IFX concentrations (ADA) were determined. IFX levels from 3 - 7 µg/L were considered therapeutic. IFX treatment decisions based on TDM were documented. Costs / savings related to TDM use were estimated by documenting alterations to IFX regimens prompted by TDM and extrapolating annualised total dose increases / reductions.

Results
N=64 IBD patients were included, 51% male, 63% Crohn's disease. 27%, 43% and 30% of patients had a therapeutic, subtherapeutic and supratherapeutic IFX-level. N=21 (33%) had significant ADA present. N=35 patients (55%) patients had alterations to IFX dosing based on TDM: 23% had IFX dosing interval increased, 20% had IFX dosing interval decreased and 11% discontinued IFX therapy. The use of proactive-TDM was found to be cost-effective with annual savings of €70,083.34.

Conclusions
The use of a proactive-TDM strategy in IBD patients receiving IFX appears to be cost effective in routine clinical practice.

ABSTRACT 82 (18W192)

Clozapine-Induced Ischaemic Colitis: A Case Report

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Introduction
Antipsychotics can cause gastrointestinal hypomotility, with subsequent constipation. Paralytic ileus and ischemic colitis are rarer adverse effects, with significant morbidity and mortality.

Aims/Background
We present a case of a delayed diagnosis of clozapine induced ischaemic colitis.

Method
Information was obtained retrospectively from the medical notes and hospital-based computer system.

Results
A 45-year-old female with a history of schizoaffective disorder and mild intellectual disability was voluntarily admitted (to a psychiatric ward) with a recurrent manic episode. Medications included clozapine and sodium valproate, on which she was well controlled. Haloperidol and lorazepam were initiated on admission. During the third-week of admission she developed abdominal pain and bloody diarrhoea. She became acutely unwell necessitating transfer to a medical ward, where she remained tachycardic (110bpm). A CT-abdomen-pelvis showed a left-sided colitis. A repeat PFA demonstrated a toxic megacolon at 6.8cm requiring emergency partial-colectomy with end-ileostomy formation. Biopsies established a diagnosis of ischaemic colitis; with severe necrosis within the mucosa and submucosal features of chronic angiodysplasia. After careful consideration and other causes out-ruled this was attributed to her antipsychotic therapy.

Conclusions
In this case, clozapine, haloperidol and other anticholinergic agents likely precipitated an acute ischaemic colitis on a background of chronic undiagnosed colonic ischaemia/angiodysplasia. It is proposed that the anti-cholinergic effects lead to increased intra-luminal pressure and reduced perfusion in antipsychotic-induced ischemic colitis. Although ischemic colitis is a rare side effect of antipsychotic therapy it is important to consider as the sequaelae can be severe.

ABSTRACT 83 (18W193)

Assessment of liver imaging in a diabetic population with an abnormal AST-to-platelet-ratio-index (APRI) or Fibrosis-4-score (FIB4)

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Introduction
APRI and FIB4 scores can be used to estimate degree of liver fibrosis. APRI score >1 has 76% sensitivity, 72% specificity for predicting cirrhosis. APRI score >0.7 has 77% sensitivity, 72% specificity for predicting significant fibrosis. A FIB4 score > 3.25 has 97% specificity and 65% positive predictive value for advanced fibrosis. However these scores have not been validated in a diabetic population.

Aims/Background
To assess liver imaging correlation with FIB4 and APRI scores in a diabetic population.

Method
We conducted a retrospective study examining the prevalence of abnormal liver function tests (LFTs) in a diabetic population attending a tertiary referral centre. APRI and FIB4 scores were also calculated and imaging results correlated with these figures.

Results
Of 1777 patients 600 (33.76%) had at least one abnormal LFT. APRI and FIB4 scores could not be calculated in 734 (41.31%). Of the remaining 1043 (58.69%), 31 (2.97%) had an APRI score >0.7, 18 (1.73%) ≥1. Of these 31, 22 had recent liver imaging performed. 3 (13.6%) of these were reported normal, 2 (9.1%) as mild fatty change and 17 (77.3%) as advanced fibrotic change or cirrhosis. 265 (25.41%) had a FIB4 ≥1.45 and <3.25, and 18 (1.73%) ≥3.25. Of these 18 patients, 12 had recent liver imaging. 4 (33%) were reported normal, 1 (8.3%) showed metastases and 7 (58.3%) showed fibrosis or cirrhosis.

Conclusions
This study shows that APRI may have a role in screening patients with diabetes for significant fibrosis or cirrhosis. However it does not account for the aetiology of liver disease and these results should be interpreted in correlation with a full clinical history and exam including a thorough alcohol history.

ABSTRACT 84 (18W194)

Incidental Inflammatory Bowel Disease Diagnoses in Patients Undergoing Colorectal Cancer Screening

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Introduction
Evaluation for a diagnosis of inflammatory bowel disease (IBD) is usually prompted by symptoms. Data are limited on the prevalence of pre-clinical IBD in patient populations undergoing colorectal cancer screening.

Aims/Background
We aimed to determine the prevalence of IBD in patients undergoing Colorectal Cancer Screening at a single centre over a one year period.

Method
A retrospective study to determine and characterise incidental cases of pre-clinical IBD diagnosed at time of colorectal cancer screening endoscopies performed as part of the BowelScreen National Programme at St James's Hospital. Screening colonoscopy reports for a 1 year period from 1st January 2017 to 1st January 2018 were reviewed. Only patients undergoing an index screening colonoscopy were included. Endoscopy and histopathology reports were reviewed and findings documented. A diagnosis of IBD was made by standard diagnostic criteria.

Results
N=625 patients underwent screening colonoscopy during the study period. 461(74%) were index screening colonoscopies. A diagnosis of IBD was assigned in 10 of 461(2.2%) cases. For IBD cases(n=10), mean age was 61.2 years, 60% were male. At subsequent clinical review all 10 IBD cases were confirmed to be asymptomatic. 2 of 10 cases at clinical review were found to have a prior history of ulcerative colitis. Therefore a new diagnoses of pre-clinical IBD was made in 8 of 461(1.7%) of our colorectal cancer screening population.

Conclusions
New diagnoses of pre-clinical IBD are being made as a result of national colorectal cancer screening programmes. A minority of patients in these programmes will need Gastroenterology OPD follow up for management of IBD.

ABSTRACT 85 (18W198)

Endoscopic Evaluation for Gastrointestinal Graft-Versus-Host Disease: A Five Year Retrospective Review from The National Adult Allogeneic Stem Cell Transplant Programme

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Introduction
Graft-versus-host disease (GvHD) represents a multisystem disorder that commonly complicates allogeneic stem cell transplant (SCT). The skin, liver and gastrointestinal (GI) tract are the most frequently affected sites. Diagnosis of GI GvHD is based on clinical, endoscopic and histological criteria.

Aims/Background
To describe the endoscopic and histological findings of GvHD in patients undergoing endoscopy for evaluation of suspected GI GvHD.

Method
This was a retrospective study using the St James's Hospital allogeneic SCT database. A five year period (2013-2017) was reviewed and cross-matching performed with the SJH endoscopy database to identify patients who underwent endoscopic assessment for GI symptoms post-SCT. Demographic, clinical, endoscopic and pathological data were reviewed. Occurrence and anatomical distribution of GI GvHD on endoscopic biopsies was documented.

Results
N=132 patients post allogeneic SCT during the study period underwent subsequent endoscopic evaluation. Median (range) interval from transplant to index endoscopy was 44 days (14-1003). Initial endoscopic evaluations were OGD, colonoscopy, sigmoidoscopy, OGD & colonoscopy and OGD & sigmoidoscopy in 49.2%, 21.9%, 6.8%, 15.1% and 6.1% of patients respectively. N=58 (44%) of patients who underwent endoscopic assessment had biopsy-proven GvHD. Of the n=96 patients who had upper GI endoscopy and biopsies, n=22 (23%) had upper GI GvHD diagnosed. Positive histology for GvHD was found most commonly in the stomach (73%), followed by D2 (68%), D1 (23%) and oesophagus (9%). For n=70 who had lower GI endoscopy, n=36 (51%) had a diagnosis of lower GI GvHD made. For n=28 patients who underwent full colonoscopy, resulting in diagnosis of lower GI GvHD, positive histology was found on both left- and right-sided biopsies, left-sided biopsies alone and right-sided biopsies alone in 71.4%, 14.3% and 14.3% respectively.

Conclusions
GI GvHD is frequently diagnosed following endoscopic assessment of post allogeneic SCT patients with GI symptoms. Consistent with previous reports, the diagnostic yield of left-sided colonic biopsies for lower GI GvHD is high with a minority of patients having right-sided histological findings alone.

ABSTRACT 86 (18W199)

Diagnosis and Management of Eosinophilic Oesophagitis

Author(s)
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Department(s)/Institutions
Immunology and Gastroenterology Departments, St. James's Hospital, September 2018

Introduction
Eosinophilic oesophagitis (EoE) is a chronic, immune/antigen-mediated oesophageal disease characterized clinically by symptoms related to oesophageal dysfunction and histologically by eosinophil-predominant inflammation.

Aims/Background
The aim was to audit current diagnostic and management practice for patients with EoE and identify areas for improvement.

Method
A retrospective audit of medical records from patients diagnosed with EoE between 2008 and 2018 was carried out. Patients were identified by interrogation of coded histology diagnoses and charts were obtained for review. International (UEGJ) standards were identified and compared with practice in St. James's Hospital.

Results
19.14% of patients underwent a reassessment endoscopy within 8 weeks of their initial OGD. Full data regarding follow-up endoscopy within 12 weeks, 6 months and 1 year are awaited at this time. Many patients do not undergo short term follow-up endoscopy to assess for histological remission after commencement or change of therapy. Specific IgE testing was carried out in 36% of patients (n = 17). Most commonly, specific IgE to milk, wheat, egg, nuts, soya and fish were tested.

Conclusions
Follow-up endoscopy for patients with EoE to assess histological response to commencement or change of therapy should optimally occur within 6 to 12 weeks. This reflects the knowledge that patients can remain asymptomatic in the context of histological eosinophilic inflammation. Most patients in St. James's have repeat endoscopy outside of this recommended window. Many patients underwent skin prick and specific IgE testing. These poorly predict food triggers, and current data supports a non-IgE mediated inflammatory process. Their use in the assessment of EoE is not recommended.

ABSTRACT 87 (18W201)

Irish Data on the Safety and Effectiveness of Vedolizumab in the Treatment of Crohn's Disease

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Introduction
Vedolizumab (VDZ) is a monoclonal antibody designed to inhibit α4β7 integrin to stimulate gut-selective anti-inflammatory activity. Randomised control trials have shown VDZ to an effective and safe therapy for the treatment of Crohn's disease (CD). However, real-world data are limited on the use of VDZ in routine clinical practice.

Aims/Background
We aimed to evaluate the safety and efficacy of VDZ as therapy for CD in real world clinical practice.

Method
A multi-centre, retrospective study was conducted across 10 Irish academic hospitals. Patients receiving VDZ for CD were evaluated. N=112 patients were identified, of which n=72 had follow up of at least 6 months and were included in the final study cohort. Primary study endpoint was therapy success as defined by duration of time patients remained free of VDZ discontinuation. Secondary endpoints included 3-month clinical response, 6-month corticosteroid-free remission, and adverse events. Clinical response was defined as ongoing receipt of VDZ with a reduction in Harvey Bradshaw Index (HBI) of ≥3 points, or HBI score of ≤4. Remission was defined as ongoing corticosteroid-free receipt of VDZ with a HBI of ≤4 points.

Results
72 patients were identified (male 51.4%; median [range] age 45 [18 – 77]; median follow up 15.5 months [6 – 35 months]. Disease characteristics included; 59.7% of patients had ileocolonic involvement (Montreal L3); 22.2% had perianal disease; 9.7% were anti-TNF naïve; 72.2% previously received ≥2 anti-TNF medications; median HBI at baseline 12 [0 – 29]. 27.8% discontinued VDZ during follow up; median time to discontinuation 7 months [0 – 31 months]. 3-month clinical response was 58.3%, however 45.2% of these patients still required systemic corticosteroid at this point. The 6-month corticosteroid-free remission rate was 47.2%. Adverse events occurred in 8.3% (n=6) of subjects, of which most were minor and self-limiting.

Conclusions
These data support vedolizumab as a safe and effective induction and maintenance therapy in the treatment of Crohn's disease within a refractory cohort. Use of vedolizumab as a first-line agent appears to be increasing both in Ireland and internationally.

ABSTRACT 88 (18W203)

3 years of Obeticholic Acid (OCA) Therapy Results in Histological Improvements in Patients with Primary Biliary Cholangitis: Further Analysis of the POISE Biopsy Substudy

Author(s)
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Introduction
Primary biliary cholangitis (PBC) is a rare autoimmune liver disease. Ursodeoxycholic acid (UDCA) is first line PBC therapy, however, up to 40% of patients have an inadequate response and remain at a high risk of progression.

Aims/Background
Obeticholic acid (OCA), is a selective, potent farnesoid X receptor (FXR) agonist with preclinical and clinical evidence suggesting that FXR activation exerts anti-fibrotic effects. This analysis evaluates the effect of 3-years of OCA therapy on histological progression of PBC in patients with inadequate response to UDCA.

Method
The POISE study included an optional biopsy substudy. Participants had biopsies prior to (≤1 year from double-blind baseline) and after ~3 years (range: 2.9-3.1y) of OCA treatment. The primary objective was fibrosis stage; defined using a 6-tier staging system (F0-F5). Secondary parameters included Nakanuma staging for histologic evaluation.

Results
Analysis included 17 patients with adequate paired biopsies (Baseline precirrhotic fibrosis [F0-F3] n=14, baseline cirrhosis [F4-F5] n=3, baseline ductopenia n=11). After 3 years of OCA treatment 12/17 (71%) patients showed improvement or no progression in fibrosis stage compared to 5 (29%) patients who worsened. By Nakanuma staging criteria, 12 (71%) and 13 (76%) patients had an improvement or no progression of Fibrosis Score and Bile Duct Loss Score, respectively. Nakanuma Disease Stage showed, 13 (76%) patients had improvement or no progression after OCA treatment.

Conclusions
In this analysis of non-responders to UDCA at high risk for histologic disease progression, the majority of patients had improvement or no progression in fibrosis stage after 3 years of OCA treatment.

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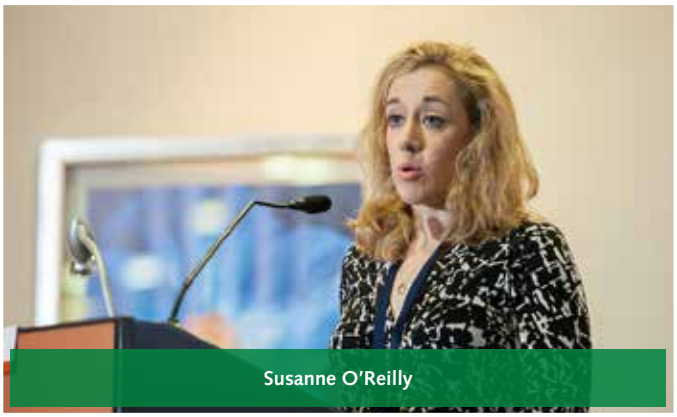

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References: 1. Bisschops R, *et al.* Presented at UEGW 2016, poster number P0179. **2.** Schreiber S, *et al.* Presented at UEGW 2016, poster number P1266. **3.** DeMicco MP, *et al.* Gastrointest Endosc 2018;87(3):677-687.e3; doi: 10.1016/j.gie.2017.07.047. **4.** Norgine Ltd. DOF-PLENV-008 version 1.0. August 2017. **5.** PLENVU® IE Summary of Product Characteristics. October 2017. **6.** MOVIPREP® IE Summary of Product Characteristics. August 2017; **7.** MOVIPREP® Orange IE Summary of Product Characteristics. August 2017.

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received by Jawad Rasool and Prof. Larry Egan

Owen Murphy AbbVie, 2nd Place Poster Pardeep Maheshwari
received by Fiona Jones, Prof. Larry Egan

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Lakshman Kumar 1st Place Clinical Case and Prof. Larry Egan

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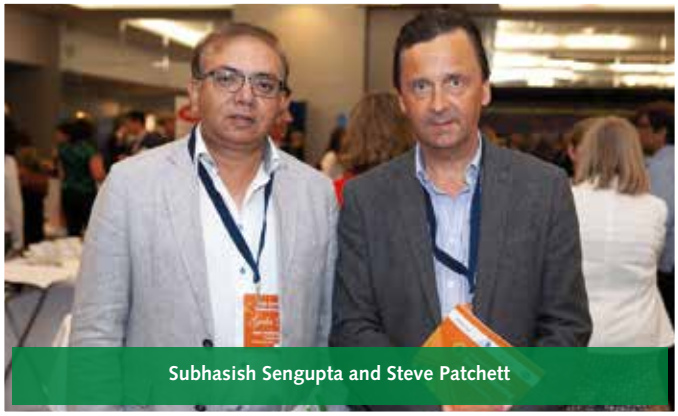

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Uses: Targaxan is indicated for the reduction in recurrence of episodes of overt hepatic encephalopathy in patients ≥ 18 years of age.

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

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

Warnings and precautions for use: The potential association of rifaximin treatment with *Clostridium difficile* associated diarrhoea and pseudomembranous colitis cannot be ruled out. The administration of rifaximin with other rifamycins is not recommended. 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:
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Ref: UK/XIF5/0318/0386

Date of preparation: March 2018

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.

References:

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
2. TARGAXAN® 550 Summary of Product Characteristics. Available for the UK from: https://www.medicines.org.uk/emc/medicine/27427. Available for Ireland from: http://www.medicines.ie/medicine/15936/SPC/TARGAXAN+550mg+film-coated+tablets/.
3. Mullen KD, *et al.* Clin Gastroenterol Hepatol 2014;12(8):1390-97.

UK/XIF5/0718/0418

Date of preparation: August 2018

NORGINE
Partner for a healthy life

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 or kidney transplant patients: 12 weeks in liver or kidney transplant recipients with or without cirrhosis, 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. 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. 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. **▼ 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 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 Deutschland GmbH & Co. KG, Knollstrasse, 67061 Ludwigshafen, Germany. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. **DATE OF REVISION:** June 2018 PI/1213/004

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

IRFMAV1706180(2) **Date of Preparation:** July 2018

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