abbvie

Takeda

Pfizer

Irish Society of Gastroenterology

Winter Meeting

21-22 November 2019
Fitzpatrick's Castle Hotel
Killiney, Co. Dublin

MSD

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

NORGINE

ASACOLON® mesalazine 1600 mg

OPTICORE®

Maintenance: Simple; one tablet, once daily*

whole

SEIZE THE DAY

MAINTENANCE: ONE TABLET, ONCE DAILY.

***ASACOLON® 1600 mg modified-release tablets are indicated for the treatment of mild-to-moderate acute ulcerative colitis and for the maintenance of remission in patients 18 years and over. In acute disease, the dose can be increased to 4800 mg daily, once daily or in 2-3 divided doses. Once clinical remission is achieved, the dose should gradually be decreased to maintenance dose.**

OPTICORE® technology uses a unique combination of two triggers to allow targeted mesalazine delivery throughout the colon. OPTICORE® has been developed based on Phloral® technology.[1,2]

ASACOLON® 1600 mg modified-release tablets: Red-brown, oblong, film-coated tablets each containing 1600 mg mesalazine. INDICATIONS: Ulcerative colitis. For the treatment of mild-to-moderate acute disease. For the maintenance of remission. DOSAGE AND ADMINISTRATION: Oral use. To be swallowed whole (not chewed, crushed, or broken) with water, with or without food. Acute ulcerative colitis: Adults and elderly: Adjust the dosage to the severity of the disease and tolerance. During exacerbation, the dose may be increased to 4800 mg daily, once daily or in 2-3 divided doses. Monitor by week 8. Maintenance of remission: 1600 mg once daily. Elderly: As for adults, provided renal or hepatic function is not severely impaired. No study data. Children: Not for use in children or adolescents. CONTRAINDICATIONS: Hypersensitivity to salicylates, mesalazine or any excipient. Severe hepatic or renal (GFR < 30 mL/min/1.73 m2) impairment. 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). Caution in elderly; use subject to renal and hepatic function. Limited data in children. INTERACTIONS: Caution recommended for the concomitant use of mesalazine with known nephrotoxic agents, including NSAIDs and azathioprine, or methothrexate as these may increase the risk of renal adverse reactions. 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: Headache, abdominal pain, ulcerative colitis, dyspepsia, rash, haematuria, proteinuria. Uncommon: Eosinophilia (as part of an allergic reaction), paresthesia, urticaria, pruritus, pyrexia and chest pain. Rare: Dizziness, myocarditis, pericarditis, diarrhoea, flatulence, nausea and vomiting, photosensitivity. Very rare: Altered blood counts (aplastic anemia, agranulocytosis, pancytopenia, neutropenia, leukopenia, thrombocytopenia), blood dyscrasia, hypersensitivity reactions such as allergic exanthema, drug fever, lupus erythematosus syndrome, pancolitis, peripheral neuropathy, allergic and fibrotic lung reactions (including dyspnoea, cough, bronchospasm, alveolitis, pulmonary eosinophilia, lung infiltration, pneumonitis), interstitial pneumonia, eosinophilic pneumonia, lung disorder, acute pancreatitis, changes in liver function parameters (increase in transaminases and cholestasis parameters), hepatitis, cholestatic hepatitis, alopecia, myalgia, arthralgia, impairment of renal function including acute and chronic interstitial nephritis and renal insufficiency, nephrotic syndrome, renal failure which may be reversible on early withdrawal, oligospermia (reversible). Frequency not known: lupus-like syndrome, changes in weight and blood parameters. Refer to Summary of Product Characteristics for details. LEGAL CATEGORY: POM. MARKETING AUTHORISATION NUMBER: ASACOLON® 1600 mg MR Tablets PA 2018/4/1. MA HOLDER: TILLOTTS PHARMA GMBH, Warmbacher Strasse 80, DE- 79618 Rheinfelden, Germany. DATE OF PREPARATION: March 2019. CODE: 2019/7. 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.

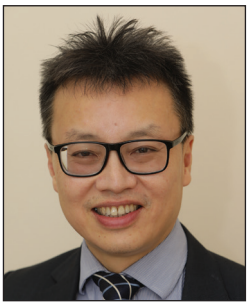
References

1. Varum FO, et al. Poster presented at AAPS National Biotechnology Conference 2016; [Poster number 02WO200].
2. Ibekwe VC, et al. A new concept in colonic drug targeting: a combined pH-responsive and bacterially-triggered drug delivery technology. Aliment Pharmacol Ther. 2008; 28(7):911-916

ZERIA GROUP

TILLOTTS PHARMA

GI-health is our passion™



Welcome Message

Dear Friends and Colleagues,

It gives me great pleasure to welcome you to Dublin for my first meeting as President of the Irish Society of Gastroenterology. We have an exciting program ahead and we look forward to hearing from our world-renowned international speakers.

I would like to extend a warm welcome to our various nursing groups, I hope that they will have a worthwhile and informative meeting.

Once again I would like to acknowledge the support from our friends in Industry. Without their continued sponsorship our meetings may not have reached the level that they are now at.

The sessions cover gastrointestinal bleeding; Barrett's oesophagus; inflammatory bowel disease and liver. We look forward to welcoming and learning from international speakers from the USA, the Netherlands and UK. Jacques Bergman from the Netherlands has published many landmark papers on the management of early cancers and dysplastic Barrett's. Janusz Jankowski is going to tell us how we could prevent dysplasia in Barrett's in the first place. We are delighted to welcome back Ed Loftus from the Mayo Clinic who is speaking on the natural history of IBD. We are going to hear about some exciting new data with regards to personalised care for IBD patients from Tariq Ahmad. The theme of the liver session is on immune disorders including primary sclerosing cholangitis (Roger Chapman). A native of Cork, Dermot Gleeson, is returning to update us on autoimmune hepatitis. Dermot is currently writing the new guidelines on this subject. The gastrointestinal bleeding session will include talks on upper bleeding from Richard Wong from Cleveland who is a world expert on this topic, mid gut bleeding from our very own Deirdre McNamara and lower bleeding from Jonathan Hoare who wrote the recent guidelines on this subject. There will of course be oral free papers and posters sessions, showcasing the best of Irish gastroenterology and upcoming young investigators. The top oral presentations and posters will win prizes, so why don't you see whether your selections match those of our judges!

We hope that this meeting will not only be educational, but you will find opportunities to network with friends and colleagues which can also be learning opportunities. I also hope you get to speak to our international speakers on an informal basis as some of them are staying for dinner. It's a bit like being up close and personal with Coldplay if they come to play in Vicar Street!

Yours sincerely,
Tony Tham
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 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Discontinue treatment if no evidence of therapeutic benefit by 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 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 by 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): 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. Preferable to avoid use of Entyvio during pregnancy unless benefits clearly outweigh potential risk to both the mother and foetus. Entyvio has been detected in human milk. The effect on infants is unknown. Use of Entyvio in lactating women should consider the benefit of therapy against potential risks to the infant. **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, 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(3) **Date of revision:** March 2019.

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(1)
Date of preparation: April 2019.

Takeda

Programme for the ISG Winter Meeting
21-22 November 2019
Fitzpatricks Castle Hotel Killiney Co. Dublin

Thursday November 21st

08.00 **Takeda Satellite Symposium**
Professor Edward V. Loftus
Mayo Clinic College of Medicine

09.15 **Oral Free Papers 1 - 6**

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

Gastrointestinal Bleeding –
Upper, Mid & Lower Session

10.45 ***Update on acute UGIB***
Prof. Richard C. K. Wong
Professor of Medicine,
Case Western Reserve University Consultant,
Division of Gastroenterology and Liver Disease
University Hospitals Cleveland Medical Center
Cleveland, Ohio, USA.

11.30 ***Lower GI Bleed – The BSG Guidelines***
Dr Jonathon Hoare,
Consultant Gastroenterologist,
St Marys Hospital, Imperial NHS Trust. London

12.15 ***Mid Gut Bleeding***
Prof. Deirdre McNamara,
Consultant Gastroenterologist,
Tallaght University Hospital, Dublin

13.00 **Lunch, Poster Viewing and Meet the Industry**

14.15 **Oral Free Papers 7 – 12**

Barretts Oesophagus Session

15.15 ***Early cancers and dysplastic Barretts***
Prof. J.J Bergman,
NARCIS, Holland
Professor of Gastrointestinal Endoscopy
University of Amsterdam's Faculty
of Medicine (AMC-UvA).

16.00 **Coffee break, View posters and visit Industry**

IBD Session

16.15 ***Natural history and epidemiology of IBD***
Professor Edward V. Loftus Jr.
Consultant, Division of Gastroenterology
and Hepatology
Professor of Medicine,
Mayo Clinic College of Medicine

17.00 ***Personalised medicine in IBD– are we there yet?***
Dr Tariq Ahmad,
Consultant Gastroenterologist,
Royal Devon & Exeter Hospital, UK.

17.45 **Close of Session**

18.00 **Janssen Satellite Symposium**
Dr Tim Raine
Clinical Lead IBD Service
Addenbrooke's Hospital, Cambridge, UK

20.00 **Conference Dinner**

Friday November 22nd

08.00 **Pfizer Satellite Symposium**
Professor Geert D'Haens
University of Amsterdam

09.15 **Video Clips**

Liver Session

10.00 ***Primary sclerosing cholangitis: new concepts***
Dr Roger Chapman,
Group Head/PI Consultant Physician,
John Radcliffe Hospital, Oxford, UK

10.45 **Coffee break, View posters and visit Industry**

11.15 ***Autoimmune Hepatitis – an update***
Prof. Dermot Gleeson,
Professor of Hepatology.
Sheffield Teaching Hospitals. UK.

12.00 ***Chemoprevention in Barretts***
Prof. Janusz Jankowski,
Senior Consultant Physician,
University Hospitals Morcambe Bay, UK

12.45 **Prize Giving and Close of Meeting**

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

Aisle Seat-itis?

Continuous clinical response:[1,2] 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.[3]

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. Patients who have an adequate response should receive 50 mg at week 6 and every 4 weeks thereafter. Patients who have an inadequate response may benefit from continuing with 100 mg at week 6 and every 4 weeks thereafter. *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 golimumab in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Golimumab 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 golimumab, including patients previously treated for latent TB. Patients should be evaluated for active or latent TB before golimumab treatment. All such tests should be recorded on the Patient Reminder Card provided with the product. If active TB is diagnosed, treatment with golimumab should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of golimumab. Patients on golimumab 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 golimumab who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with golimumab Malignancies and lymphoproliferative disorders: Caution is advised when considering golimumab 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 golimumab 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 golimumab use should be carefully assessed. Melanoma and Merkel cell carcinoma (all TNF-blocking agents including golimumab) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. Heart Failure: Golimumab should be used with caution in patients with mild heart failure (NYHA class I/II). Patients should be closely monitored and golimumab 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 golimumab, 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 golimumab 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 golimumab therapy should be closely monitored for infections. Autoimmune processes: If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with golimumab 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, agranulocytosis, aplastic anaemia, and thrombocytopaenia in patients receiving TNF-blockers, including golimumab. 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 golimumab 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 golimumab therapy, paediatric patients be brought up to date with all immunisations in agreement with current immunisation guidelines. Excipients: Simponi contains sorbitol (E420). In patients with rare hereditary problems of fructose intolerance, the additive effect of concomitantly administered products containing sorbitol (or fructose) and dietary intake of sorbitol (or fructose) should be taken into account. **INTERACTIONS** Combination of golimumab and other biological therapeutics used to treat the same conditions as golimumab, including anakinra and abatacept is not recommended. **PREGNANCY AND LACTATION** Administration of golimumab 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 golimumab 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, leukopenia (including neutropenia), anaemia, allergic reactions, autoantibody positive, depression, insomnia, dizziness, headache, paraesthesia, hypertension, asthma and related symptoms, dyspepsia, gastrointestinal and abdominal pain, nausea, gastrointestinal inflammatory disorders, stomatitis, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, rash, alopecia, dermatitis, pyrexia, asthenia, injection site reaction, chest discomfort, bone fractures were reported. Serious, including fatal adverse events have been reported including septic shock, lymphoma, leukaemia, melanoma, Merkel cell carcinoma, hepatosplenic T-cell lymphoma*, leukopenia, thrombocytopaenia, pancytopaenia, aplastic anaemia, agranulocytosis, serious systemic hypersensitivity reactions (including anaphylactic reaction), skin exfoliation, vasculitis (systemic), sarcoidosis, demyelinating disorders, congestive heart failure, arrhythmia, ischaemic coronary artery disease, thrombosis, interstitial lung disease and lupus-like syndrome. * Observed with other TNF-blocking agents. *Paediatric population: pJIA:* The safety of golimumab has been studied in a phase III study of 173 pJIA patients from 2 to 17 years of age. The average follow-up was approximately two years. In this study, the type and frequency of adverse events reported were generally similar to those seen in adult RA studies. **PACKAGE QUANTITIES** 1 x 50 mg pre-filled pen containing 50 mg of golimumab in 0.5 ml solution for injection 1 x 50 mg pre-filled syringe containing 50 mg of golimumab in 0.5 ml solution for injection 1 x 100 mg pre-filled pen containing 100 mg of golimumab in 1 ml solution for injection **Legal Category:** Prescription Only Medicine. **Marketing Authorisation Number** 50 mg Pre-filled Pen EU/1/09/546/001 50 mg Pre-filled Syringe EU/1/09/546/003 100 mg Pre-filled Pen EU/1/09/546/005 **Marketing Authorisation Holder** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands **Date of Revision of Text:** February 2019 *Simponi/PI-IRE/02-19*

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. Long-term benefit of Golimumab for patients with moderately to severely active ulcerative colitis: Results from the PURSUIT -Maintenance Extension. Journal of Crohn's and Colitis, 2018 1-14. **2.** Sandborn WJ, Feagan BG, Marano C, et al. Subcutaneous golimumab maintains clinical response in patients with moderate-to-severe ulcerative colitis. Gastroenterology. 2014;146(1):96-109. **3.** SIMPONI (Golimumab) Summary of Product Characteristics. April 2019

Date of preparation: September 2019.

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

IE-GOL-00046

Irish Society of Endoscopy Nurses
Agenda
Friday 22 November 2019

08.30	**Registration**
09:00	Chair: **Devika Ghosh**
	Richard Marshall CNM2 St Vincent's Private Hospital **Welcome to Dublin**
09:15	Chair: **Liz Waters** Kieran Healy / ERBE ***Breakfast Symposium*** ***Diathermy & APC***
10.30	Chair: **Sinead Foley**
	Danny Cheriyan Consultant Gastroenterologist Beaumont Hospital ***Upper GI Bleed***
11:15	**COFFEE**
11.45	Chair: **Liz Waters**
	Fleetwood Boston Scientific Cook Medical ***Interventional Modalities***
12.15	Chair: **Bridget Meehan**
	Open Forum ***Issues in endoscopy*** ***"Have your say"***
13:00	**LUNCH**
14:00	Chair: **Fiona Spellman**
	Dr Teresa Lynn ***A Patients Journey with IBD***
15.00	Chair: **Glenda Hahn**
	Leah Palado ***Clinical Facilitator*** SVUH ESGENA Presentation

FLEETWOOD HEALTHCARE EXCELLENCE THROUGH INNOVATION

ovesco innovation in scope

Ovesco OTSC System

OTSC® – The first choice: highest efficacy in GI bleeding.

The OTSC® System is a innovative clipping system to be applied via flexible endoscopes. It offers the physician unique features superior to any other device:

- dynamic compression, continuous adaption to tissue thickness
- larger volume of tissue secured
- higher stability at the lesion site
- minimal strain on surrounding tissue

The exceptional features and therapeutic functions of the system are based on its unique material and design: the superelastic Nitinol® is biocompatible and, if needed, even suited to be applied as a long-term implant.

OTSC® SYSTEM

www.fleetwoodhealthcare.ie

www.ovesco.com

Biographical Sketches

Prof. Richard C. K. Wong
Professor of Medicine,
Case Western Reserve University
Consultant, Division of Gastroenterology and Liver DiseaseUniversity Hospitals Cleveland Medical Center
Cleveland, Ohio, USA.

Dr. Richard C.K. Wong is Professor of Medicine at Case Western Reserve University, Cleveland, OH, USA, and is a Consultant Gastroenterologist at University Hospitals Cleveland Medical Center in Cleveland, OH, USA (1996-present). Professor Wong was formerly an Associate Editor for the journal Gastrointestinal Endoscopy for 8 years and formerly Medical Director of Endoscopy at his institution for 14 years. Professor Wong received his medical degree from St. George's Hospital Medical School, University of London, London, UK, completed residency and chief medical residency in Internal Medicine at Northwestern Memorial Hospital, Northwestern University, Chicago, IL, USA, and was trained in gastroenterology and advanced therapeutic endoscopy at Brigham & Women's Hospital, Harvard University in Boston, MA, USA. Professor Wong's research interests includes all aspects of GI bleeding, including upper, mid-gut and lower, as well as variceal GI bleeding, and he pioneered the use of the endoscopic Doppler ultrasound probe for GI bleeding in the USA.

Dr Jonathon Hoare
Consultant Gastroenterologist,
St Marys Hospital, Imperial NHS Trust.
London

Dr Jonathan Hoare was appointed at St Mary's Hospital, Paddington in 2006.
His specialist interests encompass all aspects of therapeutic luminal endoscopy, including balloon enteroscopy and difficult gastrointestinal bleeding. He was endoscopy lead for the Imperial College Healthcare NHS Trust for 11 years. He chaired the BSG guideline committee which published the BSG guideline on Lower GI Bleeding in January 2019.

Prof. J.J Bergman
NARCIS, Holland

Professor of Gastrointestinal Endoscopy at the University of Amsterdam's Faculty of Medicine (AMC-UvA).

Jacques Bergman was born in 1965 and qualified from the University of Utrecht in 1991. He undertook his PhD-training, dedicated to the endoscopic management of gallstone disease, in Amsterdam. He was trained in Gastroenterology in Den Bosch and Amsterdam and was appointed Consultant Gastroenterologist, at Academic Medical Center in Amsterdam in 2001 as Associate Professor in 2005, and was appointed as Head of department of Endoscopy and Professor of Gastrointestinal Endoscopy in 2011.
Jacques Bergman is Special Section Editor for "Gastroenterology", member of the International Editorial board of "Gastrointestinal Endoscopy" and member of the International Editorial board of "Endoscopy". He has authored and co-authored on over 250 peer reviewed publications and text book chapters and has lectured at many national and international meetings.
Jacques Bergman is the head of the AMC esophageal research team. He leads a variety imaging studies on detection of early neoplasia in the upper GI tract. Techniques that are currently under investigation include high resolution endoscopy, optical chromoscopy, volumetric laser endomicroscopy, and spectroscopy techniques. His group also investigates computer assisted endoscopic detection of early neoplasia as part of a consortium with the Technical University Eindhoven and the Catharina Hospital Eindhoven. In addition, his group has a strong focus on the endoscopic treatment of early neoplasia using endoscopic resection and endoscopic ablation techniques as well as in organizing training programs in this field (www.barrett.nl and www.best-academia.eu). Jacques Bergman leads ReBus: a large tissue bank project that incorporates clinical data and tissue samples of 1,000 patients treated for early Barrett's neoplasia; 3,500 Barrett's surveillance patients in the Amsterdam region; 1,500 proscpectively followed Barrett's patients in the Amsterdam Prospective Barrett's Registration Project; and 750 Barrett's patients with low-grade dysplasia. Jacques Bergman is also involved in studies investigating the use of duodenal mucosal ablation for metabolic regulation (diabetes mellitus and NAFLD/NASH) in which he collaborates with endocrinologists and hepatologists at the AMC and a number of European institutes. He is the PI of two clinical trials in this field.
The team currently consists of two physicians/endoscopists, eighteen clinical research fellows, three research nurses, and 2 physician assistants. The group has extensive experience with clinical trials and is trained according to GCP standards. The team coordinates several international multi-center studies.

Edward V. Loftus Jr.
M.D. Consultant, Division of
Gastroenterology and Hepatology
Professor of Medicine,
Mayo Clinic College of Medicine

Edward V. Loftus, Jr. is a gastroenterologist with extensive experience as a lecturer and clinician researcher in the field of inflammatory bowel diseases. He currently holds the position of Co-Director of the Inflammatory Bowel Disease Advanced Fellowship and is also a Professor of Medicine at Mayo Clinic College of Medicine in Rochester, Minnesota, USA.

Professor Loftus completed his medical degree at the University of Pennsylvania and subsequently, his residency in internal medicine at Temple University Health Sciences Center in Philadelphia. He later completed his fellowship in gastroenterology at the Mayo Graduate School of Medicine and has been on the Mayo Clinic consulting staff since 1995. He was director of the Inflammatory Bowel Disease Interest Group from 2008 to 2019. Professor Loftus is a Fellow of the American College of Physicians (ACP), the American College of Gastroenterology (ACG), and the American Gastroenterological Association (AGA).

Among Professor Loftus's awards are the Mayo Department of Medicine Laureate Award and the CCFA, Minnesota - Dakotas Chapter, Physician of the Year Award. He gave the Internal Named Professor lecture to Mayo's Division of Gastroenterology and Hepatology in 2018. He was awarded AGA's Distinguished Clinician Award and the IMIBD section's Research Mentor Award in 2019. He has been named to the list of Best Doctors in America since 2005 and to Castle Connolly's Top Doctors in America list since 2010.

Professor Loftus has published over 380 original articles, book chapters, or editorials and more than 500 abstracts. He previously served as Associate Editor of both the American Journal of Gastroenterology and Inflammatory Bowel Diseases. Professor Loftus was the principal investigator on several funded studies focusing on the epidemiology and natural history of inflammatory bowel disease and has served as the local PI on multiple clinical trials of investigational agents for IBD.

Dr Tariq Ahmad
Consultant Gastroenterologist,
Royal Devon & Exeter Hospita, UK.

Dr Tariq Ahmad is a Consultant Gastroenterologist at the Royal Devon and Exeter NHS Foundation Trust, Lead Clinician for the Exeter Inflammatory Bowel Disease (IBD) Service and Honorary Associate Professor at the University of Exeter Medical School. He is the elected UK representative of the European Crohn's and Colitis Organisation and medical advisor to Crohn's & Colitis UK. Dr Ahmad studied medicine at the University of Bristol and obtained a doctorate from the University of Oxford on the genetics of IBD.

The Exeter IBD team integrates research into the routine clinical practice of the department delivering translational research and clinical trials for patients with IBD. The Exeter IBD research group focusses on the development and implementation of genetic and serological tests to allow individualised treatment strategies for patients with IBD. Dr Ahmad is the chief investigator of PRED4 (www.ibdresearch.co.uk) which has led to actionable pharmacogenetic findings, and PANTS (https://pantsdb.co.uk) which has driven the rapid adoption of biologic monitoring into UK practice. The Exeter IBD team has run a successful PhD and overseas clinical fellowship programme since 2010.

Dr Roger Chapman
Group Head/PI Consultant Physician,
John Radcliffe Hospital, Oxford, UK

Dr Roger W Chapman BSc; MBBS; MD(Lond); FRCP(Lond); MA (Oxon), FAASLD

Roger Chapman was born in South Wales and qualified from St Bartholomew's Hospital, University of London. He trained in liver disease, firstly as a registrar in the Liver Unit in Southampton with Prof Ralph Wright, and then as a lecturer on the Liver Unit, at the Royal Free Hospital in London, under the supervision of Prof Sheila Sherlock, obtaining an MD on "Iron Metabolism in Liver Disease" .

He moved to Oxford as senior registrar, becoming a Consultant in Gastroenterology at the John Radcliffe Hospital. He is currently a Emeritus Consultant in Gastroenterology/ Hepatology attached to the Oxford University Translational Gastroenterology Unit.

Whilst at the Royal Free he developed a research interest in liver disease associated with Inflammatory Bowel Disease which he has continued to this day. He has published 6 books, over 70 Book chapters and 255 original articles mainly in

the field of autoimmune liver disease, viz Primary Sclerosing Cholangitis (PSC), Primary Biliary Cirrhosis (PBC) and latterly IgG4 related disease.
He is one of the authors of the current European (EASL) guidelines for "Cholestatic liver diseases" and the first author of the North American (AASLD) guidelines on the "Management of Primary Sclerosing Cholangitis".
He is a founding member (in 1992) of the International Autoimmune Hepatitis Group (IAHG) producing position papers in the field of Autoimmune Hepatitis. More recently he has been involved in the foundation of the International PSC Study Group (2009) facilitating collaboration between different international centres researching into PSC. He is a Trustee and medical advisor to the PSC patient Support group. He was a member of the NICE Interventional Procedures committee from 2002 to 2008.
He was awarded a Fellowship of American Association for the Study of Liver Disease (AASLD) in 2014 and a lifetime achievement award from the British Association for the Study of Liver Disease (BASL) in 2016. He received Honorary Life Membership of BASL in 2017

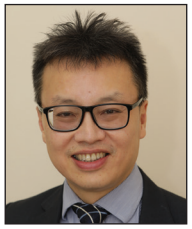
Prof. Dermot Gleeson
Professor of Hepatology.
Sheffield Teaching Hospitals, UK.

Dermot Gleeson qualified at University College Cork and trained in Birmingham, Cardiff, London, Manchester and Yale University . He is a Consultant Hepatologist at Sheffield Teaching Hospitals and hasa an Honorary Professorship in Hepatology at the University of Sheffield
He has been on the BASL and BSG Liver Section Committees and was Chair of the BSG Clinical Standards and Services Committee (2016-18). He has made research contributions in the fields of Gallstones, Hepato-biliary ion transport, Haemochromatosis, Primary Biliary Cirrhosis and Alcoholic Liver Disease but his main interest in recent years has been Autoimmune Hepatitis , on which he co-wrote (with Professor M Heneghan) the BSG Management Guidelines (currently being updated), and super vised the first UK Multi-Centre Audit.
His extra-medical interests include playing classical guitar and mandolin, reading and creative writing.

Prof Janusz Jankowski
Senior Consultant Physician,
University Hospitals Morcambe Bay, UK

Janusz is an expert in creating Collegiate Cultural Change, Successful Functional Teams and National Policy Impacts. Janusz has trained and taught in pre-eminent Universities e.g. Oxford, Cambridge, London, and San Francisco.
His research, including in Nature and Lancet series journals, is rated world-class (h-index>68).
He is currently a National Policy Adviser but previous senior leadership experience includes a range of Higher Education and Public roles including Charity CEO, Pro/Deputy Vice Chancellor Research and Innovation, Dean for Research & International Research Committee Chair.
He built successful Innovation Teams winning many National Prizes for Enterprise in the UK & EU. He has engaged in Knowledge Transfer winning awards for Education, Mentoring & Research.

ISG Board Members



Dr Tony C.K. Tham
President ISG
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 is the President the Irish Society of Gastroenterology.
He has more than 80 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 Vice Chair of the Specialist Advisory Committee for general internal medicine at the Joint Royal Colleges of Physicians Training Board and Training Program Director in General Internal Medicine. He is the Chair of the British Society of Gastroenterology (BSG) Clinical Services and Standards Committee and was the Deputy Chair of this 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.

Dr Garret Cullen
Hon Secretary ISG
Consultant Gastroenterologist
St Vincent's University Hospital, Dublin

Dr Garret Cullen is a Consultant Gastroenterologist at St. Vincent's University Hospital and an Associate Clinical Professor at University College Dublin. He is the Clinical Lead for Endoscopy in Ireland East Healthcare Group. His main clinical interests are inflammatory bowel disease and therapeutic endoscopy.

Dr Manus Moloney
Hon Treasurer ISG,
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.

Dr Patrick Allen
Consultant Gastroenterologist
South East Trust

Dr Patrick Allen is a Consultant Gastroenterologist working in the South East Trust. He graduated from Queen's University of Belfast in 2002. He completed his training in NI and completed a fellowship in St Vincent's Hospital, Melbourne in Endoscopy and IBD. He has been Secretary for the Ulster Society of Gastroenterology from 2012 to 2017 and was on the organising committee for BIG Meeting 2013 and 2017. He is a BSG IBD committee member and is the BSG Four Nations Chair. His main interests are IBD and Endoscopy.

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

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

Professor Laurence Egan,
Professor of Pharmacology
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.

Professor Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin

Deirdre is a graduate of Trinity College Dublin and completed Higher Specialist Training in Gastroenterology in Ireland before travelling abroad to complete periods of training in Interventional Endoscopy in Magdeburg, Germany and Cancer Prevention at the National Institute of Health, USA.
Deirdre was appointed to her first substantive post as a Luminal Interventional Gastroenterologist at Aberdeen Royal Infirmary in 2004. During her time in Aberdeen, she developed additional interests in minimally invasive capsule endoscopy and device assisted enteroscopy.
Deirdre returned to Trinity College and Tallaght Hospital as an Associate Professor of Medicine in 2010. She is Co-Founder and Director of the TAGG Research Centre (Trinity Academic Gastroenterology Group) and was Head of the Department for Clinical Medicine from 2012-2015. Clinically, she helped develop Tallaght's reputation as a centre of excellence for both Device Assisted Enteroscopy and Capsule Endoscopy.
In her spare time, Deirdre can usually be found in wellies outdoors, as a dedicated gardener, rider and dog owner.

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 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.

Prof Larry Egan and Roisin Stack. Case Poster Winner

Honorary Officers and Board Members

Dr Tony Tham,
President ISG
Consultant Gastroenterologist

Dr Garret Cullen, Hon Secretary ISG
Consultant Gastroenterologist

Dr Manus Moloney, Hon Treasurer ISG
Consultant Gastroenterologist

Dr Patrick Allen,
Consultant Gastroenterologist

Dr Glen Doherty,
Consultant Gastroenterologist

Professor Laurence Egan
Professor of Pharmacology

Dr Geraldine McCormack
Consultant Gastroenterologist

Professor Deirdre McNamara,
Consultant Gastroenterologist

Mr Jurgen Mulsow
Consultant Surgeon

Dr Susanne O'Reilly
Gastroenterology SpR

Chief Executive ISG
Mr Michael Dineen

Admin Secretary
Ms Cora Gannon

Mespil House, Sussex Road. Dublin 4
Tel: +353 (0) 1 231 5284
Email: info@isge.ie

Non Executive Board Members

Professor Aiden McCormick
Professor John Hyland
Dr Maeve Skelly
Professor Ronan O'Connell
Dr John Collins
Professor John Crowe
Mr John Moorehead
Professor Stephen Patchett
Professor Kieran Sheahan
Dr Kevin Ward
Professor Suzanne Norris
Dr Suzanne McKiernan
Professor Paud O'Regan
Professor Fergus Shanahan
Professor Garry Courtney
Professor Richard Farrell
Professor Colm O'Morain
Professor Humphrey O'Connor
Dr Barbara Ryan
Professor Padraic MacMathuna
Dr Gavin Harewood
Dr Subhasish Sengupta
Dr Johnny Cash
Dr Paul Lynch

Past Presidents

2017-2019	Professor Laurence Egan
2015-2017	Professor Padraic MacMathuna
2013-2015	Professor Humphrey O'Connor
2011-2013	Professor Aiden McCormick
2009-2011	Professor John Hyland
2007-2009	Professor Fergus Shanahan
2005-2007	Professor John Crowe
2002-2005	Professor Colm O'Moráin
1999-2002	Dr John Collins
1997-1998	Professor Paud O'Regan
1995-1996	Professor Diarmuid O'Donoghue
1993-1994	Mr Gerry O'Sullivan (R.I.P.)
1991-1992	Dr Tom O'Gorman
1989-1990	Professor Tom PJ Hennessy
1987-1988	Dr Michael J Whelton
1985-1986	Professor TG Parks
1983-1984	Mr Joseph McMullin (R.I.P.)
1981-1982	Dr John Fielding (R.I.P.)
1979-1980	Mr Sean Heffernan (R.I.P.)
1977-1978	Dr Robert Towers (R.I.P.)
1975-1976	Professor Donald Weir
1973-1974	Professor Ciaran McCarthy
1971-1972	Professor Patrick Collins (R.I.P.)
1969-1970	Professor Peter Gatenby
1967-1968	Dr Byran G Alton (R.I.P.)
1964-1966	Professor Patrick Fitzgerald (R.I.P.)
1962-1964	Professor Oliver Fitzgerald (R.I.P.)

Oral Presentations - ISG Winter Meeting

Abstract No.	Time:	Ref:	Title of Paper	Author
1	9.15	19W102	Helicobacter pylori Infection Inhibits Notch Signalling In Gastric Epithelial Cells And The Gastric Mucosa.	Rebecca FitzGerald
2	9.25	19W103	The DUBLIN inflammatory burden score predicts early clinical and biochemical response to Golimumab treatment in UC; Early results of the GOAL-ARC study	Ciara Egan
3	9.35	19W105	No change in circulating or intrahepatic Mucosal Associated Invariant T (MAIT) cells of NAFLD patients following a nutritional weight loss intervention	Sara Naimimohasses
4	9.45	19W119	Measuring the value of Endoscopic Ultrasound (EUS) guided drainage of Pancreatic Fluid Collection (PFC): an opportunity to stratify a single endoscopist based on the value of the procedure	Vikrant parihar
5	9.55	19W122	Faecal calprotectin shows poor correlation with endoscopic activity in Crohn's Disease patients with an end-ileostomy compared to those with an ileo-colonic resection	Fiona Jones
6	10.05	19W140	Colon capsule endoscopy (CCE) is an effective filter test for colonic polyp surveillance.	Serhiy Semenov
7	14.15	19W123	Risk Factors For Developing Paediatric Inflammatory Bowel Disease In An Irish Prospective Cohort	Ilona Csizmadia
8	14.25	19W124	The use of ROC Curve analysis to identify specifics cut off values for Anti -drug antibodies….	Neasa McGettigan
9	14.35	19W133	Does the use of Angiotensin Receptor Blockers (ARB) in biopsy proven Coeliac Disease impact upon the assessment of disease activity?	Neil O'Morain
10	14.45	19W146	Long – Term Clinical Outcome of Patients Diagnosed By Small Bowel Capsule Endoscopy with Non-Specific Enteritis.	Dr Sandeep Sihag
11	14.55	19W154	Post-colonoscopy colorectal cancer rates in a N. Ireland Trust	Paul Rooney
12	15.05	19W190	Early Vedolizumab Trough Levels Are Associated with Induction Therapy Outcome	Jim O'Connell

ORAL PRESENTATIONS

ABSTRACT 1 (19W102)

Helicobacter pylori Infection Inhibits Notch Signalling In Gastric Epithelial Cells And The Gastric Mucosa.

Author(s)
R. Fitzgerald1, H. Windle1, D. Kelleher2, A.R. Douglas1, C. O'Morain1, D. McNamara1, S. Smith1.
Department(s)/Institutions
1School of Medicine, Trinity College Dublin, Dublin, Ireland; 2Faculty of Medicine, University of British Columbia, Vancouver, Canada.

Introduction
Helicobacter pylori causes chronic gastritis, ulcers and gastric cancer. As antibiotic resistance rates continue to rise, understanding host-pathogen interactions is crucial for uncovering alternative therapies. The Notch pathway is central to many biological processes including cell differentiation and proliferation.
Aims/Background
To monitor expression of components of the Notch signalling pathway during H. pylori infection.
Method
RNA was isolated from AGS gastric epithelial cells infected with H. pylori and from antral biopsies of H. pylori-infected and uninfected patients. Gene expression was measured using reverse transcription quantitative PCR. The Student's T-test and Mann-Whitney U-test were used to compare gene expression.
Results
H. pylori infection led to a significant increase in IL-8 mRNA expression in AGS cells, and a significant decrease in several Notch pathway components, including Notch receptors; 1 and 3, Notch ligands; Jagged1, Jagged2 and Delta-like1, and Notch target genes Hes1 and Hey1. Biopsy samples from 25 H. pylori-infected and 17 uninfected patients (mean age 50.8 ± 12.9 versus 49.8 ± 17.5 years, respectively; P=0.82) were analysed. Histology findings reported chronic gastritis in all of the H. pylori-infected patients. Significantly lower median expression levels of Notch4 (46%; P=0.02), Jagged2 (39%; P=0.01), Hes1 (38%; P=0.02) and Hey1 (45%; P=0.03) were observed in the gastric mucosa of H. pylori-infected patients compared to uninfected controls.
Conclusions
H. pylori infection is associated with reduced Notch signalling in gastric epithelial cells and in gastric mucosa of infected patients. Further experiments will be necessary to fully elucidate the role of Notch signalling in H. pylori pathogenesis.

ABSTRACT 2 (19W103)

The DUBLIN inflammatory burden score predicts early clinical and biochemical response to Golimumab treatment in UC; Early results of the GOAL-ARC study

Author(s)
C Egan, F Jones, J Sheridan, CA Coe, P Doran, G Cullen, J Leyden, M Galligan, J McCarthy, A O'Toole, D Kevans, L Egan, GA Doherty
Department(s)/Institutions
St Vincents University Hospital, UCD, Mater Misericordiae University Hospital, Mercy University Hospital, Beaumont Hospital, St James Hospital, Galway University Hospital

Introduction
Golimumab is an anti-TNF agent licensed for the treatment of UC. Higher trough levels are associated with enhanced response to therapy. GOAL-ARC is a randomized multi-centered trial of the impact of personalized dosing of Golimumab based on inflammatory burden and therapeutic drug monitoring versus standard of care.
Aims/Background
We aimed to evaluate the impact of inflammatory burden in UC on drug levels and early response to GLM treatment.
Method
Clinical response was defined as a decrease in baseline modified partial mayo score of 2 points or a decrease of ≥30% from baseline. GLM was administered at 200mg at week 0, 100mg at week 2 in all patients in advance of week 6 assessment.
Results
70 patients have been recruited to GOAL-ARC. 90% have completed the induction phase to week 6. Clinical response was achieved in 57% at week 6. The median modified partial mayo score decreased from 4 to 2($p<0.001$). Median FCP reduced from 1380 to 180($p=0.001$). A lower baseline DUBLIN score was associated with clinical response at week 6 ($p=0.048$). Higher week 6 drug levels were associated with clinical response. ($p=0.012$).
Conclusions
Early results of GOAL-ARC demonstrate the majority of UC patients treated with GLM show early clinical response (by week 6) with higher drug levels being significantly associated with achieving clinical response and reductions in FCP. Lower baseline DUBLIN (inflammatory burden) scores are associated with higher trough drug levels and clinical response at week 6 indicating that a higher inflammatory burden is associated with poorer outcomes.

ABSTRACT 3 (19W105)

No change in circulating or intrahepatic Mucosal Associated Invariant T (MAIT) cells of NAFLD patients following a nutritional weight loss intervention

Author(s)
Dr. Sara Naimimohasses, Philip O'Gorman, Deirdre Ni Fhloinn, Ciara Wright, Mr. Dean Holden, J. Lysaght, Dr. Peter Beddy, Dr. Niall Conlon, Dr. Stephen P Finn, Dr. Margaret R Dunne,Professor Bernadette Moore, Professor Jacintha O'Sullivan, Professor Suzanne Norris
Department(s)/Institutions
Department of Hepatology, St James' Hospital

Introduction
MAIT cells are innate-like T lymphocytes that are enriched in the liver and may promote fibrogenesis. Weight loss has been shown to promote histological improvement in NAFLD.
Aims/Background
The aim of this study was to assess changes in MAIT cell populations amongst patients with NAFLD following a nutritional weight loss intervention.
Method
20 patients with biopsy proven NAFLD were recruited to the study.15 patients were allocated to a nutritional intervention (NI) group and 5 patients were recruited as controls. Baseline investigations included bloods, fibroscans, DEXAs and these were repeated post NI. The NI consisted of bi-weekly group nutritional education sessions for 12 weeks. Following completion, patients had repeat bloods, fibroscans and DEXAs. 12 patients in the NI with steatohepatitis on their initial liver biopsy had a repeat biopsy to re-assess histological stage. Liver

tissue and whole blood samples were stained with antibodies specific for CD45, CD3, CD8, CD161, Vα7.2, CD69 and CD95 and were analysed with multi-colour flow cytometry using a BD FACSCanto II (BD Biosciences) and FlowJo software (Tree Star, Asland, OR). Statistical analysis of paired samples was performed using the Wilcoxon matched pair rank test.

Results

A significant reduction was observed in % body fat-1.3% (-4.2, +2.2%), p=0.0254, HbA1c p=0.0054, ALT p=0.0108 and GGT p=0.0001 in the intervention group. Repeat biopsies showed a significant reduction in NAS score p=0.027. On further analysis, this was due to reductions in hepatic steatosis p=0.0078. No reductions were observed in lobular inflammation, p=0.75, ballooning, p=0.375 or fibrosis, p >0.999. Table 1 shows the characteristics of circulating and intrahepatic MAITs pre and post NI. Pre NI Post NI P value % Circulating MAITs 1.27% 0.97% 0.5305 Circulating MAIT MFI CD69 350 202 0.0479* Circulating MAIT MFI CD95 1690 1622 0.8904 % Intrahepatic MAITs 7.12% 6.56 0.4238 Intrahepatic MAIT MFI CD69 3345 3924 0.4238 Intrahepatic MAIT MFI CD 95 3428 3432 0.7480

Conclusions

No significant changes were observed in peripheral and intrahepatic MAIT cell levels or terminal activation marker expression despite improvements in patients' metabolic profile and hepatic steatosis. MAIT cells have been shown to promote inflammation and fibrosis through hepatic stellate cell activation. Our study may be limited by the study timeline and because the intervention did not result in fibrosis regression or resolution of steatohepatitis. Given that these are key mechanisms by which MAIT cells are thought to contribute to NAFLD, further studies are required in patients who achieve fibrosis regression.

ABSTRACT 4 (19W119)

Measuring the value of Endoscopic Ultrasound (EUS) guided drainage of Pancreatic Fluid Collection (PFC): an opportunity to stratify a single endoscopist based on the value of the procedure

Author(s)

V.Parihar, G. Mellotte*,*Y.Basir, ** D. Nally, **T. Manoharan,*P. Ridgeway, **K.Conlon, **G.Harewood, *** B.M.Ryan*+

Department(s)/Institutions

*Department of Gastroenterology Tallaght University Hospital; Tallaght; Dublin-24 + Department of Clinical Medicine, Trinity College Dublin ** Department of Surgery Tallaght University Hospital; Tallaght; Dublin-24 *** Department of Gastroenterology Beaumont University Hospital; Dublin-9

Introduction

The value in healthcare can be defined as patient health outcomes achieved per monetary unit spent. Attempts have been made to quantify the value of luminal endoscopy but there is little in the medical literature describing the value of the complex therapeutic activity.

Aims/Background

This study aimed to characterize the value of Endoscopic Ultrasound (EUS) guided drainage with either plastic or Lumen Apposing Metal Stents (LAMS) of patients with Pancreatic Fluid collections (PFC).

Method

We carried out a retrospective–prospective study of 39 patients who underwent EUS guided PFC drainage between 2006 and 2018. Procedure value was calculated using the formula Q/ (T/C), where Q is the quality of the procedure, T procedure duration and C is the complexity adjustment. Quality and complexity were estimated on a 1–4 Likert scale on the basis of American Society for Gastrointestinal Endoscopy criteria; time was recorded from the patient entering and leaving the room. Endoscopists time calculated from procedure time was considered a surrogate marker of cost as individual components of procedure cost were not itemized.

Results

39 patients including 11 patients with plastic and 28 patients with LAMS were included. The two groups were comparable in age, gender and aetiology. 50% of the LAMS interventions were considered high value but only 10% of the Plastic stent interventions. The difference was due predominantly to a higher rate of complications.

Conclusions

EUS drainage of PFC using LAMS is a higher value procedure as compared to the plastic stent and would likely become the standard of care in future.

ABSTRACT 5 (19W122)

Faecal calprotectin shows poor correlation with endoscopic activity in Crohn's Disease patients with an end-ileostomy compared to those with an ileo-colonic resection

Author(s)

F. Jones, C. Rowan, C. Egan, D. Storan, G. Cullen, J. Sheridan, H. Mulcahy & G. A. Doherty

Department(s)/Institutions

Centre for Colorectal Disease, St. Vincent's University Hospital School of Medicine, University College Dublin

Introduction

Faecal Calprotectin(FCP) is an accurate surrogate marker for post-operative recurrence in Crohn's disease(CD), however, it's use in patients with an ileostomy due to CD has not been established.

Aims/Background

We assessed the performance characteristics of FCP in CD patients with an ileostomy and compared this to patients post ileo-colonic resection.

Method

Post-operative patients with CD attending a single academic centre were identified using a database of >4000 IBD patients, cross-referenced with the endoscopy reporting system. Endoscopic activity was classified using Rutgeert's score(RS>2 defined endoscopic recurrence). FCP cut-off of 150µg/g was used to define disease activity.

Results

1,896 surgeries for CD were identified. 79 (ileostomy: n=26, anastomosis: n=53) contemporaneous endoscopic and FCP results in 73 patients were analysed. Patients with an ileostomy had significantly higher rates of negative disease predictors: younger age at diagnosis($p<0.05$); longer disease duration($p=0.001$); higher proportion of perianal disease ($p=0.01$). 72% had i0-1 disease, and 28% i2-4 disease in the ileostomy group compared to 47.2% and 52.8% respectively in the anastomosis group, with a trend towards more active disease in the anastomosis group($p=0.052$). No significant correlation was identified between endoscopic scores and FCP results in patients with an ileostomy ($p=0.884$, $R=0.034$). In the anastomosis group, there was a significant correlation between level of FCP and endoscopic activity($p=0.032$, $R=0.313$), particularly in patients with FCP >150($p=0.008$, $R=0.371$).

Conclusions
Our study confirms the strong correlation between FCP and endoscopic activity in post-operative CD, showing a high degree of accuracy with 150µg/g as a cut off. There was poor correlation in CD patients with an ileostomy, highlighting a lack of non-invasive tools in this group.

ABSTRACT 6 (19W140)

Colon capsule endoscopy (CCE) is an effective filter test for colonic polyp surveillance.

Author(s)
S. Semenov*, T. Manoharan, S. Sihag*, K. Hazel*, D. Molloy*, B. Ryan, N. Breslin, A. O'Connor*, D. McNamara*.
Department(s)/Institutions
Department of Gastroenterology, Tallaght University Hospital, Tallaght, Dublin 24 and Trinity Academic Gastroenterology Group, Trinity College Dublin*.
Introduction
Surveillance accounts for 30% of colonoscopy workload, the majority are normal. Identifying patients who require polypectomy would be advantageous. Current risk stratification performs poorly.
Aims/Background
Assess CCE and/or faecal immunochemical test (FIT) as a filter in surveillance.
Method
Following ethical approval, patients due polyp surveillance only, aged 18–80 were identified from our waiting list, then invited for CCE and FIT, and grouped according to BSG risk stratification. Any polyps, CRC (colorectal cancer), IBD or bleeding were significant CCE findings. ESGE defined CCE significant lesions (>3 polyps, >6mm), incomplete studies, positive FITs (≥225ng/ml) required endoscopy.
Results
Of 803 surveillance patients, 300 (37%) met the inclusion criteria, 250 were invited with a 47% (118/250) uptake rate. Of 84 analysed CCEs (mean age 66 (38-80), 48 (57%) males), 72 (86%) returned FITs. Completion rate was 71% (60/84). Image quality was inadequate in 5 (6%). Overall, CCE positivity was 69% (58/84) with 48% (28/58) having significant polyps. Of colonoscopies completed to date, the true positive CCE rate was 90% (18/20). BSG high risk surveillance patients were more likely to have a positive CCE (n=58, p<0.0001, OR 4.4, 95%CI -0.43 to -0.22) as were older patients ≥70 (OR 3.6, p=0.02, 95%CI 1.2135 to 11.0267). There were no CCE complications and extracolonic findings were reported in 2% (2/84). 2/72 (3%) FIT results were positive. (+)FIT and CCE concordance was 100%, but FIT sensitivity was inadequate (4%). In all, only 45/84 (54%) require endoscopy (31 (37%) colonoscopy, 14 (17%) sigmoidoscopy).
Conclusions
Unlike FIT, CCE is useful in selecting patients for polypectomy in polyp surveillance and avoiding unnecessary colonoscopy.

ABSTRACT 7 (19W123)

Risk Factors For Developing Paediatric Inflammatory Bowel Disease In An Irish Prospective Cohort

Author(s)
Csizmadia I.1, Cooper S.1, Ekpotu L.P.1,2, O'Driscoll K.3, O'Connell M.3, Quinlan J.3, Kiernan S.3, Quinn S.3, Broderick A.1,3,4, Bourke B.1,3,4, Hussey S.1,2,4, on behalf of the DOCHAS Study
Department(s)/Institutions
1National Children's Research Centre, Children's Clinical Research Unit, Dublin, Ireland, 2Royal College of Surgeons in Ireland, Department of Paediatrics, Dublin, Ireland, 3Children's Health Ireland at Crumlin, Department of Gastroenterology, Hepatology and Nutrition, Dublin, Ireland, 4University College Dublin, Department of Paediatrics, Dublin, Ireland
Introduction
The incidence of Pediatric Inflammatory Bowel Disease (PIBD) is increasing in Ireland. Role of environmental and familial factors in the Irish population remains elusive.
Aims/Background
To assess potential risk factors for developing PIBD in the The Determinants and Outcomes in Children and Adolescents with IBD (DOCHAS) study.
Method
Children aged 0-16 presenting with symptoms of IBD were recruited to DOCHAS between 01/01/2012 and 31/06/2019. Patients and families answered questions at enrollment regarding birth history, exposure to smoking, antibiotics and NSAIDs, urban/rural/farm dwelling and family history of autoimmune disease.
Results
835 patients were recruited. 200 were non-IBD, 339 had Crohn's disease (CD), 239 had Ulcerative Colitis (UC). Mean age at diagnosis was 11.7 years in CD, 11.9 years in UC patients. Males were more likely to be diagnosed with CD than with UC (M:F ratio: 2.5:1/1.2:1, p< 0.0001). A family and personal history of autoimmune disease (atopic disease, ankylosing spondylitis, autoimmune thyroid disease, coeliac disease, multiple sclerosis, rheumatoid arthritis, SLE/lupus, psoriasis or type 1 diabetes) gave a more likely diagnosis of CD than UC (60%/46%, p=0.002 and 39%/28%, p=0.01 respectively). A lower rate of breastfeeding was more associated with CD than with UC (44%/53%, p=0.04). No significant differences were found between CD and UC regarding exposure to smoking, NSAIDs or antibiotics, urban/rural/farm dwelling, prior infectious gastroenteritis and caesarian section delivery.
Conclusions
In the Irish population, a family history of autoimmune disease was more associated with CD than with UC, as was a lower rate of breastfeeding. Ongoing prospective research is needed to elucidate these associations.

ABSTRACT 8 (19W124)

The Use of ROC Curve Analysis to Identify Specific Cut-Off Values for Anti-drug Antibodies to Infliximab for Important Clinical Outcomes

Author(s)
N Mc Gettigan, A Alfridi, G Harewood, D Cheriyan, S Patchett, K Boland, A O'Toole
Department(s)/Institutions
The Department of Gastroenterology, Beaumont Hospital
Introduction
Anti-drug antibodies (ADAs) to Infliximab (IFX) can cause a secondary loss of response to IFX. With ADA formation, the clearance of IFX can increase by up to 30% . A landmark study has shown that ADAs >8.0 µg/mL before an IFX infusion was associated with a shorter duration of response and a higher risk of infusion reactions.
Aims/Background
To determine the ADA cut-off levels which result in adverse outcomes including treatment failure, switch to other Biologic, need for emergency surgery/acute steroid therapy and acute crisis admission for IBD flare.
Method
Retrospective study of patients receiving IFX with ADAs >8mg/L over 3 years. ROC curve analysis was used to identify ADA cut-off values to predict specific adverse outcomes.
Results
132 patients were included. ROC curve analysis for ADAs predicting treatment failure found an area under the curve (AUC) of 0.642 (p-value 0.003) with Youden's index of 0.28 for ADAs >16ug/ml with sensitivity 91%, specificity 38%. The AUC for ADA level and switch to another biologic was 0.739 (p-value 45ug/ml, sensitivity 78%, specificity 65%. The AUC for admission to hospital was 0.568 (p-value 0.24) with Youden's index of 0.28 for ADA >19ug/ml with sensitivity 95.7, specificity 32.69. The AUC for steroids was 0.61 (p-value 0.051) with Youden's Index 0.24 for ADAs >19ug/ml. The AUC for surgery was 0.61 (p-value 0.128) with Youden's Index 0.24 for ADAs >19ug/ml.
Conclusions
Specific ADA cut-off values can be used to predict treatment failure and adverse outcomes for patients on IFX therapy.

ABSTRACT 9 (19W133)

Does the use of Angiotensin Receptor Blockers (ARB) in biopsy proven Coeliac Disease impact upon the assessment of disease activity?

Author(s)
O'Morain N, McManus J, Warner V, Egan B, Byrnes V
Department(s)/Institutions
Department of Gastroenterology Galway University Hospital Ireland
Introduction
Angiotensin Receptor Blocker-associated Enteropathy (ARB-E) is an increasingly recognised clinical entity that presents with symptoms and histological findings identical to coeliac disease. These are transient and resolve upon removal of the ARB. The impact of ARBs in patients with established coeliac disease is not known.
Aims/Background
Analyse the effects of ARBs on patients with biopsy proven coeliac disease (BPCD
Method
A retrospective observation case-control study was performed including 41 patients with BPCD treated with an ARB for hypertension attending a coeliac specific OPD (2012-present). We collected data establishing the diagnosis of BPCD, most recent coeliac serology and D2 biopies, vitamin D, iron, and haemoglobin levels. We age and sex-matched these patients in a 1:2 ratio and compared disease activity in these 2 groups. Unpaired student T-Test was used to compare means and Chi-square test to compare proportions.
Results
In the coeliac/ARB group (A) there were a total of 41 patients (female n=26, 63%). Mean age 66.2 years. Mean duration of disease 9.1 years. Compliance with GFD was 53%. In control group (B) there were 82 patients (female n=52, 63%). Mean age of 66.2years. Mean duration of disease 13.3y. Compliance with GFD was 56%. In group A, coeliac serology was positive in 13%, compared with 32% positive serology of control, and negative in those taking Olmesartan (p=0.035). Symptoms were reported in 10/40 (25%) in group A compared with 7/82 (9%) (p=0.28) in controls. Vitamin D levels were lower in those taking Olmesartan (p=0.0015). Histological disease severity was comparable across the groups (p=0.1)
Conclusions
Concomitant ARB use in our BPCD cohort resulted in increased symptoms with histological evidence of disease activity without raised TTG titres. ARB use in BPCD confounds the assessment of non-responsive or refractory coeliac disease. Alternative anti-hypertensive agents should be considered in coeliac patients.

ABSTRACT 10 (19W146)

Long – Term Clinical Outcome of Patients Diagnosed By Small Bowel Capsule Endoscopy with Non-Specific Enteritis.

Author(s)
Sihag S1, Tan B, Semenov S1,2, Ismail MS1,2,Ryan B1, O'Connor A1, Breslin N1, McNamara D1,2 .
Department(s)/Institutions
Affiliations: 1. Department of Gastroenterology, Tallaght University Hospital, Dublin, Ireland. 2. Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin, Ireland.
Introduction
The findings of nonspecific small bowel enteritis (NSE) on capsule endoscopy (CE) not meeting established diagnostic criteria poses a clinical challenge.
Aims/Background
To define the natural history of NSE.
Method
A retrospective longitudinal cohort study of patients with NSE on CE, identified from a database. Subsequent investigations (Endoscopies, Faecal calprotectin, CRP and haemoglobin), treatments and diagnosis were recorded. Exclusion criteria: known Crohns disease (CD), enteritis meeting a diagnostic threshold, < 3 moths follow up, external referral. Patients were grouped based on ultimate diagnosis: CD, Irritable bowel syndrome (IBS), NSAIDs enteritis (NSAIDs), no significant disease (NAD), other non-inflammatory conditions and persistent NSE. Clinical and demographic parameters were compared according between groups.
Results
157 (48%) enteritis patients were identified. 169 & 69 were excluded; external study and known CD. Of the NSE group (n= 88), 46 (52%) were male, mean age 52 ±17.8 year, Mean follow up was 23 ±19

months (range 3 to 88). The ultimate diagnoses were: NAD 35 (40%), CD 17 (19%), NSAIDs 12 (14%), IBS 14 (16%), other diagnoses 8 (9%), persistent NSE 2 (2%). Female gender was associated with IBS (OR 4.7, p <0.02) and older age with NSAIDs enteritis (mean 64 vs 49 yrs, p <0.006). Both NSAIDs and CD were associated with a higher baseline Lewis Score (831.7 vs 308.5, p=0.02) and a trend for a higher FC (82.1 vs 55.2, P=0.3). Significantly more CD patients were referred with suspected CD and had a trend for a higher CRP than the NSAID group, 82% vs 17% , p < 0.009 and 16.9 mg/dl vs 5.9, p=0.1 respectively.

Conclusions

33% (19/88) of patient had clinical significant disease which highlights the importance of follow up of NSE. Clinical suspicion and capsule severity are predictive of CSD.

ABSTRACT 11 (19W154)

Post-colonoscopy colorectal cancer rates in a N. Ireland Trust

Author(s)

Rooney P, Halim KAA, Boal J, Gilsenan A, Hillemand C, Murphy SJ

Department(s)/Institutions

Gastroenterology Department, Daisy Hill Hospital, Southern Health and Social Care Trust

Introduction

Colonoscopy is the gold standard diagnostic for colorectal cancer (CRC). However, it still has the potential to miss colorectal cancer. Patients may present with colorectal cancer after a negative colonoscopy. Previously termed 'missed cancer', the standardised term is post-colonoscopy colorectal cancer (PCCRC). Rates of 5% are reported in the literature.

Aims/Background

To review the rates of PCCRC within the Southern Trust (Daisy Hill Hospital, Newry; Craigavon Area Hospital, Craigavon; and South Tyrone Hospital, Dungannon) and to identify any contributing factors.

Method

Data were analysed retrospectively using the Trust's cancer trackers database and Unisoft GI reporting. All CRC in the 3 year period 2015-2018 in Southern Trust were reviewed. We identified patients who had a negative colonoscopy 3 years prior to diagnosis of CRC along with negative flexible sigmoidoscopies for left-sided CRCs. Data analysed included site of tumour, time from negative test to diagnosis, quality of bowel prep, identification of landmarks, withdrawal times, presence of IBD or diverticulosis, bowel cancer screening patients, and site of previous polyps.

Results

670 patients were identified with lower GI cancer in the Southern Trust from 2015-2018. After exclusion of anal, appendiceal and other cancers, 613 patients had CRC. Of these, 26 (4.2%) had negative colonoscopy or flexible sigmoidoscopy within the previous 3 years. Only 6 out of 26 patients had all of the following: good bowel prep, landmarks photographed and withdrawal time well documented.

Conclusions

PCCRC in the Southern Trust from 2015-2018 was 4.2%, similar to rates quoted in the literature. There was no correlation found between the site of tumour and PCCRC. Factors have been identified for improvement and prospective audits are planned.

BSTRACT 12 (19W190)

Early Vedolizumab Trough Levels Are Associated with Induction Therapy Outcome

Author(s)

J O'Connell1, R Corcoran1, R Argue1PMcDonagh1, , MS Ismail3, G Cullen2, G Doherty2, F MacCarthy1, D McNamara3, A O'Connor3, C O'Moráin3, J Sheridan1, K Hartery1, B Ryan3, D Kevans1.

Department(s)/Institutions

1Department of Gastroenterology, St James's Hospital, Dublin 2Department of Gastroenterology, St Vincent's University Hospital, Dublin 3Department of Gastroenterology, Tallaght University Hospital, Dublin INITIative IBD Research Network

Introduction

Vedolizumab(VDZ) is a monoclonal antibody which is used for the induction and maintenance of remission in patients with Ulcerative Colitis(UC) and Crohn's Disease(CD).

Aims/Background

We aimed to determine factors, associated with success of VDZ induction therapy.

Method

Patients were recruited prospectively from three Irish Academic Medical Centres. Individuals were included if >18 years, with a diagnosis of UC or CD and due to commence VDZ therapy. Disease activity scores were assessed on day of infusion and at week 14. Standard VDZ induction therapy for UC and CD was used. Trough VDZ levels were collected prior to week 2 and 6 infusions. The primary endpoint was steroid-free remission(SFR) following VDZ induction at week 14. SFR was defined as the absence of corticosteroid use and a partial mayo score≤1 (for UC) or HBI<5 (for CD). All continuous data are presented as median(range).

Results

43 patients were recruited of whom n=39 had follow up to week 14. Median age at study entry was 46.4(18.2–75.8); 49% of cohort had CD. Week 2 and week 6 trough VDZ concentrations were 24.1mcg/ml(0–56) and 20.2mcg/ml(0–66) respectively. Baseline CRP was 3.6 mg / L (1 – 43). 20 patients(51%) were in SFR after induction at week 14. There was an association between increased week 6 trough VDZ levels and SFR at week 14,p=0.009. An elevated baseline CRP was significantly associated with and absence of SFR at week 14,p=0.027.

Conclusions

Early vedolizumab trough levels are associated with SFR following induction therapy. Vedolizumab therapeutic monitoring may have value in a clinical setting, however, further prospective studies and clinical validation is required.

Muteeb Ashraf, Muhammad Shakoor, Abrar Ahmed Ansari

Summer Meeting 2019

Linda Duane, Mary Nwaezeigwe & Aine Keogh

Dr John Ryan, Prof Philippe Mathurin, Prof Eilish Gilvarry,
Dr Diarmaid Houlihan, Michele Bourke & Dr Stephen Stewart

Preferred Drugs
THE RIGHT CHOICE, RIGHT NOW.

MEDICINES MANAGEMENT PROGRAMME

MMP† BEST VALUE

IMRALDI, MMP† BEST-VALUE BIOLOGICAL MEDICINE FOR ADALIMUMAB[1]

MMP† BEST VALUE

EXPERIENCE SHOWS THE WAY[2]

Together we have opened the door to treating >170,000 patients on Biogen biosimilars across Europe[2]

Imraldi™ ▼
Adalimumab

THE ADALIMUMAB FROM BIOGEN®

PRESCRIBING INFORMATION: ▼ IMRALDI™ (ADALIMUMAB) 40 MG SOLUTION FOR INJECTION IN PRE-FILLED SYRINGE AND PRE-FILLED PEN

Please refer to the Summary of Product Characteristics for further information. **Composition:** Each 0.8 ml single dose pre-filled syringe or pre-filled pen contains 40 mg of adalimumab. **Indications:** Rheumatoid Arthritis (RA): Moderate to severe active RA in adults, in combination with methotrexate (MTX) treatment, when response to diseasemodifying anti-rheumatic drugs (DMARDs), including MTX (unless contraindicated), has been inadequate. Severe, active and progressive RA in adults, in combination with MTX treatment, in adults without prior MTX treatment. Juvenile Idiopathic Arthritis (JIA): Active polyarticular JIA, in combination with MTX treatment, in patients from 2 years of age with inadequate response to one or more DMARDs. Active enthesitis-related arthritis (ErA) in patients from 6 years of age who have had an inadequate response to, or who are intolerant of, conventional therapy. Axial Spondyloarthritis: *Ankylosing spondylitis* (AS): Adults with severe, active AS who have had an inadequate response to conventional therapy. Non-radiographic axial spondyloarthritis *(nr-axSpA):* Adults with severe nraxSpA with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or Magnetic Resonance Imaging (MRI), who have had an inadequate response to, or are intolerant to, nonsteroidal anti-inflammatory drugs (NSAIDS). Psoriatic Arthritis (PsA): Active and progressive PsA in adults when the response to previous DMARD therapy has been inadequate. Psoriasis: Moderate to severe chronic plaque psoriasis in adults who are candidates for systemic therapy. Paediatric Plaque Psoriasis (pPP): Severe chronic plaque psoriasis in patients from 4 years of age who have had an inadequate response to or are inappropriate candidates for topical therapy and phototherapies. Hidradenitis suppurativa (HS): Active moderate to severe HS (acne inversa) in adults and adolescents from 12 years of age with inadequate response to conventional systemic HS therapy. Adult Crohn's Disease (CD): Moderately to severely active CD in adults who have not responded to a corticosteroid and/or an immunosuppressant, or who are intolerant to, or have medical contraindication for such therapies. Paediatric Crohn's Disease (pCD): Moderately to severely active CD in paediatric patients from 6 years of age, who have not responded to conventional therapy. Ulcerative Colitis (UC): Moderately to severely active UC in adults with inadequate response to conventional therapy or who are intolerant to, or have medical contraindications for such therapies. Uveitis: Non-infectious intermediate, posterior and panuveitis in adults with inadequate response to corticosteroids. Paediatric Uveitis (pU): chronic non-infectious anterior uveitis in patients from 2 years of age who have had an inadequate response to or are intolerant to conventional therapy, or in whom conventional therapy is inappropriate. **Administration and dosage:** By subcutaneous injection. Other concomitant therapies such as corticosteroids and/or immunomodulatory agents should be optimised. *Adults: RA:* single 40 mg dose every other week. MTX should be continued during treatment. Monotherapy patients who experience a decrease in response may benefit from 40 mg every week, or 80 mg every other week. If no response within 12 weeks, continued therapy should be reconsidered. *Axial Spondyloarthritis: AS, nr-axSpA, and PsA:* 40 mg every other week If no response within 12 weeks, continued therapy should be reconsidered. *Psoriasis:* 80 mg in week 1 followed by 40 mg every other week from week 2. If no response after 16 weeks, continued therapy should be reconsidered. If inadequate response beyond 16 weeks, 40 mg every week can be considered, or 80 mg every other week. *HS:* 160 mg at Day 1 (given as four 40 mg injections in one day or two 40 mg injections/day for two consecutive days), followed by 80 mg two weeks later at Day 15 given as two 40 mg injections in one day. From day 29, 40 mg every week, or 80 mg every other week (two 40 mg injections in one day). Antibiotics may be continued during treatment if necessary. If no response within 12 weeks, continued therapy should be reconsidered. Continued long-term treatment should be periodically evaluated. *CD:* Induction: 80 mg at week 0 and 40 mg at week 2. For a more rapid response: 160 mg at week 0 (four 40mg injections in one day or two 40mg injections/day for two consecutive days), and 80 mg at week 2 (two 40 mg injections in one day); risk of adverse events may be higher with higher induction dose. Maintenance: 40 mg every other week. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Patients with decreased response to 40 mg every other week may benefit from 40 mg every week, or 80 mg every other week. If no response by week 4, benefit may be seen from continued maintenance therapy through week 12. If no response within 12 weeks, continued therapy should be reconsidered. *UC:* Induction: 160 mg at week 0 (four 40 mg injections in one day or two 40 mg injections/day for two consecutive days) and 80 mg at week 2 (two 40mg injections in one day). Maintenance: 40 mg every other week. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Patients with decreased response may benefit from 40 mg every week, or 80 mg every other week. If there is no response after 2-8 weeks, treatment should be discontinued. *Uveitis:* 80 mg initial dose, followed by 40 mg every other week starting one week after the initial dose. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be tapered in accordance with clinical practice. Continued long-term treatment should be evaluated on a yearly basis. *Dose adjustments in specific populations: Paediatrics:* Where less than a full 40 mg dose is required, alternative adalimumab products offering the correct dose should be used. *JIA:* For patients with polyarticular JIA from age 2 yrs, dose is based on body weight (see SmPC, Table 1 for dosing). *ErA:* From 6 years of age, dose is based on body weight (see SmPC, Table 2 for dosing). *pPP:* From 4-17 years of age, dose is based on body weight (see SmPC, Table 3 for dosing). It is not possible to dose patients above 4 years of age with a weight less than 30 kg with this product. If no response after 16 weeks, continued therapy should be reconsidered. *Adolescent HS:* From 12 years of age, weighing at least 30 kg, the recommended dose based on pharmacokinetic modelling and simulation is 80 mg at week 0 followed by 40 mg every other week starting at week 1. If inadequate response, 40 mg every week, or 80 mg every other week can be considered. Continued long-term treatment beyond 12 weeks should be periodically evaluated. *pCD:* From 6-17 years of age, dose is based on body weight (see SmPC Table 4 for dosing). Patients ≥ 40 kg with insufficient response may benefit from 40 mg every week, or 80 mg every other week. pU: From 2 years of age, dose is based on body weight (see SmPC, Table 5 for dosing). No experience without concomitant treatment with methotrexate. For paediatric JIA, HS, and CD, if no response within 12 weeks, continued therapy should be reconsidered. **Contraindications:** Hypersensitivity to the active substance or excipients listed in the SmPC. Active tuberculosis or other severe infections such as sepsis, and opportunistic infections. Moderate or severe heart failure (NYHA class III/IV). **Warnings and Precautions:** Please refer to the SmPC for the full list of Warnings and Precautions. Patients treated with IMRALDI should be given the Patient Reminder Card. *Serious infections:* Do not start IMRALDI during an active infection until infections are controlled. If an infection develops, monitor carefully, and stop IMRALDI if infection becomes serious. *Tuberculosis (TB):* All patients must be evaluated for both active and inactive TB before initiation of treatment. If diagnosed with active TB IMRALDI must not be initiated. *Hepatitis B virus (HBV) reactivation:* Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop IMRALDI and begin anti-viral therapy. *Demyelinating disease (Neurological events):* Exacerbation or new onset, may occur. Consider discontinuation if these disorders develop. *Anaphylaxis or serious allergic reactions* may occur, administration of IMRALDI should be discontinued. *Malignancies:* Incidence of malignancies was greater in IMRALDI-treated patients than in controls. *Haematologic reactions:* Discontinuation of IMRALDI therapy should be considered in patients with confirmed significant haematologic abnormalities. *Vaccinations:* Patients may receive concurrent vaccinations, except for live vaccinations which should not be given. Paediatric patients should be brought up to date with all immunisations prior to initiating IMRALDI. *Heart failure:* Worsening or new onset may occur. *Autoimmune Processes:* If symptoms of lupus-like syndrome develop: further treatment with IMRALDI should not be given. *Concurrent administration of biological DMARDS or TNFantagonists:* Concomitant administration of IMRALDI with other biological DMARDS or other TNF antagonists is not recommended due to increased risk of infections, including serious infections. *Small bowel obstruction:* Failure to respond to treatment for Crohn's disease may indicate the presence of fixed fibrotic stricture that may require surgical treatment. *Elderly (≥ 65 years):* Particular attention regarding the risk for infection should be paid when treating the elderly. *Excipients with known effects:* Patients with rare hereditary problems of fructose intolerance should not take this medicinal product. **Interactions:** See SmPC. **Fertility, Pregnancy and Lactation:** Women of childbearing potential should consider the use of adequate contraception to prevent pregnancy and continue its use for at least 5 months after the last IMRALDI treatment. Adalimumab should only be used during pregnancy if clearly needed. Administration of live vaccines (e.g. BCG vaccine) to infants exposed to adalimumab in utero is not recommended for 5 months following the mother's last adalimumab infusion during pregnancy. No effects on the breastfed newborns/infants are anticipated. Consequently, adalimumab can be used during breastfeeding. **Undesirable effects:** *Very common:* Respiratory tract infections, leucopenia, anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash, musculoskeletal pain, injection site reaction. *Common:* Systemic infections, intestinal infections, skin and soft tissue infections, ear infections, oral infections, reproductive tract infections, urinary tract infections, fungal infections, joint infections, skin cancer excluding melanoma, benign neoplasm, leucocytosis, thrombocytopenia, hypersensitivity, allergies, hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphatemia, dehydration, mood alterations, anxiety, insomnia, paraesthesias, migraine, nerve root compression, visual impairment, conjunctivitis, blepharitis, eye swelling, vertigo, tachycardia, hypertension, flushing, haematoma, asthma, dyspnoea, cough, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, worsening or new onset of psoriasis, urticaria, bruising, dermatitis, onychoclasis, hyperhidrosis, alopecia, pruritus, muscle spasms, renal impairment, haematuria, chest pain, oedema, pyrexia, coagulation and bleeding disorders, autoantibody test positive, blood lactate dehydrogenase increased, impaired healing. Serious adverse reactions: Serious infections (refer to SPC for full list), malignancies, haematological reactions (pancytopenia, aplastic anaemia), demyelinating disorders, lupus, lupus-related conditions, Stevens-Johnson syndrome. Please refer to SmPC for full list. **Legal Classification:** POM. **Pack Size:** IMRALDI is available in packs of 2. **Package Quantities:** IMRALDI 40 mg solution for injection in prefilled syringe (PFS): 0.8 ml solution for injection in single-use prefilled syringe. IMRALDI 40 mg solution for injection in prefilled pen (PFP): 0.8 ml solution for injection in single-use prefilled pen for patient use containing a pre-filled syringe. **Marketing Authorisation Numbers:** PFS 2-pack EU/1/17/1216/002, PFP 2-pack EU/1/17/1216/006. **Marketing Authorisation Holder:** Samsung Bioepis NL B.V, Olof Palmestraat 10, 2616 LR Delft, The Netherlands. Manufacturer: Biogen (Denmark) Manufacturing ApS, Biogen Allé 1, 3400 Hillerød, Denmark. **Further information:** available on request from Biogen MI (see details below). **Date of last revision of Prescribing Information:** May 2019

Adverse events should be reported.
Ireland: Adverse events can be reported to HPRA Pharmacovigilance, Earlsfort Terrace, IRL – Dublin 2, Tel: +353 1 6764971; Fax: +353 16762517. Website: www.hpra.ie, e-mail: medsafety@hpra.ie. Adverse events should also be reported to Biogen Idec (Ireland) Ltd. Tel: +353(0)1513 33 33: Email: Medinfo_biogen@quintiles.com

Reference:
1. Medicines Management Programme Best-Value Biological Medicines: Tumour Necrosis Factor-α Inhibitors on the High Tech Drug Scheme 2nd May 2019
2. BIOGEN Q2 2019 earnings presentation

† Medicines Management Programme

Biogen-22403 Date of Preparation August 2019 IE

▼ This medicinal product is subject to additional monitoring.

Biogen

'Posters of Distinction'
ISG Winter Meeting 21 November 2019

Abstract No.	Ref:	Title of Paper	Author
13	19W106	Transient Elastography (Fibroscan®) is unreliable at assessing liver disease stage in patients post Fontan procedure for congenital cardiac disease.	Niamh Mehigan
14	19W117	IBD Surveillance across Ireland: Dye-ing to know what you do	Grace Harkin
15	19W121	Initial Experience of Tofacitinib for the treatment of Moderate to Severe Ulcerative Colitis in the South Eastern Trust	Richard Howard
16	19W143	Familial, Environmental And Clinical Factors Affecting Progression To Colectomy In Children With Severe Ulcerative Colitis	Sarah Cooper
17	19W147	Is it worth repeating Capsule endoscopy (CE) in suspected small bowel bleeding?	Dr Sandeep Sihag
28	19W149	The burden of alcohol on hospital services: A single tertiary centre experience	Alan Marrinan
29	19W152	Trends in emergency liver transplantation for acute hepatic failure, a retrospective analysis	Paul Armstrong
20	19W166	Five years of EUS guided management of post-pancreatitis collections: the St James's Hospital experience	Susanne O'Reilly
21	19W167	Association between Adalimumab Drug levels, Faecal Calprotectin and Therapy-Related Adverse Events in an Inflammatory Bowel Disease Cohort	E.H.D. Wouda
22	19W168	No association between Post-inflammatory pseudopolyps and colorectal neoplasia in patients with Inflammatory Bowel Diseases.	Olga Fagan
23	19W171	The Safety and Efficacy of Endoscopic Mucosal Resection for Large and Intermediate Rectal Polyps Performed in an Irish University-Affiliated Hospital	Eilís McCarthy
24	19W182	Changes in Faecal Calprotectin levels during pregnancy in Non-IBD patients	Jayne Doherty

POSTERS OF DISTINCTION

ABSTRACT 13 (19W106)

Transient Elastography (Fibroscan®) is unreliable at assessing liver disease stage in patients post Fontan procedure for congenital cardiac disease.

Author(s)
Niamh Mehigan, Grace Harkin, Caroline Conlon, Stephen Stewart
Department(s)/Institutions
The Liver Centre, Mater Misericordiae University Hospital, Dublin 7.

Introduction
Fontan-related liver fibrosis occurs as a result of chronic liver congestion following the Fontan procedure for congenital heart disease. Some patients can develop cirrhosis, portal hypertension or hepatocellular carcinoma (HCC). The role of transient elastography (TE) in determining liver fibrosis stage has not been formally assessed in this cohort. It is known that TE can give false positive results in hepatic congestion.

Aims/Background
Our aim was to determine the prognostic value of liver stiffness score in predicting histologically confirmed fibrosis/cirrhosis in patients under investigation for Fontan-related liver disease.

Method
This was a retrospective cohort study of Fontan patients that had undergone a Fibroscan® and a liver biopsy. Data was analysed using GraphPad Instat.

Results
Of the 14 patients included, 50% were male. The median age was 28 (21-40) years. Liver was assessed a mean of 19 (8-39) years after the Fontan procedure was performed. The median liver stiffness measurement (LSM) was 17.6kPa (13-74.6kPa). 57% of patients had advanced fibrosis (F3-4 Metavir). There was no correlation between LSM and Metavir score ($p = 0.99$) or difference between LSM in those patients with or without advanced fibrosis (23 ± 10 v 27 ± 23; $p=0.68$).

Conclusions
Fibroscan® is unreliable at assessing liver disease stage in this cohort of patients. Liver biopsy is still required to select patients for HCC surveillance.

ABSTRACT 14 (19W117)

IBD Surveillance across Ireland: Dye-ing to know what you do

Author(s)
G Harkin, C Rowan, K Boland, G Harewood, J Ryan, D Cheriyan, S Patchett, A O'Toole
Department(s)/Institutions
Beaumont Hospital

Introduction
Inflammatory Bowel Disease (IBD) is associated with an increased risk of colorectal cancer. Guidelines recommend regular surveillance colonoscopy to detect polyps, dysplasia or early cancers. Chromoendoscopy with targeted biopsies is recommended as it is associated with improved dysplasia detection rates.

Aims/Background
Establish current practice in surveillance and the use of dye-spray chromoendoscopy in the Irish IBD cohort.

Method
A survey was distributed to gastroenterology consultants and registrars working in Ireland.

Results
Among the 47 respondents, 60% were male and 51% were consultant gastroenterologists. 62% percent had less than 10 years of endoscopy experience, whereas 31% had 11-25 years. Responses were identified from secondary and tertiary referral centers across Ireland. For 49%, greater than 50% of their practice involved IBD. Seventy percent typically surveil IBD patients where appropriate, whereas only 23% sometimes do. The majority at 72% follow ECCO guidelines, with 26% following the BSG and 2% follow AGA. During surveillance colonoscopy, 85% perform random biopsies. Among these endoscopists, the majority (58%) perform segmental biopsies, whereas the remainder perform serial biopsies every 10cm (32%) or right and left biopsies (11%). Ninety-three percent perform targeted biopsies, typically when a visible abnormality is seen. Among respondents 28% (n=12/43) use white light endoscopy alone whereas 58% (n=25/43) occasionally or sometimes do. Only 5% (n=2/43) typically preform chromoendoscopy whereas 44% (n=19/43) never do. Solutions used for chromoendoscopy varied but the majority at 52% (n=15/29) use indo-carmine 0.2%.

Conclusions
Currently, IBD surveillance practice varies considerably. Improved education may enhance the incorporation of guidelines into the standard of care.

ABSTRACT 15 (19W121)

Initial Experience of Tofacitinib for the treatment of Moderate to Severe Ulcerative Colitis in the South Eastern Trust.

Author(s)
R Howard, N Maybin, P Allen
Department(s)/Institutions
Gastroenterology Department, Ulster Hospital

Introduction
Tofacitinib has recently been approved by National Institute for Health and Care Excellence (NICE) as an option for treating moderate to severe Ulcerative Colitis (in adults) when conventional therapy or a biological agent cannot be tolerated or the disease has responded inadequately or lost response to treatment. It is the first oral, small molecule Janus Kinase inhibitor approved for treatment of UC.

Aims/Background
To review our initial experience using Tofacitinib in real world clinical setting. From December 2018 until August 2019 10 patients in the South Eastern trust have commenced Tofacitinib.

Method
We performed a retrospective analysis of patients using electronic care record and phone interview with patients to assess current Partial Mayo Score and assess for any adverse events.

Results
At time of submission our patients had been on Tofacitinib for cumulative duration of 48 months (range 2-9months). Three (30%) were in clinical remssion (Partial Mayo 0-1). 5 (50%) had clinical response (improvement of Partial Mayo by 3 points) Two (20%) patients required colectomy, Other than the two patients requiring surgery, the other 8 patients remained on Tofacitininb. There were no serious adverse events. There were no cases of pulmonary embolism

and no Herpes Zoster infections reported in our cohort.

Conclusions

Our initial experience of Tofacitinib has shown the drug to be well tolerated and with promising response rates. Potential benefits are early onset of action seen in Phase 3 trials and its oral route. More evidence is required to determine position of Tofacitinib in treatment of Ulcerative Colitis.

ABSTRACT 16 (19W143)

Familial, Environmental And Clinical Factors Affecting Progression To Colectomy In Children With Severe Ulcerative Colitis

Author(s)

S. Cooper1,2, I. Csizmadia1,2, L.P. Ekpotu1,2,3, K. O'Driscoll2, M. O'Connell2, J. Quinlan2, S. Kiernan2, M. McDermott4, M. O'Sullivan4, S. Quinn2, A. Broderick1,2,5, B. Bourke1,2,5, S. Hussey1,2,3,5, on behalf of the DOCHAS Study 1,2,3,5

Department(s)/Institutions

1 Children's Clinical Research Unit, National Children's Research Centre, Children's Health Ireland at Crumlin, Dublin, Ireland, 2 Department of Gastroenterology, Hepatology and Nutrition, Children's Health Ireland at Crumlin, Dublin, Ireland, 3 Department of Paediatrics, Royal College of Surgeons in Ireland, Dublin, Ireland, 4 Department of Histopathology, Children's Health Ireland at Crumlin, Dublin, Ireland. 5 Department of Paediatrics, University College Dublin, Dublin, Ireland,

Introduction

The incidence of paediatric inflammatory bowel disease (PIBD) including ulcerative colitis (UC) has increased significantly in Ireland over the last 20 years. A subset of children with ever severe (S1) UC will fail to respond to medical management and ultimately progress to colectomy. The reasons for this remain largely unknown.

Aims/Background

The aim of this study was to probe for risk factors for progressing to colectomy in children with S1 UC.

Method

Patients under investigation for PIBD were recruited to the DOCHAS (Determinants and Outcomes in Children and Adolescents with Inflammatory Bowel Disease) study in CHI at Crumlin between January 2012 and August 2018. Familial, environmental and clinical features at diagnosis were compared between patients with severe UC who progressed to colectomy versus those who were medically managed. Independent categorical variables were compared using Chi-squared analysis.

Results

830 patients were recruited, 85 (10.2%) of these were diagnosed with UC with a S1 phenotype of which 74 (87.1%, 39M) were managed medically and 11 (12.9%, 4M) progressed to colectomy. Urban dwelling (90.9% vs 47.3%, p= .009) and NSAID use (81.8% vs 52.7%, p= .04) was significantly higher in the colectomy versus medically managed group. Although significance was not reached, breastfeeding rates were lower in the colectomy versus medically managed group (36.4% vs 45.9%). No association was seen with age at diagnosis, gender, disease extent, family history of IBD or autoimmune disease, caesarean section delivery or smoking exposure.

Conclusions

Further examination of urban dwelling and NSAID effects is warranted. A larger population may yield more significant information on the impact of breastfeeding.

ABSTRACT 17 (19W147)

Is it worth repeating Capsule endoscopy (CE) in suspected small bowel bleeding?

Author(s)

Sihag S1, McCarthy E1, Semenov S1,2, M Syafiq Ismail1,2, Molloy D1, Ryan B1, O'Connor A1, Breslin N1, McNamara D1,2.

Department(s)/Institutions

Affiliations: 1. Department of Gastroenterology, Tallaght University Hospital. 2. TAGG Research Centre, School of Medicine, Trinity College Dublin.

Introduction

CE is now the primary investigation for small bowel (SB) bleeding. The utility of repeat CE in patients with ongoing concern of bleeding following initial investigation with CE is unclear.

Aims/Background

To review the yield of repeat CE with on-going concern of SB bleeding.

Method

Repeat CE procedures over 9 years for a suspicion of ongoing SB bleeding were identified from database. Patient's demographics, CE findings and additional investigations were recorded. Potential factors associated with improved yields were explored.

Results

339/3,735 (9%) had >1 CE. 152/339 (46%) for bleeding, male 86/152 (57%), mean age 63.9, range 18-92 years, mean CE's interval was 461 days (1 – 2576). Hemoglobin (Hb) was available in 81 (52%), low in 65 (80%), mean 11.1, SD 2.12. 1stCE findings: Normal 19 (13%), angiodysplasia 24 (16%), active bleeding unclear origin 30 (20%), inflammation 20 (13%), gastric abnormality 20 (13%), Incomplete/retained CE 33 (22%), other 6 (4%). 2nd CE completion rate was 96% (n=146) and overall yield was 55% (n=83). Positive or negative index CE did not influence the diagnostic yield of subsequent CE, 8/19 (42%) normal vs 75/133 (56%) abnormal, p =0.1. Patients with active bleeding or angiodysplasia were almost 3 times more likely to have a positive 2nd CE, (OR = 2.8, p = 0.004, CI 1.3-5.6). Older patients (>70) were also more likely to have a positive 2nd CE, OR 2.3, p=0.01, CI 1.17-4.45. Subjects with index retained/incomplete CE were more likely to have a subsequent incomplete study, OR 7, p = 0.01, CI 1.55 to 30.62.

Conclusions

Second look CE in obscure bleeding can be an effective clinical tool with a diagnostic yield of 55%. Along with clinical suspicion, older age and initial small bowel bleeding/vascular lesion are predictive of higher yield.

ABSTRACT 18 (19W149)

The burden of alcohol on hospital services: A single tertiary centre experience

Author(s)

Marrinan A (1), McKenna-Barry M (1), Gilligan E (2), Quirke M (3), Hiliary F (3), Clerkin P (4), Ryan Y (4), Houlihan P (3), MacHale S (2), Ryan JD (1)

Department(s)/Institutions

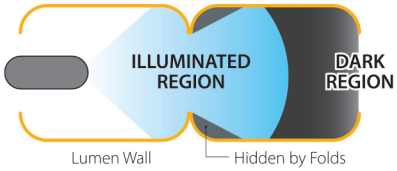
1. Hepatology Unit, Beaumont Hospital, Dublin 2. Psychiatry Department, Beaumont Hospital, Dublin 3. Emergency Department, Beaumont Hospital, Dublin 4. Medical Directorate, Beaumont Hospital, Dublin

Experience the 360º difference with the all-new CapsoCam® Plus

- 360 Panoramic Visualisation of the **Small Bowel**
- 15 hour battery life
- Smart Motion Sense – images captured only when in motion

- No data-recorder or belts required – wire-free technology
- Automatically adjusted light intensity

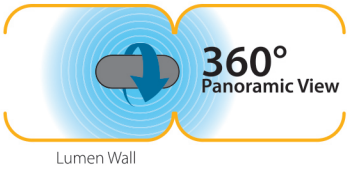
Disadvantages of an End-Facing Camera

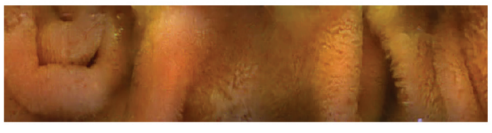


TUNNEL PATTERN
Limiting depth of view causes dark regions where it is hard to see.

WALL PATTERN
Capsule is pressed against wall resulting in very small region being captured.

CapsoCam® Plus Advantage





CapsoCam Plus 360º panoramic view of mucosa.

Ardmore Healthcare

info@ardmorehealthcare.com
www.ardmorehealthcare.com

Call our Sales Team today for more information or to arrange a demonstration on +44 (0)1494 721820

Introduction
In Ireland, 54% of adults drink alcohol at harmful levels. Alcohol costs the country €3.7 billion each year. Limited published data exists on the direct impact alcohol has on hospital services.
Aims/Background
This study examined clinical areas in a tertiary hospital where harm related to alcohol is apparent, to asses the associated cost and resource burden it imposes on the hospital
Method
Data on alcohol-related presentations to the Emergency Department were collected over a 9-month period (December 2018-August 2019). Data on alcohol-related adult admissions to hospital general wards (HIPE) and trauma admissions to Neurosurgery ICU (ICU Audit team) were obtained for 12 months (January 2018-2019). The hospital Finance department provided cost estimates.
Results
Between December 2018 and August 2019, 39,017 ED presentations were recorded, of which 4751 (12%) were deemed alcohol-related. This ranged from 29% in February 2019 to 5% in May 2019. During the 12-month period studied, alcohol-related inpatient admissions to the hospital amounted to 725 admissions; the average length of stay was 13.3 days. This equated to 9664 days, costing €8,146,752 for bed days used. Alcohol was a factor in 25/85 (29.4%) of trauma admissions to the Neurosurgery ICU (7% of total admissions); the average length of stay for alcohol-related trauma was 11 days. This equated to 284 days, costing €834,392 for bed days used.
Conclusions
This study highlights the detrimental impact that alcohol has on service provision and care across the hospital site. Funding to provide integrated alcohol care networks is urgently required to address this problem, and the strategies outlined in the Public Health (Alcohol) Bill must be prioritised.

ABSTRACT 19 (19W152)

Trends in emergency liver transplantation for acute hepatic failure, a retrospective analysis

Author(s)
Armstrong P, Gallagher A, Houlihan D
Department(s)/Institutions
Liver Transplant Unit, St. Vincent's University Hospital, Dublin 4
Introduction
Acute Liver Failure (ALF) is a rare condition resulting in the sudden loss of hepatic parenchyma and metabolic function. ALF is associated with a high mortality rate, and emergency orthotopic liver transplantation (OLT) is a necessary life-saving treatment. Paracetamol overdose is one of the most common indications for emergency liver transplant.
Aims/Background
OLT was first performed in St Vincent's University Hospital in 1993. In this study we examined if over our first two decades of practice we have seen trends in terms of mortality and indications for emergency liver transplant.
Method
We compared our first decade of practice to our second (1994-2003, 2004-2013) to assess short and long term survival measured at 1 and 5 years respectively. We also examined the numbers of emergency OLT for paracetamol overdose (POD) vs others. All statistical analysis was performed using SPSS v24. A Kaplan Meier survival curve was constructed to assess the primary outcome.
Results
We have seen a statistically significant increase in transplant for POD, p=.004 [CI .08-.64]. The trend towards improved survival as shown on a Kaplan Meier curve is promising however due to smaller numbers transplanted in the first decade we did not achieve statistical significance.
Conclusions
We are now performing more emergency liver transplants than before, with increasing numbers for POD.

ABSTRACT 20 (19W166)

Five years of EUS guided management of post-pancreatitis collections: the St James' Hospital experience

Author(s)
SM O'Reilly, F MacCarthy
Department(s)/Institutions
Department of Gastroenterology, St James' Hospital, Dublin 8
Introduction
Post pancreatitis collections are a potentially significant complication of acute pancreatitis. They can be associated significant post-acute morbidity & mortality, including mechanical problems such as gastric outlet or biliary obstruction or by secondary infection and frequently overwhelming sepsis. Transgastric or transduodenal endoscopic ultrasound-guided drainage, using a single-device, lumen-apposing, covered self-expanding metal stent (LAMS), where available is currently the preferred first treatment. We present our centre's experience with the use of LAMS for post pancreatitis collection management over the first five years of its use.
Aims/Background
Our aims were to review all patients who have undergone EUS-guided drainage of post pancreatitis collections, and their subsequent outcomes.
Method
Data from January 2016-August 2019 was retrospectively reviewed. Patient demographics, size of pseudocyst, date of procedure, insertion route, progress, date of removal, resolution of collection, complications and mortality were all recorded. Analysis was descriptive in nature.
Results
20 patients in total had a LAMS inserted during the study period (pseudocysts n=12, walled off necrosis (WON) n=7, perigastric collection n=1). Mean size of fluid collection was 79mm maximal diameter (median 74mm, rang 50-150mm). 19/20 cases were inserted via transgastric route, 1/20 was transduodenum. One patient had a 10x10mm Axios inserted, all others were 15x10mm. Mean number of days before removal was 49. WON patients had a longer length of insertion, and 2-6 gastroscopies for cavity lavage and necrosectomy prior to removal. One patient required a second LAMS insertion four weeks after the first for management of WON, as the first port did not allow complete access to the necrotic cavity. Use of the second point improved access and allowed removal of the first stent and rapid complete debridement. One patient required further drainage by interventional radiology. Two patients had acute bleeds at stent insertion, but haemostasis was quickly achieved using balloon dilatation, and expansion of the stent without further complication. One patient had a GI bleed post insertion, but this settled spontaneously. One stent was dislodged into the stomach lumen on the planned removal date, but was removed using a grasper and resulted in no complication. One patient had a buried LAMS as had not attended for removal, which had to be resected from within gastric wall endoscopically. One patient had a free perforation as caity not as well defined as appeared on imaging. This was managed

conservatively. In terms of mortality, there were no deaths at 30 days post procedure. One patient died eight weeks post insertion, from overwhelming sepsis. 1 year mortality was 5%. One patient had a recurrence of his pseudocyst upon recommencement of excessive alcohol use and recurrent pancreatitis. No patients to date have required repeat drainage

Conclusions

LAMS is an effective method of draining post pancreatitis collections. Our centre has experienced low rates of migration/dislodgement (5%), low rates of complications (10%) and 5% one year mortality. Neither surgery nor repeat endoscopic intervention has been required in any patient to date. These results are on a par with other centres internationally. The use of LAMS for management of this cohort of patients is important in reducing morbidity and mortality, and healthcare costs as well as improving quality of life post severe acute pancreatitis.

ABSTRACT 21 (19W167)

Association between Adalimumab Drug levels, Faecal Calprotectin and Therapy-Related Adverse Events in an Inflammatory Bowel Disease Cohort

Author(s)

E.H.D. Wouda, R Corcoran, J Doherty, M Healy, M McCormack, F MacCarthy, S McKiernan, K Hartery, D Kevans.

Department(s)/Institutions

Department of Gastroenterology, St James's Hospital, Dublin 8 School of Medicine, Trinity College Dublin Department of Biochemistry, St James's Hospital.

Introduction

Therapeutic drug monitoring of anti-tumour necrosis factor monoclonal antibodies is important in clinical practice. Adequate Adalimumab (ADA) drug concentrations are known to be associated with improved disease control.

Aims/Background

To audit our practice, we aimed to assess the association between ADA drug levels, faecal calprotectin (FC) concentrations and therapy-related adverse events.

Method

A cross-sectional study was undertaken on IBD patients receiving maintenance ADA therapy at a single academic centre. Serum samples were drawn during routine blood work collection. Baseline demographic data, FC values and information on therapy-related adverse events were collected. ADA levels were assayed using a commercial assay (Immundiagnostik). An elevated FC was defined as a FC concentration > 250 mcg / g. Association between ADA levels, FC concentration and treatment-related adverse events was evaluated. P values < 0.05 were considered significant in analyses.

Results

N=31 IBD patients were included. Median [range] age at study entry 39 years [16 - 58], 29% female, 90% Crohn's disease, median [range] disease duration 2.3 years (0.2 – 10.6). 17% of patients had prior biologic exposure and 20% had concomitant immunomodulator use. Median [range] ADA level was numerically higher in subjects with a normal versus elevated FC: 13.8 AU / ml [4 – 37.9] vs. 10.2 AU / ml [0.69 – 24.3] p=0.21. There was no association between ADA levels and therapy-related adverse effects adverse events (p=0.86).

Conclusions

Higher ADA drug levels are associated with a numerically increased likelihood of mucosal healing assessed by faecal calprotectin. Increased ADA drug levels do not appear to be associated with more frequent therapy-related adverse events.

ABSTRACT 22 (19W168)

No association between Post-inflammatory pseudopolyps and colorectal neoplasia in patients with Inflammatory Bowel Diseases.

Author(s)

Fagan O, Varley R, Wouda EHD, Mac Eoin N, McKiernan S, MacCarthy F, Kevans D, Hartery K.

Department(s)/Institutions

Department of Gastroenterology, St. James's Hospital, Dublin 8.

Introduction

Patients with longstanding inflammatory bowel disease (IBD) are at increased risk of development of colorectal dysplasia and cancer. Guidelines recommend surveillance colonoscopies at regular intervals. Post-inflammatory "pseudo"polyps (PIPs) are an endoscopic hallmark of previous severe inflammation. Current European guidelines advocate that their presence is used to risk stratify patients. Current published data is conflicting as to their association with advanced colorectal neoplasia (ACRN, high grade dysplasia or colorectal cancer).

Aims/Background

Our primary objective was to assess the occurrence of ACRN according to PIP status.

Method

Retrospective study of IBD patients who underwent colonoscopic surveillance, from January 1st, 2009 to December 31st, 2018, from an academic teaching hospital. Eligible IBD patients had confirmed colonic disease with duration of ≥8 years or any duration if diagnosis of primary sclerosing cholangitis and no history of ACRN or colectomy. Clinical data, endoscopy and histology reports were obtained from patient's electronic health record.

Results

Of the 568 eligible patients, 151 had PIPs (26.6%). No association was found patients with PIPs and ACRN (OR 1.67 [95% CI 0.39 – 7.08], p=0.49), occurring in 1.2% of patients with PIPs and 1.3% of those without. There was a significant association between patient with PIPs and colectomy (OR 2.37 [95% CI 1.11 – 5.06], p<0.03). Colectomy occurred in 9% (n=13) of patients with PIPs compared with 4% of those without (n=16).

Conclusions

This study further adds to growing evidence that endoscopic finding of PIPs are not associated with ACRN. This observation should be taken into account in development of future guidelines.

ABSTRACT 23 (19W171)

The Safety and Efficacy of Endoscopic Mucosal Resection for Large and Intermediate Rectal Polyps Performed in an Irish University-Affiliated Hospital

Author(s)

McCarthy E 1, Ryan E.J. 2, Griffin S 2, O'Riordan J 2, Ryan BM 1, O Connor A 1, Breslin N 1, McNamara D 1,3.

Department(s)/Institutions

1 Department of Gastroenterology, Tallaght University Hospital 2 Department of Colorectal Surgery, Tallaght University Hospital 3. TAGG Research Centre, School of Medicine, Trinity College Dublin

Introduction

EMR represents a safer alternative to surgical removal of large and intermediate rectal polyps and is recommended by the ESGE. R0 and en-bloc resections - associated with lower recurrence, perforation

rates <0.2% and bleeding in <1% are recommended.

Aims/Background

To determine the safety and efficacy of EMR for removal of rectal polyps

Method

EMR's for rectal polyps over 7 years were identified from a database. Demographics, indications, site and size of polyp, en-bloc or piecemeal, histological diagnosis, complications and recurrence rates were documented.

Results

285 rectal EMR's were performed over 87 months, mean age 62.3 years, mean size 9.15mm (range 2-50mm). Histology; 81% (n=233) adenomas, 8% (n=22) high grade dysplasia, 1% (n=3) malignant. En bloc resection was achieved in 86% (n=244), recurrence occurred in 4% (n=12). 179 polyps were <10mm and excluded from further analysis. 89 were 10-19mm - intermediate and 17 were >=20mm - large lesions. There was no difference in en bloc resection rates for large and Intermediate lesions, 13/17 (76%) versus 77/89 (86%). R0 resection was infrequently reported for Intermediate, 31/89 (34%) V's 14/17 (82%) large lesions, p=0.0004. Reported R0 resection rates were similar; 22/31 (70%) intermediate and large 9/14 (64%). Follow up colonoscopy was available in 92 (87%). Larger polyps were more likely to recur, 4/14 (40%) v's 2/78 (2.5%), OR 15, 95% CI 2.5 to 93.9, p=0.003. R0 resections were less likely to recur, 2/28 (7%) versus 4/11 (36%), p=0.03. Overall complication rate was 4.7% (n=4); all self-limiting bleeding not requiring transfusion or admission.

Conclusions

EMR is safe and efficacious for resection of large and intermediate rectal polyps. Higher recurrence rates with larger lesions warrants their careful selection and uptake of enhanced EMR techniques, such as pre-cutting EMR.

Lorraine Coady, Katarzyna Ryszka, Luxy Varghese, Dina Divinagracia

ABSTRACT 24 (19W182)

Changes in Faecal Calprotectin levels during pregnancy in Non-IBD patients

Author(s)

J Doherty, R Moore, C Kivlehan, P Twomey, F McAuliffe, G Cullen.

Department(s)/Institutions

Centre for Colorectal Disease, St Vincent's University Hospital and School of Medicine, University College Dublin, Ireland. UCD Obstetrics & Gynaecology, School of Medicine, University College Dublin, National Maternity Hospital, Dublin, Ireland.

Introduction

As of yet no optimal marker exists to assess the activity of IBD during pregnancy. Faecal calprotectin (FCP) is the most commonly used test to identify flares during pregnancy. For a test that is being widely used minimal data exists on the determinants of normal levels and trends during pregnancy in healthy individuals.

Aims/Background

To determine normal FCP levels during pregnancy and post-partum and whether levels change during pregnancy and post-partum in healthy individuals.

Method

We performed a prospective study analysis of FCP levels from pregnant women at 1 and 3months gestation and 1 and 3 months post-partum. Basic demographics were collected including age, medical history and smoking history. FCP concentrations were measured with a quantitative lateral flow assay.

Results

99 patients were included in our study. Median age was 34.00 years (22-44). 34 patients had samples analysed at 1month gestation, 21 from 3months gestation, 24 from 1month post-partum and 40 from 3months post partum. The median FCP levels from 1month gestation was 22.35(10-318), median level from 3months gestation was 30.80(10-216), from 1month post-partum was 29.50(10-204) and 3months post-partum was 24.60(10-259). There was no significant change in median levels over the course of pregnancy and post-partum (P = 0.294). Interestingly median FCP levels were normal at all time points however they were significantly higher in patients who were overweight and were ex-smokers.

Conclusions

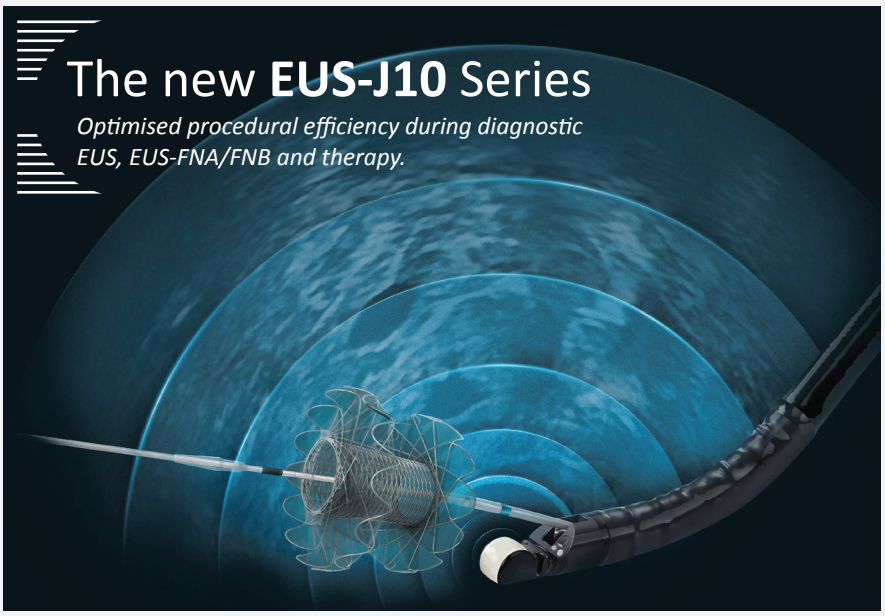
Faecal calprotectin levels are not affected by physiological changes in pregnancy or post-partum in normal healthy individuals without IBD. This confirms FCP is an effective tool for identifying flares of colitis in pregnancy. However, when using this tool, one should be aware that levels can be affected by a patients' smoking history and there weight.

Mrs Aileen Egan and Prof Larry Egan

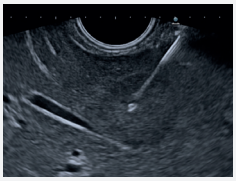
Explore the new PENTAX line-up

The new **EUS-J10** Series

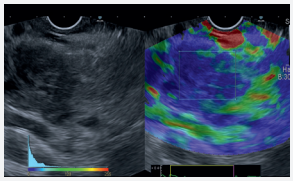
Optimised procedural efficiency during diagnostic EUS, EUS-FNA/FNB and therapy.



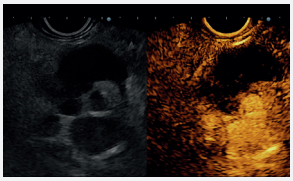
EUS-FNA/FNB
with clear needle visibility



Hitachi Real-Time Tissue Elastography
aids characterisation and targeting



Contrast Harmonic Imaging (CHI)
aids differential diagnosis and monitoring



TaeWoong Medical Niti-S™ SPAXUS™ Stent

EG-36-J10UR
The best ultrasound technology in a radial endoscope, designed for diagnosis.

EG-34-J10U
The unique combination of a slim design in a linear ultrasound endoscope for day-to-day diagnostic EUS and EUS-FNA.

EG-38-J10UT
For expanded therapeutic capabilities with an enlarged 4.0 mm working channel to advance EUS-guided intervention.

EB19-J10U
The ultrasound video bronchoscope featuring crystal clear imaging to improve diagnostic outcomes.

Learn more www.eus-j10.com

PENTAX MEDICAL

DEC™ Video Duodenoscope ED34-i10T2

Lock in. Elevate your care.

Disposable Elevator Cap (DEC™) allows simplified reprocessing and increased cleaning capability.

Setting the new standard in **ERCP**

New Elevator Every Time

35%
reduction in steps for distal end reprocessing* in comparison to the standard duodenoscopes of the major manufacturers. Source: PENTAX Medical internal benchmarking.

The PENTAX Medical solution
The innovative design of the PENTAX Medical DEC Duodenoscope introduces a unique solution in the market and simplifies the overall reprocessing process.

Distal end with open access incorporating single use elevator
The DEC™ Duodenoscope distal end, a crucial element for the prevention of patient infection, has been designed to offer easier access for brushing.

PENTAX MEDICAL

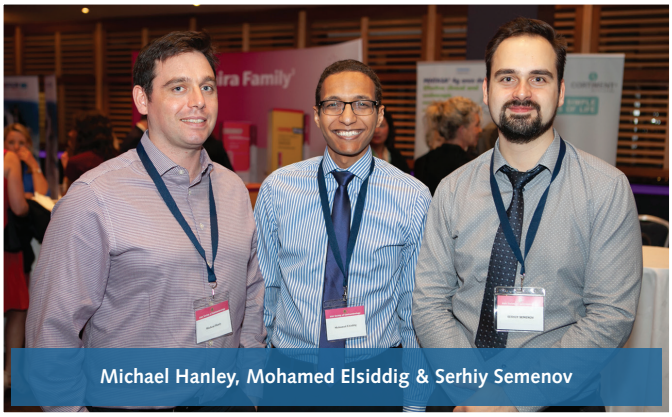
Sword Medical
ADVANCED HEALTHCARE SOLUTIONS

Sword Medical, Unit 4, Block 4B, Blanchardstown Corporate Park, Blanchardstown, Dublin D15 FR52
W: www.swordmedical.ie | **E:** info@swordmedical.ie | **Sales:** 353 (0)1 8242700 | **Service:** 353 (0)1 8242701

Summer Meeting 2019

Dr Tony Tham Incoming ISG President and
Prof Larry Egan Outgoing ISG President

Prof Padraic MacMathuna



Michael Hanley, Mohamed Elsiddig & Serhiy Semenov

Susanne O'Reilly, Orla Smith, Fiona Jones,
Lakshman Kumar & Jayne Doherty

POSTER PRESENTATIONS

ABSTRACT 25 (19W101)

Optimisation of Percutaneous Endoscopic Gastrostomy (PEG) Tube placement

Author(s)
Thomas Cronin
Department(s)/Institutions
Newcastle University

Introduction
Percutaneous endoscopic gastrostomy (PEG) feeding is an effective way of providing enteral nutrition to patients who have functionally normal gastrointestinal tracts but who cannot meet their dietary requirements because of inadequate oral ingestion. Gastrostomy tubes are increasingly being requested and inserted for indications where long term outcomes are uncertain.

Aims/Background
To investigate indications and complications within the department's PEG placement service.

Method
Data were collected from all patients who underwent a PEG placement over a one year period. Using EndoSoft and hospital electronic patient records the following data were extracted to a pre-formed anonymised Excel spreadsheet: patient age, indication for procedure, antibiotic administration, satisfactory PEG placement confirmed, complications and where applicable length of survival following PEG placement.

Results
A total of 81 PEG procedures were carried out. The mean age of insertion was 74 years (range 37-94 years). The most frequent indications were stroke (54%), and Parkinson's disease and related disorders (10%). Nineteen (23%) patients experienced a complication. On all occasions this related to an infection; pneumonia or localised skin infection around the PEG site. In 9% of cases, mortality was identified within the first month following PEG placement.

Conclusions
Patients who undergo PEG insertion can represent a high-risk patient group with often significant co-morbidity. In this department, a comprehensive assessment proforma for PEG requests has been devised. This includes identification of patient risk factors, and multi-disciplinary healthcare team and patient/family perspectives to ensure appropriate patient selection and optimisation prior to PEG procedure.

Prof Larry Egan and David Johnston. Case Poster Winner

ABSTRACT 26 (19W104)

The Readability Of Medication Information Sheets In Commonly Used Medications In Inflammatory Bowel Disease

Author(s)
H. Kerr, C. Moran, A. O'Toole
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Dublin 9

Introduction
Medication information sheets (MIS) are a widely used resource that facilitate patient education. They contain important information such as directions for use, warnings and side effects. Several studies have shown the readability of medication information sheets (MIS) of medications used in the management of chronic diseases to be above the level recommended for health related information. This can negatively impact adherence to medications. Our study aimed to assess the readability of MIS for 31 medications commonly prescribed to Inflammatory Bowel Disease (IBD) patients.

Aims/Background
Our aim was to assess the readability of MIS available online of medications commonly used in inflammatory bowel disease (IBD).

Method
Google search engine identified MIS of 31 medications used in the treatment of IBD. The medications assessed included biological agents, aminosalicylate drugs, immunomodulators, bone protection agents, venous thromboembolism prophylactic medications and antibiotics. The readability of MIS was assessed by determining the Flesch reading ease (FRE) and Flesch-Kinkaid grade level (FGL) on Microsoft Word.

Results
31 MIS were analysed. The Flesch reading ease (FRE) ranged from 23.5 to 62.1 (mean 43, standard deviation 11). Flesch-Kinkaid grade leve (FGL) was above 7th grade level in all 31 MIS, ranging from 7.7 to 17.7 (mean 11.5, standard deviation 2.5).

Conclusions
FRE and FGL were above the recommended reading level in all MIS of selected medications. This is a potential barrier to informed decision making for patients with IBD. We recommend that all MIS for patients with IBD are at an appropriate reading level.

ABSTRACT 27 (19W108)

The Impact of a Nurse-led Pre-assessment Service on Endoscopy Waiting Lists: A Single-centre Pilot Study

Author(s)
Orla Smith
Department(s)/Institutions
Centre for Colorectal Disease, St. Vincent's University Hospital, Elm Park, Dublin 4

Introduction
The demand for endoscopy services continues to increase each year leading to lengthy waiting lists. Patients failing to attend for their scheduled procedure, so-called "DNAs", lengthen waiting lists further. Other factors such as inadequate bowel preparation and failure to withhold anticoagulants can lead to further delays. Pre-assessment of endoscopy patients has the potential to limit these issues.

Aims/Background
To assess the impact of a pre-assessment service on endoscopy waiting lists.
Method
A nurse-led pre-assessment service was introduced in St. Vincent's University Hospital endoscopy department from Feb 2019- end of August 2019 for 2x weekly endoscopy lists. A pre-assessment nurse telephoned patients one week prior to their procedure to clarify instructions re bowel preparation and medications. DNA rates following pre-assessment were compared to the 7 month period prior to the introduction of pre-assessment. 100 patients received a questionnaire on the day of their procedure for feedback on the pre-assessment service.
Results
DNA rate improved from 99/906 (11%) to 53/962 (6%). 149 patients cancelled their appointment during the pre-assessment phone call. In the feedback data, 88% had questions regarding fasting and 66% regarding bowel preparation despite posted instructions. 40/909 patients were on anticoagulation and required advice for same. 49/909 patients were diabetic and also required advice.
Conclusions
A significant reduction in DNA numbers was observed following the introduction of pre-assessment. Patient feedback showed the majority found the pre-assessment call helpful and encouraged them to attend their appointment.

ABSTRACT 28 (19W109)

Audit and Review of Infliximab therapeutic drug monitoring in Inflammatiory Bowel Disease(IBD) in Mayo University Hospital.

Author(s)
Akhtar, Hassan Ahmed,Aftab Egan,Brian O'Donnell,Luke Petrie,Arthur
Department(s)/Institutions
Department of Gastroenterology, Mayo University Hospital, castlebar,Co.Mayo
Introduction
This is a retrospective audit of Inflammatory Bowel Disease(IBD) Patients currently on Infliximab enrolled between 2014 & 2019 in Mayo University Hospital,castlebar.Co.Mayo
Aims/Background
Infliximab(IFX) is a monoclonal antibody against TNF-Alpha which is implicated in the inflammatory response of IBD. Loss of response(LOR) has emerged as a major concern recently. Therapeutic drug monitoring(TDM) has been proposed as a way of identifying patients at risk of LOR,as it is assoctaed with sub-therapeutic infliximab levels and presence of antibodies to Infliximab(IFX-ATIs).
Method
Objectives of this study were to audit whether all IBD patients on Infliximab had TDM at the end of IFX induction(i.e, Fourt Infusion).
Results
Fourty-One IBD patients were initiated on Infliximab between 2014 and 2019. 38 patients were included in the study. 3 patients were excluded because they have not completed their induction period(i.e, Four infusions) Infliximab TDM was done in 07/38 (3%) patients at the end of induction(Fourth INF Infusion). Three patients acheived therapeutic levels(4-8 mg/l).Four patients had sub-therapeutic levels at the end of induction.Infliximab Antibodies were detected in 3 patients and they also had sub-therapeutic Infliximab levels.
Conclusions
Our results demonstrate that TDM is helpfull in identifying patients at risk of loss of response(LOR). Given the low number of patients having had their therapeutic levels checked at the end of induction,suggestion was given to introduce virtual clinic for regular monitoring and follow-up of IBD patients started on biologic therapies.

ABSTRACT 29 (19W110)

Simethicone clears the way for capsules

Author(s)
Douglas A.R1, Sihag S1, Semenov S1, Ryan B2, O'Connor A2, Breslin N2, McNamara D.1, 2
Department(s)/Institutions
Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin, Dublin, Ireland, 2 Department of Gastroenterology, Tallaght University Hospital, Tallaght, Dublin 24, Ireland
Introduction
Capsule endoscopy is a useful test for small bowel (SB) disease. Image quality as with all endoscopic tests can vary; Simethicone has been recommended to improve image quality by the ESGE but is not routinely used in our practice.
Aims/Background
To assess the impact of Simethicone addition on capsule quality
Method
A prospective uncontrolled pilot study. Consecutive patients were given 100mg of Simethicone (Wind-Eze) over 2 months in accordance with ESGE recommendations. Cases were compared to matched controls from our capsule endoscopy (CE) database. Outcome measures were reported image quality, completion rates and diagnostic yield. Groups were compared using Chi-2 test, $P<0.05$ was considered significant.
Results
96 capsules were reviewed, 32 cases and 64 controls. The mean age was 52yrs (range 18-86) and 42 (44%) were males. Indications were Iron Deficiency Anaemia (IDA) 40% (n=38), Crohn's disease (CD) 35% (n=34) and others 25% (n=24); there was no difference between groups P=0.9. Image quality did not differ between cases and controls being good/excellent in 11/32 (34%) vs 23/64 (36%) respectively, P=0.5. Diagnostic yield was also similar between groups, 16/32 (50%) vs 36/64 (56%). However, completion rates were higher in the Simethicone group, 59/64 (92%) vs 100%, P=0.03. Of note, there were no reported side effects.
Conclusions
Similar to international results, Simethicone did not improve overall diagnostic yield. Unlike previous studies we found no improvement in image quality. However, the improved completion rates possibly due to less friction and air pockets; thus improving transit warrants further investigation.

The HUMIRA Family[3]

PRESCRIBING INFORMATION

Humira (adalimumab) 20mg and 40mg solution for injection in pre-filled syringe, Humira 40mg and 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 or 0.4 ml pre-filled syringe 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 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 Patient Reminder 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

HUMIRA®
adalimumab

destination you™

Currently used by just under *1. 2 million* patients worldwide[2]

***14* indications*[3]**

A future built on *experience*

Write Humira^[4,5]**

* Please see the SmPC for full dosing and indication details.
EOW = Every Other Week / EW = Every Week
^Brand name should be used if the prescribed product is a biologic medicine
Further information is available upon request from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, D24 XN32
Full prescribing information is available on www.medicines.ie
Legal Category: POM (S1A)

References
1. Burmester GR. et al Ann Rheum Dis. 2009; 68(12): 1863 – 1869
2. AbbVie Data on File REF – 36948
3. HUMIRA SmPC. Available on www.medicines.ie
4. Commission implementing directive 2012/52/EU of 20 December 2012
5. Medicinal Products (Prescription and Control of Supply) (Amendment) (No.2) Regulations 2014. SI No. 504 2014

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 tapered in accordance with clinical practice starting two weeks after initiating treatment with Humira. Evaluate on a yearly basis the benefit and risk of continued long-term treatment.

Paediatric Uveitis, 2 years 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 nonmelanoma 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 dysplasia or colon cancer is unknown. Patients with UC, history of dysplasia or colon carcinoma 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 (S1A).

Marketing Authorisation Numbers: EU/1/03/256/022, EU/1/03/256/013, EU/1/03/256/017, 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: October 2018, PI/256/024

Date of preparation: July 2019, IE-HUM-190030

ABSTRACT 30 (19W111)

Inpatient Colonosocopy – Should the answer always be no?

Author(s)
L McCann, D Storan, F Zeb, G Courtney, A Aftab
Department(s)/Institutions
Department of Gastroenterology, St. Luke's Hospital, Kilkenny

Introduction
Colonoscopies performed on inpatient cohorts are associated with worse bowel preparation than outpatient procedures potentially reducing diagnostic yield. As a result they are often deferred and patients placed on lengthy outpatient waiting lists which could lead to delayed diagnosis.

Aims/Background
To assess the indications, quality markers and diagnostic yield for inpatient colonoscopies.

Method
Inpatient colonoscopies performed from October 2018-Jan 2019 were included. Data was extracted from the electronic endoscopy reporting software.

Results
62 colonoscopies were performed on 56 patients. Mean age was 62. Rectal bleeding was the most common indication (n=23, 37%), followed by abdominal pain (24%), anaemia (19%), abnormal radiology (19%) diarrhoea (10%) and constipation (6%). Physician assessment of bowel preparation was Excellent/Good in 4 patients (6%), Adequate/Satisfactory in 63%, and Poor in 31%. Caecal intubation rate was 77%. Colorectal cancer (CRC) was detected in 7 patients (13%), polyps in 26%, haemorrhoids in 21% and colitis in 9%. 32% were reported as normal (including diverticulosis). CRC was identified in those with abnormal radiology, PR bleeding and anaemia.

Conclusions
Inpatient colonoscopies failed to meet key quality markers for bowel preparation (excellent/adequate in ≥90%) and caecal intubation (≥90%). Despite this, diagnostic yield for both polyps and CRC was high, with polyp detection rate above target (ADR >25%) and the cancer detection rate of 13% double that of the 1st round of BowelScreen, the national colorectal cancer screening programme. These findings suggest that inpatient colonoscopy is an important diagnostic tool.

ABSTRACT 31 (19W112)

Haematinics Assessment Prior to Red Cell Transfusion: How good are we?

Author(s)
Foley C., Connerton A., Ryan JD.
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Beaumont, Dublin 9. Blood Transfusion Service Beaumont Hospital Hepatology Unit, Beaumont Hospital

Introduction
The types and causes of anaemia are multiple. The measurement of haematinics is a vital step in evaluating a patient with anaemia, as different aetiologies of anaemia require specific investigation and treatment. A basic haematinic screen comprises of iron studies, ferritin, vitamin B12 and folate. Failure to determine the type of anaemia prior to correction of haemoglobin leads to an inability to appropriately investigate the cause. In particular, iron deficiency can indicate an underlying gastrointestinal malignancy, and should prompt endoscopy if detected in the appropriate setting. Moreover, deciphering the underlying cause allows the appropriate use of supplementation or blood products which are in limited supply, costly, and have potential side effects.

Aims/Background
Our aim was to retrospectively assess whether haematinic screeens were completed in patients prior to receiving red cell transfusions. The secondary aim of this study was to assess whether red cell transfusion therapy was indicated in keeping with current World Health Organisation (WHO) practice guidelines; • Hb <8g/dL for patient undergoing cardiovascular surgery, orthopaedic surgery or acute GI bleeding. • Chronic anaemia: <7g/dL • Acute blood loss: >30% of volume of blood.

Method
Red cell transfusion data for the month of July 2019 was obtained from the blood transfusion service in Beaumont Hospital. Laboratory results were reviewed for these patients over this time period to assess whether a haematinic screen was completed prior to transfusion.

Results
A total of 289 patients received red cell transfusion therapy in July 2019. haematinics were assessed in 37.7% of these patients (n=109/289). 39% of these patients (n=114/289) received red cell transfusions outside of practice guideline indications.

Conclusions
Failure to screen for haematinics prior to red cell transfusion appears common. We propose to provide an education session regarding hemotinic screening and red cell transfusion indications. Subsequently we plan to re-audit our hemotinic screening practices to ensure iron deficiency anaemia and the potential risks associated with same are not being missed.

ABSTRACT 32 (19W113)

Defining Gastrointestinal Transit Time Using Video Capsule Endoscopy: A Study Of Healthy Controls

Author(s)
John O'Grady, Clodagh L. Murphy, Lillian Barry, Fergus Shanahan, Martin Buckley
Department(s)/Institutions
University College Cork, Cork, Ireland Mercy University Hospital, Cork, Ireland

Introduction
Determining the aetiology and location of gastrointestinal motility disorders can be challenging. A range of investigations targeting specific areas of gastrointestinal transit are available, but many provide clinical data for a given gastrointestinal region alone or for non-specific whole gut transit, and are otherwise of limited use. Video capsule endoscopy allows endoscopic visualisation of the entire gastrointestinal tract, and may also provide more specific data for regional transit time abnormalities.

Aims/Background
To determine gastric and small bowel transit times, in the fasting state, among ambulatory healthy controls.

Method
Video capsule data, ingested by 71 ambulatory healthy controls, were recorded and analysed to determine gastric and small bowel transit times in the fasting state.

Results
Median, and interquartile range (IQR), gastric transit time was 22 (10- 48) minutes, and median (IQR) small bowel transit time was 198.5 (157-240.5) minutes.
Conclusions
These data, for the first time to our knowledge, provide references for gastrointestinal transit times among healthy ambulatory subjects using capsule endoscopy. This potentially strengthens the clinical use of video capsule endoscopy in the investigation of patients with suspected gastrointestinal motility disorders.

ABSTRACT 33 (19W114)

Time to OGD in Upper Gastrointestinal Haemorrhage

Author(s)
TJ Matthews, A Fennessy, B Ryan, S Anwar
Department(s)/Institutions
Department of Gastroenterology, Tallaght University Hospital, Dublin
Introduction
We analysed admissions via the Emergency Department with a diagnosis of upper gastrointestinal (UGI) haemorrhage.
Aims/Background
We aimed to analyse time to oesophagogastroduodenoscopy (OGD) and its relationship with predictors of UGI haemorrhage severity.
Method
A query of the ED database for referrals with principal diagnoses of haematemesis, bleeding PR, or GI bleed upper / lower over the period 01/01/2017 to 31/12/2018 returned 417 attendances. This dataset was cross referenced with 8453 OGDs returned from the endoscopy database over the period 01/01/2017 to 07/07/2019. A partial Rockall Score was calculated based on age, systolic blood pressure and heart rate at triage. Information on co-morbidities was unavailable. Multivariate analysis determined the relationships of arrival mode and a partial Rockall Score with the number of hours until inpatient OGD.
Results
Inpatients waited an average of 3.4 days. 16% of inpatients were scoped within 24 hours. Multivariate analysis demonstrated no significant relationship between arrival mode (p=0.24), Rockall Score (p=0.54) and hours until inpatient OGD.
Conclusions
European Society of Gastrointestinal Endoscopy guidelines recommend early (≤ 24 hours) OGD. Just 16% of the studied population underwent endoscopy within this timeframe. Given the predictable frequency of bleed presentations, institution of a pathway and reservation of inpatient slots might improve the percentage scoped within 24 hours. A partial Rockall score bore no relationship with the number of hours to inpatient OGD. A very small number of emergent bleeds scoped out-of-hours in theatre were excluded and may explain some findings. However, other criteria, such as list availability, likely have a role.

ABSTRACT 34 (19W115)

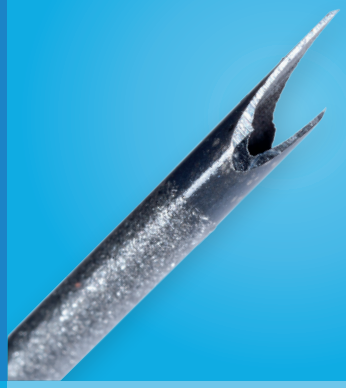
Addressing metabolic health in inflammatory bowel disease

Author(s)
John O'Grady, Fergus Shanahan, Syed Akbar Zulquernain
Department(s)/Institutions
Cork University Hospital University College Cork
Introduction
The traditional view of patients with inflammatory bowel disease (IBD) is that of underweight and malnutrition. This is, however, at odds with what is seen in the waiting room of a modern outpatient clinic for patients with IBD. Here, one will note predominantly robust, well- nourished and often overweight patients. In a systematic review, low body mass index (BMI) was seen in just 37% of patients with Crohns disease (CD) and 20% with Ulcerative colitis (UC), and obese BMI in 33% of all IBD cohorts.
Aims/Background
Our aim was to review the BMI of patients attending the IBD outpatient clinic at Cork University Hospital (CUH), the sole source of IBD care for these patients.
Method
Patient charts were reviewed on the day of clinic attendance and current BMI, demographic and IBD characteristics were recorded.
Results
267 patients were analysed, of which 131 were male and 136 female. The median age was 43 years (interquartile range 35- 54 years). 164 of the patients had confirmed Crohn's disease, 99 confirmed ulcerative colitis, with 4 indeterminate IBD. The mean BMI was 26.7 kg/m2 (standard deviation (SD) ± 4.9). For those with Crohn's disease the mean BMI was 26.8 kg/m2 (SD ± 5.38), and for ulcerative colitis the mean BMI was 26.7 kg/m2 (SD ± 4.17). The mean BMI of each group based on treatment received were also all above normal BMI reference range.
Conclusions
None of the different patient groups in this review had a mean BMI in the normal range (defined as 18.5- 25 kg/m2). Current trends for overweight and obesity seen among the general population (5) are also being reflected in IBD clinics. In addition, the mean BMI is higher than expected among this group of patients. Perhaps inflammation associated with metabolic syndrome and obesity contributes to inflammation and the need for treatment escalation in IBD. The need to effectively manage the malnutrition of overweight, obesity and the metabolic syndrome among patients with IBD now appears to be as important as nutritional support for underweight patients. Key recommendations from this review include incorporating weight loss strategies with evidence-based dietary and exercise advice, as well as monitoring metabolic health parameters as part of routine care for patients with IBD.

TAKING GI CARE FURTHER, TOGETHER

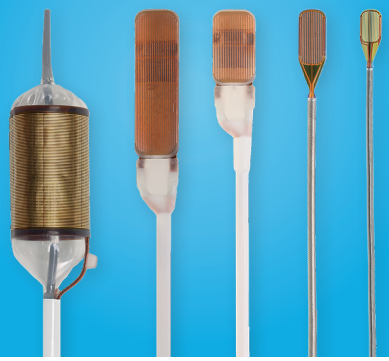
PillCam™
SB 3 capsule

SharkCore™
FNB Needle



Endoflip™
Impedance Planimetry System

Barrx™
RFA System



Beacon™
EUS Delivery System

19-weu-irish-society-of-gastroenterology-meeting-3152188

medtronic.com/covidien/en-gb/index.html

Medtronic
Further, Together

Summer Meeting 2019

The Panel - Prof Frank Murray, Prof Garry Courtney, Dr Tony Tham, Dr Fiona Jones, Dr Jan Leyden, Prof Glen Doherty

Jayne Doherty, Susanne O'Reilly, Annie Coe & Orla Smith

Prof Deirdre McNamara

Prof Colm O'Morain

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

At home they are still at risk;

...TARGAXAN® rifaximin-α reduces the risk of recurrence of overt hepatic encephalopathy.[2]

Targaxan® 550

Rifaximin-α

Long-term secondary prophylaxis in hepatic encephalopathy (HE)[3]

UK&IE Prescribing Information: Targaxan 550mg (rifaximin-α)
REFER TO FULL SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING
Presentation: Film-coated tablet containing rifaximin 550 mg.
Uses: Targaxan is indicated for the reduction in recurrence of episodes of overt hepatic encephalopathy in patients ≥ 18 years of age.
Dosage and administration: Adults 18 years of age and over: 550 mg twice daily, with a glass of water, with or without food for up to 6 months. Treatment beyond 6 months should be based on risk benefit balance including those associated with the progression of the patients hepatic dysfunction. No dosage changes are necessary in the elderly or those with hepatic insufficiency. Use with caution in patients with renal impairment.
Contraindications: Contraindicated in hypersensitivity to rifaximin, rifamycin-derivatives or to any of the excipients and in cases of intestinal obstruction.
Warnings and precautions for use: The potential association of rifaximin treatment with *Clostridium difficile* associated diarrhoea and pseudomembranous colitis cannot be ruled out. The administration of rifaximin with other rifamycins is not recommended. Rifaximin may cause a reddish discolouration of the urine. Use with caution in patients with severe (Child-Pugh C) hepatic impairment and in patients with MELD (Model for End-Stage Liver Disease) score > 25. In hepatic impaired patients, rifaximin may decrease the exposure of concomitantly administered CYP3A4 substrates (e.g. warfarin, antiepileptics, antiarrhythmics, oral contraceptives). Both decreases and increases in international normalized ratio (in some cases with bleeding events) have been reported in patients maintained on warfarin and prescribed rifaximin. If co-administration is necessary, the international normalized ratio should be carefully monitored with the addition or withdrawal of treatment with rifaximin. Adjustments in the dose of oral anticoagulants may be necessary to maintain the desired level of anticoagulation. Ciclosporin may increase the rifaximin C_{max}
Pregnancy and lactation: Rifaximin is not recommended during pregnancy. The benefits of rifaximin treatment should be assessed against the need to continue breastfeeding.
Side effects: Common effects reported in clinical trials are dizziness, headache, depression, dyspnoea, upper abdominal pain, abdominal distension, diarrhoea, nausea, vomiting, ascites, rashes, pruritus, muscle spasms, arthralgia and peripheral oedema. Other effects that have been reported include: Clostridial infections, urinary tract infections, candidiasis, pneumonia cellulitis, upper respiratory tract infection and rhinitis. Blood disorders (e.g. anaemia, thrombocytopenia). Anaphylactic reactions, angioedemas, hypersensitivity. Anorexia, hyperkalaemia and dehydration. Confusion, sleep disorders, balance disorders, convulsions, hypoesthesia, memory impairment and attention disorders. Hypotension, hypertension and fainting. Hot flushes. Breathing difficulty, pleural effusion, COPD. Gastrointestinal disorders and skin reactions. Liver function test abnormalities. Dysuria, pollakiuria and proteinuria. Oedema. Pyrexia. INR abnormalities. Prescribers should consult the SmPC in relation to all adverse reactions.
UNITED KINGDOM
Legal category: POM
Cost: Basic NHS price £259.23 for 56 tablets
Marketing Authorisation holder: Norgine Pharmaceuticals Limited, Norgine House, Widewater Place, Moorhall Road, Harefield, Uxbridge, UB9 6NS, UK
Marketing Authorisation number: PL 20011/0020
IRELAND
Legal category: Prescription only
Cost: €262.41 for 56 tablets
Marketing Authorisation holder: Norgine B.V. Antonio Vivaldistraat 150, 1083 HP, Amsterdam, Netherlands
Marketing Authorisation number: PA 1336/009/001
For further information contact: Norgine Pharmaceuticals Limited, Norgine House, Moorhall Road, Harefield, Middlesex UB9 6NS
Telephone: 01895 826 606 E-mail: Medinfo@norgine.com
Ref: UK/XIF5/0519/0509
Date of preparation: May 2019

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: Tel. +44 (0)1895 826 606 Email Medinfo@norgine.com

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 Ltd on: Tel. +44 (0)1895 826 606 Email Medinfo@norgine.com

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 Available for Ireland from: www.medicines.ie
3. Mullen KD, *et al.* Clin Gastroenterol Hepatol 2014;12(8):1390-97.

UK/XIF5/0919/0549
Date of preparation: October 2019.

NORGINE
Partner for a healthy life

ABSTRACT 35 (19W116)

Bowel Preparation for Inpatient Colonoscopy at Naas General Hospital: Audit of Adherence to Gastrointestinal Endoscopy National Quality Improvement Programme Guidelines

Author(s)
M Elsiddig (1), SJ O'Connor, A Whelan (2), I Cretu (1)
Department(s)/Institutions
(1) Naas General Hospital (2) Graduate Entry Medical School, University of Limerick
Introduction
It has been documented that inpatient colonoscopy can be more challenging than outpatient colonoscopy, with poorer quality of bowel preparation and reduced rates of successful completion of the procedure.
Aims/Background
This audit aimed to investigate the quality of bowel preparation for, and success rate of, inpatient colonoscopy at Naas General Hospital.
Method
All patients undergoing inpatient colonoscopy at NGH between 1st June 2018 and 1st June 2019 were identified retrospectively. Endoscopy reports were obtained using EndoRAAD software. Successful colonoscopy was defined as intubation of the caecum with satisfactory bowel preparation as per 'Guidelines for the Implementation of a National Quality Improvement Programme in GI Endoscopy'. A further group of patients undergoing outpatient colonoscopy during the same time period were identified for comparison purposes.
Results
112 individuals were identified as having undergone inpatient colonoscopy, representing 5.4% of all procedures performed during this period. One-third (33%) were completed due to "unexplained anaemia", 15% due to "rectal bleeding", 14% due to "abdominal pain" with several other indications making up the remainder. Only 49.1% (55/112) of inpatient bowel preparation was rated by the endoscopist as satisfactory, compared with 90% of outpatient bowel preparation for the same period.
Conclusions
This audit demonstrated that the quality of inpatient colonoscopy falls short of the recommended standard for endoscopic procedures. The reasons for this are likely complex and multifactorial but may include reduced mobility and poorer adherence to bowel preparation and oral hydration. Deferring colonoscopy until after discharge from hospital is therefore advised whenever the indication for the procedure allows.

ABSTRACT 36 (19W118)

Are we CLOsing the circle?

Author(s)
Ms. Sarah Sloan, Medical Student Dr. Maire Buckley, Consultant Gatroenterologist
Department(s)/Institutions
St. Michael's Hospital, Dun Laoghaire, Co. Dublin
Introduction
A Campylobacter-Like Organism test (CLO-test) is a rapid urease test performed during Endoscopy to detect the presence of Helicobacter pylori (H.Pylori) infection. Although not associated with symptoms in many of those infected, H. Pylori can cause Gastritis, Peptic Ulcer Disease, Gastric Adenocarcinoma, Maltoma and Iron Deficiency Anaemia and is associated with Immune Thrombocytopaenia. All symptomatic patients should be tested for the presence of HP, and treated if present. Post-eradication testing should be performed at least four weeks after completion of therapy. A Carbon Urease Breath Test (CUBT) is considered the best method for confirmation of HP clearance.
Aims/Background
A weekly CUBT clinic is held in St Michael's Hospital. This audit was undertaken to determine if CLO-test positive patients are being followed up to check eradication as recommended.
Method
All patients who have a CLO-test performed in SMH are recorded, as well as the result. A retrospective audit of all patients with a positive CLO-test from 01/04/17 – 04/04/18 was undertaken. Evidence of follow-up was indicated by the presence of either a repeat endoscopy with CLO-test or a CUBT appointment.
Results
169 patients had a positive CLO-test during the audit time-frame. 9 patients were excluded, as treatment was deferred. 160 charts were reviewed. Overall 63 patients (39%) were referred for follow-up HP testing. Of these, 34/34 (100%) of Gastroenterology patients were followed up and 29/126 (23%) patients from non-Gastroenterology endoscopists.
Conclusions
: This audit showed a low rate of follow-up overall. It is important to raise awareness among all endoscopists that follow up should be performed. CUBT is available on-site in St Michael's Hospital and this presents an excellent opportunity to improve referral rates.

ABSTRACT 37 (19W120)

Mortality and Readmission Rate following Endoscopy Procedures

Author(s)
H. Kerr, E. Bradley, D. Cheriyan
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Dublin
Introduction
Endoscopy units are required to report 8-day readmission and 30-day mortality rates following Gastrointestinal (GI) endoscopic procedures as per the Joint Advisory Group (JAG) accreditation process.
Aims/Background
To determine the number and type of complications resulting in the readmission of patients within 8 days of their endoscopic procedure and to determine the number and cause of deaths of patients within 30 days of their endoscopic procedure in our institution.
Method
IT systems were used to retrospectively identify patients who underwent GI endoscopic procedures over a 6 month period and who were readmitted within 8 days of their procedure. Healthcare records were reviewed to assess whether a complication of the procedure was a cause of readmission. To assess 30-day mortality rates, all patients that died within 30 days of endoscopy, were identified. Healthcare records were reviewed to assess whether a complication of the procedure was a factor in the patient's death.
Results
4784 endoscopic procedures were performed over the 6-month period. 58 patients (1.21%) were readmitted to hospital within 8 days of their

procedure. Of those, 5 patients (0.1%) were readmitted to hospital due to complications of GI endoscopy; 2 post polypectomy bleeds, 2 lower respiratory tract infections and a fall post-sedation. 6 patients died within 30-days. The death of 1 patient (0.02%) secondary to aspiration was deemed directly caused by their procedure.

Conclusions

Rebleeding and lower respiratory tract infections were the most common causes for readmission. The episode of endoscopy-related death was caused by aspiration. It is important to continue to analyse these data to help endoscopy units to develop and plan their services and to improve safety for endoscopic procedures.

ABSTRACT 38 (19W125)

Reviewing haemochromatosis the virtual way: A pilot study

Author(s)

Carroll G R, McCormick O, McDougall N I.

Department(s)/Institutions

Regional Liver Unit, Royal Victoria Hospital, Belfast

Introduction

Over 1500 patients attend the Royal Victoria Hospital in Belfast for venesection. Providing annual clinic review for such patients places an enormous burden on outpatient clinics.

Aims/Background

Our aim was to replace outpatient visits with a 'virtual clinic' review and obtain patient feedback.

Method

Patients with genetic haemochromatosis and no evidence of cirrhosis who were attending for maintenance venesections (every 3-6 months) were identified from review of records in RVH Ambulatory Care Centre. Those who were due for review were sent a letter advising that they would have a virtual clinic review by telephone and given an appointment slot (one clinc per month set aside for 12 virtual reviews). If patients did not answer the first call, they were contacted again an hour later. If the patient could not be contacted, their latest clinic letter and blood results were reviewed via the Electronic Care Record and their treatment plan was communicated via clinic letter.

Results

Sixty patients had virtual clinic review over a 5 month period from Feb 2019. Sixteen patients replied to a patient satisfaction survey was posted after the appointment. Of those who replied, 75% were happy and 25% somewhat happy with their experience and 100% would agree to a virtual clinic review in the future, 75% answering yes and 25% to some extent. 100% were satisfied or very satisfied with the overall experience.

Conclusions

Virtual clinic is an effective method for ensuring the timely review of patients with haemochromatosis, with an overall positive response from patients.

ABSTRACT 39 (19W126)

Same day transient elastography significantly increases clinic discharges, particularly in NAFLD patients

Author(s)

M. McKenna-Barry, A. Marrinan & J.D. Ryan

Department(s)/Institutions

Hepatology Unit, Beaumont Hospital, Dublin

Introduction

The evaluation of liver fibrosis is vital to guide management and prognosis for patients with chronic liver disease. Transient elastography (TE) can reliably exclude advanced fibrosis across a variety of liver diseases.

Aims/Background

We assessed the impact of same day TE on the rate of discharge from a tertiary referral Hepatology outpatient department. Although previously performed on an ad-hoc basis at our Unit, same-day TE was formally introduced in January 2019.

Method

A retrospective analysis was conducted of TE data comparing January to July 2018 to January to July 2019. The time from referral to completion of TE and number of discharges were collected.

Results

From January to July 2018, 294 TE were performed. 16 TE were on the same day as OPD review, with 4 patients (1.4%) discharged. From January to July 2019, 370 TE were performed. 178 TE were on the same day as OPD review, with 54 patients (14.6%) discharged ($p<0.001$, Chi squared test). Of these, 56% had NAFLD. In 2018, median time from referral to completion of TE was 97 days (range 0-375 days; 226 patients with referral to completion dates available). In 2019, median time from referral to completion of TE was 0 days (range 0-448 days; 339 patients with referral to completion dates available).

Conclusions

The introduction of same day TE increased the number of TE conducted and number of patients discharged from OPD. Aligning TE to clinic date significantly increases the rate of discharge, particularly in NAFLD patients, and should be standard practice in Hepatology outpatient clinics.

ABSTRACT 40 (19W127)

Update: MMR Gene Variation in a Cohort of Lynch Syndrome Patients

Author(s)

T Ryan, S Foy, J Leyden, P MacMathuna

Department(s)/Institutions

Gastrointestinal Unit, Mater Misericordiae University Hospital, UCD, Dublin

Introduction

Lynch syndrome (LS) is the most common known cause of hereditary colorectal cancer, caused by pathogenic variants in the mismatch repair genes (MMR)- MLH1, MSH2, MSH6, PMS2, EPCAM. To date little research has been published on the specific variants that exist in Ireland. Variant classification can have a significant effect on management choices, whether pathogenic, of uncertain significance or benign. Pathogenic MMR variants vary in their predisposition to causing colorectal and gynaecological cancers.

Aims/Background

Update of genetic variations in the LS cohort from a High-Risk Family Colorectal Cancer Screening Clinic

Method

A retrospective anonymised gene variant analysis of LS patients from the family clinic database. We identified the specific variants in the MMR genes and analysed their risk classification using the CanVar UK and InSight databases.

Results

There were 110 LS patients identified, 57 male, 53 female. Gene distribution: MSH2 = 50%, MLH1 = 36%, MSH6 =13%, PMS2 =11%. There were 100 patients (both proband and first degree relatives (FDRs)) with documented variants and 34 single variants identified. Of these, 13 variants (38%) were identified only in the proband

(FDRs not tested), while in 62% the variant was documented in both proband and FDRs. Indications for testing included predictive= 82, diagnostic (post-cancer diagnosis)= 12.

Conclusions

In the majority, concordance between proband and FDR MMR variants facilitated appropriate surveillance as a cancer prevention strategy. The challenge remains to implement cascade testing within the same pedigree and arrange appropriate and cost effective GI and non GI surveillance.

ABSTRACT 41 (19W128)

Lynch Syndrome Risk Classifications: The Importance of Monitoring Changes to Variant Pathogenicity

Author(s)

T Ryan, S Foy, J Leyden, P MacMathuna.

Department(s)/Institutions

Gastrointestinal Unit, Mater Misericordiae University Hospital, UCD, Dublin

Introduction

: Lynch syndrome (LS) is the most common known cause of hereditary colorectal cancer. It is caused by pathogenic variants in the mismatch repair genes (MMR)- MLH1, MSH2, MSH6, PMS2, EPCAM. Variant classification can have a significant effect on management/surveillance choices, whether pathogenic, of uncertain significance or benign. The risk classification of these variants is not permanent and can be upgraded or downgraded over time as more information on that variant becomes available.

Aims/Background

Compare original lab classifications of the cohort of LS patients with up to date classification databases.

Method

A retrospective anonymised gene variant analysis of LS patients from the family clinic database was performed. Specific variants in the MMR genes were identified and their risk classification determined using the CanVar UK and InSiGHT databases.

Results

There were 100 LS patients/variants identified. Gene distribution: MSH2 = 48%, MLH1 = 31%, MSH6 =13%, PMS2 =8%. The testing took place in 10 different labs. Original test lab classed these variants as pathogenic=80 patients, VUS=1.When the same variants are analysed using the CanVarUK database there are 25 VUS, while the InSiGHT database gave 13 VUS results. Consequently 13-25% of individuals' risk was downgraded.

Conclusions

This study highlights the ever evolving nature of risk classification in variant analysis. The downgrading of variants from pathogenic to VUS questions the underlying diagnosis of Lynch Syndrome with the potential to avoid intense surveillance in both patient and FDRs.

ABSTRACT 42 (19W129)

Lynch Syndrome Unconfirmed: Are we getting the surveillance Right?

Author(s)

T. Ryan, S. Foy, J. Leyden. P. MacMathuna

Department(s)/Institutions

Gastrointestinal Unit, Mater Misericordiae University Hospital (MMUH), UCD Dublin

Introduction

Lynch Syndrome (LS) is now diagnosed by genetic testing of mismatch repair genes. However, before genetic testing, patients are categorised by clinical criteria (Amsterdam/Bethesda). The MMUH cohort without genetic testing but meeting the clinical criteria are categorised as 'LS Unconfirmed' in the high risk database and surveillance is arranged accordingly.

Aims/Background

1. To evaluate patients categorised as 'LS unconfirmed' in the Familial CRC clinic. 2. Critically examine the accuracy of this categorisation and whether all patients are under the same surveillance. 3. To assess the benefits of switching to more recent guidelines for surveillance.

Method

Retrospective review of the pedigrees of all patients documented as 'LS Unconfirmed' in the MMUH high risk database to confirm risk level. Reclassification of patients risk levels from original protocol to the newer Royal Marsden guidelines.

Results

N= 184. Pedigree was absent in 30, 9 RIP, 2 Gene+, 2 Gene-, 2 polyposis syndrome. Only 60% first degree relative (FDR) with CRC, 10% had an FDR with diagnosed LS. 65% are compliant with surveillance. Surveillance colonoscopy was performed 1-2 yearly in 49% and 25% yearly/2 yearly OGDs. Recategorisation saw most patients move to a 5 yearly surveillance plan starting at different ages, while 28 required one off colonoscopies and 11 reverted to average risk.

Conclusions

New guidelines redefine patient's level of risk and significantly reduce intervals for surveillance with attendant cost savings. This study highlights the need to proactively adopt international guidelines and updates to guarantee appropriate surveillance.

ABSTRACT 43 (19W130)

Hepatitis C Genotype 4 resistance; an Irish experience.

Author(s)

Dr. Ciaran McDonald, Gastroenterology/ Hepatology SpR, St. James Hospital. Ms. Miriam Coughlan, Hepatitis C Pharmacist, St. James Hospital. Dr. Cillian De Gascun, Director NVRL, UCD, Belfield, Dublin 4 Professor Suzanne Norris, Consultant Hepatologist/ Gastroenterologist, St. James Hospital.

Department(s)/Institutions

St. James Hospital, Dublin 8

Introduction

Hepatitis C virus (HCV) genotype 4 is highly heterogeneous with subtype 4r considered to be less responsive to direct-acting antiviral (DAA) drug treatment.

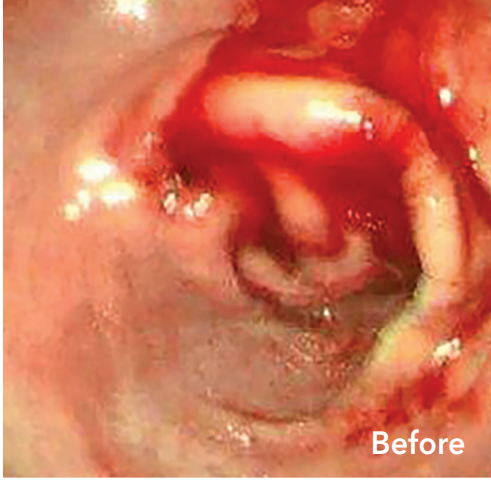
Aims/Background

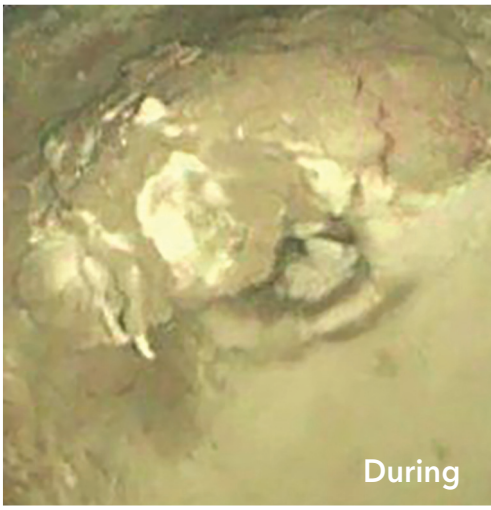
The HCV subtype 4r has a high prevalence in multiple central African countries. A recent prospective Rwandan study in adult patients infected with the HCV Genotype 4 virus treated with Sofosbuvir/ Ledipasvir highlighted the lesser degree of 4r response (54%) in comparison to other subtypes.

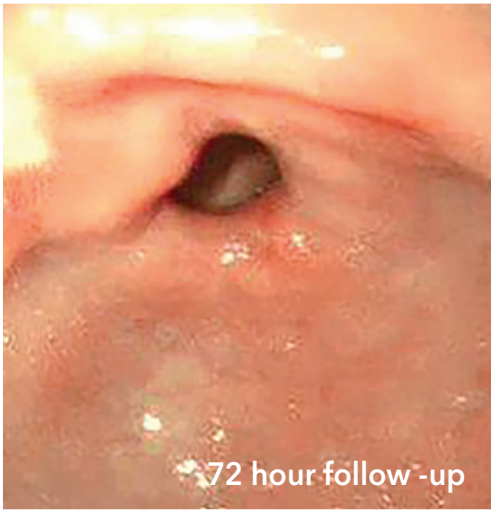
Method

A 43 year old Congolese patient underwent Hepatitis C genotyping confirming both genotypes 1 and 4 with normal pre-treatment bloods. There was no relevant background medical history nor was the patient taking any regular medications. She was a non- smoker and did not consume any alcohol. A liver biopsy which had been performed previously showed Grade 2/6 fibrosis.

A different approach to hemostasis.







Hemospray®
ENDOSCOPIC HEMOSTAT

For more information on Hemospray, visit:
hemospray.cookmedical.com

COOK® MEDICAL

Peptic ulcer bleed images courtesy of Prof. Joseph Sung, Chinese University of Hong Kong, Hong Kong, China.

Results
Treatment with 12 weeks of Harvoni (Ledipasvir/Sofosbuvir) daily showed good initial response. The viral load (VL) decreased from 1.1 E+6 to undetectable levels. However, SVR check at 12 weeks post treatment revealed a relapse of the virus back to 1.42 E+6. Repeat analysis showed detected only Genotype 4 with subtype 4r confirmed. Genomic region sequencing was performed: no NS3 mutations, two NS5A mutations (L28V, L30R) and NS3 protease (D168E) were detected. Maviret (Glecoprevir/Pibrentasvir) with Sofosbuvir was chosen as treatment regimen for a total of 16 weeks. The patient is currently week 14 of 16 with VL undetected from week 10.
Conclusions
Certain mutations should be considered in particular for patients who originate from central Africa with the Hepatitis C Genotype 4. A high index of suspicion is required from the outset but there is a considerable cost benefit in earlier detection of these mutations.

ABSTRACT 44 (19W131)

Cascade testing of Lynch Syndrome patients families; are we capturing all those at risk?

Author(s)
T. Ryan, S. Foy, J. Leyden. P. MacMathuna
Department(s)/Institutions
Gastrointestinal Unit, Mater Misericordiae University Hospital, UCD Dublin
Introduction
Lynch Syndrome (LS) one of the commonest major genetic conditions worldwide and the commonest known genetic cause of colorectal cancer (CRC). Approximately 15,000 people in Ireland have LS, with 100 CRCs/year diagnosed. It is estimated 95% of people with LS are unaware they have it. As an autosomal dominant condition, 50% of patients' first degree relatives (FDRs) are at risk of inheritance. It is important that family members are offered appropriate screening and surveillance.
Aims/Background
To determine genetic testing/referral patterns in the FDRs of LS patients and assess if all high risk patients are being captured.
Method
We examined the pedigrees of all LS patients and identified the number of FDRs referred, tested through the clinic, tested elsewhere, not tested or refused testing.
Results
LS patients included= 92, distinct pedigrees= 32, FDRs= 670. Mean number of FDRs per patient: 7.28 (Range 2-17). FDRs referred to clinic: 265 (39.6% of total FDRs). Genetic tests of the FDRs referred (excluding tested elsewhere); total=228, Gene + 169 (74%), Gene – 59 (25%). FDRs referred but not tested 27 while 15 refused testing
Conclusions
By undergoing cascade testing, 74% of those tested were gene + allowing for cancer prevention surveillance and 25% gene negative giving reassurance and can avoid unnecessary surveillance. However over 60% of FDRs are not being tested reflecting either poor compliance or awareness of benefits of gene testing for cancer prevention. Increased public awareness plus a national database would support appropriate/efficient management of individuals at risk and optimise cascade testing.

ABSTRACT 45 (19W132)

Surveillance Colonoscopy: Is a Systematic Review of the Waiting List Worthwhile?

Author(s)
RS Piggott, L Pillay, N Ganter, F Howley, S Reedy and G McCormack
Department(s)/Institutions
Midlands Regional Hospital, Tullamore, Co Offaly
Introduction
The BowelScreen programme and increased public awareness of colorectal cancer has led to an increase in colonoscopy referrals and hence waiting times. National guidelines outline criteria for initial high risk group screening and further colonoscopy surveillance. Meeting demand for first time colonoscopy and follow-up procedures is a challenge for many units.
Aims/Background
To evaluate the effectiveness of a programme to systematically review all surveillance colonoscopy waiting lists.
Method
A clinical nurse specialist reviewed the recall / surveillance waiting lists focussing initially on overdue procedures. These patients were contacted and demographics confirmed risk factors and current health status reviewed. All cases were then vetted by a Consultant Endoscopist who determined if colonoscopy was clinically appropriate and if so, an appointment given. We reviewed the outcomes of all who underwent colonoscopy or an alternative test, including endoscopy findings, histology and follow-up recommended.
Results
179 cases from our waiting list have been reviewed to date. The average time overdue for colonoscopy was 43 months in this group. Following consultant review, 100(56 %) were listed for colonoscopy and 44% were removed from the endoscopy list. To date 55% of those listed following vetting have undergone colonoscopy. Of these, the majority (61%), have been listed for future routine surveillance colonoscopy, 21% underwent other management (further procedures and clinic review). Only 18% were fully discharged from the service. No malignancies have been identified in this group to date. The polyp detection rate in our cohort was 32%, including 2 complex polyps requiring mucosal resection.
Conclusions
Our audit demonstrates that evaluating an existing waiting list is worthwhile; many procedures are deemed unnecessary following consultant review. However 61% of those endoscoped were re-listed for future surveillance. Rising demands for quality colonoscopy mean that we must continuously monitor demand and ensure appropriateness of all procedures.

ABSTRACT 46 (19W134)

Experiences and feedback of patients with Irritable Bowel Syndrome (IBS) after attending dietitian led group meetings.

Author(s)
Ana-Maria Oxenti, Sarah Gill, Elaine Neary
Department(s)/Institutions
Department of Nutrition and Dietetics, Tallaght University Hospital (TUH)
Introduction
IBS is a chronic disorder of the gastrointestinal system with a global

prevalence of 11% . Its consequences can have a high impact on quality of life.

Aims/Background

The objective was to examine feedback and experiences of groups of patients with IBS after attending a group meeting with the dietitian.

Method

The patients were given evaluation forms at the end of the information session. The forms were anonymous which ensured that their feedback is honest and accurate. The forms were analysed and evaluated.

Results

Evaluation forms from 264 patients were analysed (n=264). 92% of patients learned new information and ways of reducing the symptoms of IBS. 75% of patients were confident with the information received and 5 % would change some aspects of the meeting. 99% of patients would recommend the dietetic service to their family of friends. Patient Comments: ''Lots of helpful information, thank you!'' ''Everything is explained very well. Very helpful session.'' ''Excellent, fantastic resource!'' ''Very informative'' ''Enjoyed the session and I am going to make improvements. Really helpful information.'' ''Very easy to understand and enjoyable. Small group was good as it was relaxed.''

Conclusions

Overall, the results show that patient satisfaction following group education is very high. Information was clear and patients were motivated to change following the sessions.

ABSTRACT 47 (19W135)

Characteristics and outcome of liver transplantation for PSC a single centre study.

Author(s)

Amjed Ahmed, Orla Crosbie

Department(s)/Institutions

Cork University Hospital

Introduction

Primary sclerosing cholangitis (PSC) is a chronic cholestatic disease of the liver and bile ducts that is frequently progressive and can lead to end-stage liver disease. The cause of PSC is unknown, and multiple mechanisms are likely to play a role Liver transplantation (L.T) is the treatment of choice for patients with advanced liver disease due to PSC.

Aims/Background

PSC is and is now the most common indication for L.T in the group of cholestatic diseases in Europe accounting for 5% of overall indications of L.T We aimed to analyze our local outcome and characteristics.

Method

We did a retrospective study on all adult patients who had a L.T for PSC using our existing liver database and charts review to obtain clinical data regarding demographic features, presence of Ulcerative Colitis (UC), time to transplantation and outcome.

Results

There were 11 out of 75 patients identified (7 males and 4 females) with mean age of 52 years at present (42 years of age at diagnosis), 82% had concomitant UC, mean duration to transplantation was 4.7 yrs, 3 patients developed cholangiocarcinoma (27%), disease recurred in 2 patients (18%), and graft failure was noticed in 2 patients (18%), mean disease free survival was 6.36 yrs and mean overall survival was 9 yrs.

Conclusions

In this study we found that men in their 5th decade of life were more likely to require L.T for PSC and the Recurrence rate of PSC was 18% which is comparable to literature (14-20%).

ABSTRACT 48 (19W136)

Clinical outcomes following dietitian led group education for the management of IBS

Author(s)

Elaine Neary, Sarah Gill, Sinead Feehan

Department(s)/Institutions

Dept of Nutrition & Dietetics, Tallaght University Hospital (TUH)

Introduction

Clinical evidence supports the use of dietary intervention as first line treatment for Irritable Bowel Syndrome (IBS). Group education has been shown to be effective. Patients with IBS referred to the dietitian in TUH first attend a group education session on 1st line dietary and lifestyle strategies. Those who fail to improve after this may attend further group sessions on a low FODMAP diet.

Aims/Background

To assess the effectiveness of dietitan led group education on clinical outcomes in patients with IBS

Method

Patients completed a symptom evaluation questionnaire at baseline, at a 3 month telephone review following 1st line advice and again 6 weeks after commencing a low FODMAP diet. The questionnaire consisted of the Global Symptom Question (GSQ) and the IBS Symptom Severity Score (IBSSSS).

Results

278 patients have attended the 1st line group education session of which 170 have been reviewed at 3 months. 35.3% have reported satisfactory relief in their symptoms at this time (GSQ=yes) with a further 10.6% having a significant reduction in their symptom severity (IBSSSS change >50) 42 patients have attended group low FODMAP diet education of which 26 have been followed up to date. 65.4% of these have reported satisfactory relief of their symptoms with a further 7.7% achieving a significant reduction in their symptom severity.

Conclusions

Dietetic led group education is effective in improving symptoms in up to 65% of patients with IBS. First line dietary intervention is effective in 35% of patients and should be tried prior to the low FODMAP diet.

ABSTRACT 49 (19W137)

A retrospective Review to assess the value of Pancreatic cyst fluid analysis

Author(s)

G Mellotte, V Parihar, N Breslin, BM Ryan

Department(s)/Institutions

Tallaght University Hospital, Department of Gastroenterology

Introduction

Pancreatic cystic lesions (PCLs) are common. Only mucinous PCLs progress to pancreatic adenocarcinoma. Cytology is important in the assessment of PCLs and CEA >192ng/ml helps differentiate mucinous from other, harmless PCLs. PCL aspirate yields small volumes of fluid which limits diagnostic value.

Aims/Background
To assess clinical value of EUS-guided PCL FNA performed in TUH from 2012-2019.
Method
A retrospective review of the EUS database to identify all PCL cases. PCL characteristics, fluid cytology and CEA results were reviewed.
Results
271 patients with PCLs were identified. Mean PCL size was 11.97+/-4.9mm. 81(30%) PCLs underwent FNA and were larger (26.6+/-12.7mm) than PCLs not aspirated (12.71+/-8.2mm), p<000.1. 61/81(75.3%) FNA samples were sufficient for cytology: 31(50%) were acellular, 11(18%) were diagnostic of mucinous PCL, 1(1.6%) neuroendocrine tumour, 9(15%) inflammatory, 9(15%) serous. Mucin stained positive in 16/81(20%) FNA cases. 6 of which also had diagnostic cytology; sensitivity 53.8% (CI 25.13%-80.78%) and Specificity 89.47% (80.3%-95.34%). 40/81 samples (49.3%) were suitable for CEA analysis. 11 cases had an elevated CEA level >192ng/ml, of which 3 cases also had diagnostic cytology, Sensitivity 27.27% (CI 6.02%-60.97%) and specificity 84.29% (CI 73.62%-91.89%) Overall 36 of 81 (44%) had either positive cytology, positive mucin stain or raised CEA indicative of a mucinous PCL.
Conclusions
FNA was not deemed necessary in the majority of PCLs assesed by EUS. Where FNA was performed, the yield of cytology was low and mucin staining and CEA analysis were of additive value in the overall assessment.

ABSTRACT 50 (19W138)

Histological Outcomes of Barrett's Oesophagus Surveillance at University Hospital Kerry

Author(s)
Amad U H Bhatti, M. Mkarimi, S. sharma, C.K. Shahzad, E. Myres, I Un Nabi
Department(s)/Institutions
Department of Gastroenterology, University Hospital Kerry
Introduction
Barrett's oesophagus is a complication of gastroesophageal reflux disease, where normal squamous mucosal lining of oesophagus changes to intestinal type. About 10% of people with chronic symptoms of GORD may develop Barrett's oesophagus. There are no specific symptoms, although patients with Barrett's oesophagus may have symptoms related to GORD. It does though increase the risk of developing esophageal adenocarcinoma, which is a serious, potentially fatal cancer of the oesophagus.
Aims/Background
To Analyze histological findings of patients undergoing Barrett's surveillance at University Hospital Kerry
Method
Retrospective analysis of data from June 2017 till July 2019 performed. Data obtained from Unisoft endoscopy reporting system and histology from I-LAB.
Results
Data was obtained from 119 patients who underwent surveillance. 83(70%) patients were males and 36(30%) were females. Patients were between age from 30 to 85 years. 106 (89%) patients (n=119) had histology consistent with Barrett's Oesophagus as characterized by intestinal metaplasia with no dysplasia. Only 2(1.8%) patients had low grade dysplasia. 13(11%) patients had no histological evidence of intestinal metaplasia. None of the patients had high grade dysplasia or malignancy.
Conclusions
Our results showed very low prevalence of Barrett's oesophagus to progress to dysplasia or cancer which is in with international data,

ABSTRACT 51 (19W139)

A review of Paediatric Hepatobiliary Procedures in an Adult Tertiary Centre

Author(s)
G Mellotte, V Parihar, H O'Connor, D MacNamara, N Breslin, BM Ryan
Department(s)/Institutions
Tallaght University Hospital(TUH), Department of Gastroenterology
Introduction
The incidence of hepatobiliary disorders in children is increasing worldwide. TUH incorporates the National Children's Hospital and Paediatric ERCP and EUS is performed by adult gastroenterologists.
Aims/Background
To assess the indications and outcomes for ERCP and EUS in paediatric patients in an adult centre.
Method
Interrogation of Paediatric HIPE codes identified 27 children who underwent EUS and ERCP in TUH from 2008-2019. Endoscopy reports and notes were reviewed.
Results
27 children underwent 34 procedures. 18 patients (10 male) underwent 23 ERCP procedures, mean age 14. Indications were: Choledocholithiasis in 11(61.1%), Recurrent Acute Pancreatitis 5(27.7%), Gallstone Pancreatitis 1(5.5%), Pancreatic mass 1(5.5%); there were 5 repeat procedures. 12 patients underwent sphincterotomy. 4 stents were inserted. 4(17.3%) procedures were performed under general anaesthesia, 13(56.5%) under conscious sedation, 6(26.1%) patient's sedation was unknown. There were no serious adverse events; one episode of pain post procedure, one patient was monitored overnight. 21 procedures (91%) were technically successful. 9 patients (4 male) patients underwent 11 EUS procedures, mean age of 13. Indications: pancreatitis in 4 (44.44%), pancreatic mass in 3 (33.33%), dilated CBD 1(11.11%), pseudocyst 2(22.22%), 1(11.11%) follow up examination. 4 patients had FNA performed, all samples sufficient for diagnosis. 2 pseudocyst drainages, 1 unsuccessful. 2 procedures were performed under GA and 8 under conscious sedation, 1 unknown. One significant adverse event.
Conclusions
Outcomes of EUS and ERCP in a paediatric population are comparable to that in adults, with similar safety profile, technical and clinical success. A large percentage can be safely performed under conscious sedation.

ABSTRACT 52 (19W141)

Evaluating the Uptake of Human Papillomavirus (HPV) Vaccination and Cervical Smear Testing Amongst Women with Inflammatory Bowel Disease (IBD) at a Regional Hospital

Author(s)
L Pillay, N Ganter, RS Piggot, G McCormack
Department(s)/Institutions
Department of Gastroenterology, Midlands Regional Hospital, Tullamore, Co Offaly
Introduction
HPV is strongly linked to the pathogenesis of cervical dysplasia;

HSL™

HOSPITAL SERVICES LIMITED

SOLUTIONS FOR LIFE

Helping you deliver the highest standards of patient care.

IntroMedic Discovering Innovations · FUJIFILM · Heyinovo · Case Medical

medbar® · THE STANDARD · medwork® · NISO BIOMED

BELFAST | 2 Wildflower Way, Adelaide Industrial Estate, Belfast, BT12 6TA
+44 (0) 2890 381 481 | sales@hsl.co.uk | support@hsl.ie

DUBLIN | Unit 1A, Block 4A, Blanchardstown Corporate Park, Blanchardstown, Dublin, D15 YW26
+353 1 295 0500 | sales@hsl.ie | support@hsl.ie

women with IBD may be at greater risk of developing cervical pathology, in particular those on immunosuppressive therapies. A national cervical screening programme exists, commencing at age 25. HPV vaccination is offered to all girls entering secondary school since 2010.

Aims/Background

This was a preliminary study looking at the number of women seen at our IBD clinic that had been vaccinated against HPV and were up to date with screening smear testing.

Method

Women attending our service, over a 4 week period, were asked to complete a questionnaire regarding previous smear testing and results.

Results

45 women with a mean age of 42 and an average 9 years since diagnosis were included. 82% of this group were on immunosuppressive therapies. Neither of 2 women aged under age 21, who qualified, had been vaccinated. Of those eligible for cervical smears, 30% were either overdue or have never had a smear test. Only 51% were aware of when their next smear is due. Reassuringly, 92% had a normal result at their last smear. However 19% have had an abnormal result in their lifetime, with 6/7 of these being on immunosuppressive therapies. Details of previous smear testing and any subsequent treatment was not included in the clinical record as all were treated elsewhere.

Conclusions

A worrying number of patients are either overdue or never had a smear, even more are unaware of when their next smear is due, greater education and follow up is needed in this high risk group. Catch-up HPV vaccination should be available at no cost for young women with IBD, who have missed or declined school vaccinations. This study was not powered to assess abnormal smears and any relation to IBD therapy, further study is needed.

ABSTRACT 53 (19W142)

Peri-procedural fasting: An audit of compliance with local guidelines in a tertiary hospital over a 24 hour period

Author(s)

Jennifer O Donnell, Brian Horan, Alice O Leary, Melanie McDonnell , Aoibhlinn O'Toole, Karen Boland

Department(s)/Institutions

1. Department of Gastroenterology, Beaumont Hospital 2. Department of Nursing, Beaumont Hospital

Introduction

Prolonged fasting is uncomfortable for patients and may lead to medical complications. An audit of compliance with local guidelines for peri-procedural fasting was commissioned by the Nutrition Steering Committee

Aims/Background

To identify inpatients fasting for endoscopic, radiological or surgical procedures, and audit compliance with local guidelines for patients with prolonged fasting (> 8 hours). Secondary outcome was identification of associated adverse events.

Method

All wards were audited excluding the emergency and day ward, during one 24 hour period. Medical and nursing notes were used to document fasting times, indication and compliance with guidelines. Ethical approval was granted by the local ethics board.

Results

Excluding patients having elective endoscopy and surgery, 820 inpatients were included and 51/820 were fasting. Sixty-five per cent (n=33) were male and 88% (n=44) had prolonged fasting (>8 hours, median 14.7 hours). Indications included cardiac, radiology surgical, video fluoroscopic and endoscopic procedures. Thirty-three per cent (n=17) of patients had their procedures deferred due to lack of availability (n=16) and thrombycytopoenia (n=1), and a single patient was fasted inappropriately. Eighty-six per cent of patients were offered a meal or snack within 30 minutes of fasting restrictions being lifted. Less than half of patients with prolonged fasting (n=20) received intravenous fluids, and 25% of diabetic patients (n=2) did not have 4 hourly glucose monitoring. There was no statistically significant difference in management between core versus outlier wards. No adverse outcomes were recorded.

Conclusions

The majority of patients were fasting appropriately. However, improved communication between schedulers and the wards for cardiac and emergency theatre procedures could guide management plans and hence improve guideline compliance. Recent changes to snack availability outside core meals have had a positive impact, but further education and modification of current guidelines to improve readability may encourage compliance.

ABSTRACT 54 (19W144)

Patient education in Cirrhosis – a hard pill to swallow!

Author(s)

D.Bowles, O.Crosbie

Department(s)/Institutions

Department of Hepatology, Cork University Hospital

Introduction

Health literacy is defined as the degree to which individuals understand basic health information and services required to enable them to make appropriate health decisions. It is associated with favourable patient outcomes and efficiency of care. Access to information has been improved by way of the internet, patient leaflets and support groups – we assess if this translates to clinical practice.

Aims/Background

This cross sectional study aimed to assess the level of knowledge that patients with cirrhosis have and how this impacts on their clinical care pathway

Method

A questionnaire was constructed based on perceived knowledge deficits of patients with cirrhosis. We performed a cross-sectional study of patients attending CUH outpatient services. Patients completed the questionnaire collecting data on cirrhosis, disease aetiology and medication management.

Results

30 patients were included in this cross sectional study and we present the findings thus far (n=8). 50% (n=4) did not know the aetiology of their liver disease, 5 patients stated that you cannot take paracetamol with liver disease. 87% (n=7) of patients believed that doctors will have knowledge of their current prescription. No patients know the names and doses of their own medications. 4 patients state that drinking alcohol is necessary to get liver disease. 25% of patients knew that they were being screened for cancer with 6 monthly ultrasounds.

Conclusions

Our results conclude that patients lack the knowledge to be self-sufficient. Appropriate intervention is required to bridge the division between health and education in an effort to improve outcomes.

ABSTRACT 55 (19W145)

Prevalence and trends of Helicobacter Pylori diagnosis at University Hospital Kerry

Author(s)
Amad U H Bhatti, S. Sharma, M Mkarimi, C.K. Shahzad, E. Myres, B. Waldron, I Un Nabi
Department(s)/Institutions
Department of Gastroenterology, University Hospital Kerry
Introduction
Helicobacter Pylori is a gram negative bacterium that colonizes gastric epithelium with manifestations including asymptomatic, acute or chronic gastritis, ulceration and gastrointestinal lymphoma. It is thought to be the most common bacterial infection,affecting 50% of the world. A number of non invasive and endoscopic investigations exist for diagnosis, including the biopsy urease test (CLO test)
Aims/Background
To determine the age related prevalence of H pylori diagnosed by CLO testing during Upper GI endoscopy at University Hospital Kerry from 2015 to 2019
Method
9552 Upper GI endoscopies (OGDS) were performed between January 2015 to August 2019. All these patients had CLO test during the procedure as a routine. Results from these were analysed by age groups to determine the frequency of CLO positivity. Age-based and overall prevalence of H. Pylori was calculated.
Results
9552 CLO tests were performed, 1013(10.6%) were positive(n=9552), of these, 26(0.25%) were up to 20 years old, 91(1%) were between 21-30 years, 175(1.73%) 31-40 years, 192(2.2%) 41-50 years, 185(1.8%) 51-60 years, 186(2%) 61-70 years, 138(1.5%) 71-80 years and 20(0.12%) 81-90 years.
Conclusions
Prevalence of H. Pylori diagnosis using CLO test was found to be 10.6%. The highest age-related prevalence was found in 41-50 years age group at 2.2%, followed by 61-70 years at 2% and then 51-60 years age group at 1.8%. Overall it appears from these data that there is no much difference in age related prevalence of helicobacter pylori positivity in this population of patients.

ABSTRACT 56 (19W148)

The yield of polyp surveillance and its efficacy in current gastroenterology practice.

Author(s)
D. Molloy 1,2, S. Semenov 1,2, A. Janjua 1, S. Sihag 1,2, N. Breslin 2, B. Ryan 2, A. O'Connor 1,2, D. McNamara 1,2
Department(s)/Institutions
1. Trinity Academic Gastroenterology Group, Trinity College Dublin
2. Department of Gastroenterology, Tallaght University Hospital, Tallaght, Dublin 24
Introduction
Polypectomy prevents colorectal cancer (CRC). Post-polypectomy surveillance is recommended which adds significantly to endoscopy burden. Current risk stratification performs poorly as the majority are normal.
Aims/Background
To assess the efficacy of polyp surveillance in a recent Tallaght University Hospital (TUH) cohort.
Method
Patients who underwent a surveillance procedure over an 18 month period were identified, those with IBD, prior CRC, polyposis syndromes were excluded. Patients were risk stratified on index colonoscopy by newer ESGE guidelines. Basic demographics, index colonoscopy findings and surveillance data, including additional colonoscopies and histology was recorded.
Results
414 patients were vetted, 255 (62%) met the inclusion criteria, mean age 62 years (35-86), 55% (140/255) males, 48 (19%) positive family history. In all, 65 (25%) were deemed high risk at index colonoscopy. Average follow-up was 4 years (0-10), median colonoscopies was 1.4 (1-5). Overall, surveillance polyp yield was 58% (149/255) and did not vary according to risk group (high 62%, low 57%, p=0.56). Only one patient 0.4% was diagnosed with CRC. Similarly, only 8% of both the low (15/190) and high risk (5/65) groups had high risk lesions identified on follow up (p=0.47). While older age (≥65 years) was associated with high risk lesions, 12% (14/120) vs 4 % (6/13) p=0.04, OR 2.8, 95% CI 1.05 – 7.6, the yield did not vary with family history, gender or length of follow up.
Conclusions
The yield for significant lesions was low in both low and high-risk patients based on ESGE stratification, questioning the validity of current practice. Improved prediction models and further research are required.

ABSTRACT 57 (19W150)

The yield from surveillance colonoscopy in a BowelScreen centre

Author(s)
M. Elsiddig, D. Gandhi, J. Leyden
Department(s)/Institutions
Gastrointestinal Unit, Mater Misericordiae University Hospital
Introduction
Colorectal cancer is the second leading cause of cancer mortality in Ireland. BowelScreen was instituted in 2012 as a cost-effective programme for reducing mortality among the asymptomatic population. As the programme expands, the number of surveillance procedures is increasing without a significant increase in BowelScreen endoscopy capacity.
Aims/Background
Audit of BowelScreen clients attending the Mater Misericordiae University Hospital (MMUH) to determine volume and yield from surveillance.
Method
BowelScreen database at MMUH was used to obtain data on client preassessments in 2018. Surveillance colonoscopies performed in 2018 and the corresponding index procedures were assessed for number and size of polyps found.
Results
In 2018 there was a 50% rise in patients pre-assessed for surveillance colonoscopy. 124 clients attended for surveillance colonoscopy. 20 patients underwent more than one round of surveillance since index giving a total of 142 colonoscopies to be analysed. At index, an average of 4.1 polyps were found with 8% being 3cm or greater and 52% between 1 and 3cm. In comparison, at surveillance an average of 2.1 polyps were identified with 32% of procedures revealing no polyps and only 6% showing a polyp larger than 1cm. No cancers or polyps greater than 3cm were diagnosed at surveillance colonoscopy
Conclusions
Surveillance colonoscopy in BowelScreen population yielded half as

many polyps with a smaller proportion of large polyps in our cohort and no interval cancers. While adenoma surveillance is important, with the growing BowelScreen cohort and limited resources, there may be a role to outsourcing these procedures to non-BowelScreen endoscopy lists.

ABSTRACT 58 (19W151)

The Anorexia Nervosa Care Pathway: The Road To Better Outcomes?

Author(s)
F O'Hara, A O'Toole, S Patchett, D Cheriyan, J Ryan, K Boland
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Dublin

Introduction
Medical complications account for approximately half of all deaths in anorexia nervosa. The Anorexia Nervosa Care Pathway (ANCP) was introduced in Beaumont hospital in 2015 to optimise inpatient care.

Aims/Background
To audit compliance with the ANCP, the impact of the pathway on length of stay and readmission rates. Our secondary aim was assessment of medical complications rates in patients admitted with Anorexia Nervosa

Method
Ethical approval for the study was obtained, HIPE data was gathered on all patients admitted with a primary diagnosis of Anorexia Nervosa from 2011 to 2019. Data from medical and electronic records were collated and analysed.

Results
There were 42 individual patients (93% female) with a total of 60 admissions. 21 patients with 28 admissions came post introduction of the ANCP. Length of stay has trended downwards from 25 to 14 days post ANCP introduction (p=0.1). Thirty-six per cent of admissions were fully compliant with the ANCP (n=10). In admissions after 2015, 89% were transferred to Gastroenterology, 86% had required electrolyte monitoring. Just over half complied with ECG recommendations (54%) or had weekly MDT (57%). Looking at all medical complications, one third had refeeding syndrome, 28% had neutropoenia. Cardiac complications were noted in 42% and 18% had either reduced ejection fraction or pericardial effusion. One patient died following cardiac arrest.

Conclusions
These data highlight the importance of compliance with the ANCP and close monitoring for cardiac complications. Following further education, we intend to complete the audit cycle in 3 months.

ABSTRACT 59 (19W153)

Application of Baveno VI Criteria to oesophageal screening reduces burden of endoscopy

Author(s)
Spence AD, Braniff C, Cash WJ, McDougall NI
Department(s)/Institutions
Liver Unit, Royal Victoria Hospital, Belfast

Introduction
Oesophageal varices are a significant cause of morbidity and mortality in patients with liver disease. Historically all patients with liver cirrhosis were screened for varices. The Baveno VI guidelines have recommended that patients with a platelet count >150x109/L and a transient elastography <20kPa do not require screening endoscopy as they are unlikely to have varices.

Aims/Background
Assess the outcome of application of the Baveno VI criteria to the varices screening programme in the Royal Victoria Hospital, Belfast.

Method
A retrospective analysis of all patients with liver cirrhosis who underwent variceal screening OGD in the Royal Victoria Hospital between June 2018 and January 2019 was conducted. Patients were identified from an endoscopy master list provided by the endoscopy coordinator. Each patients electronic care record was reviewed to ascertain platelet count, transient elastography results and endoscopy reports.

Results
58 patients underwent endoscopy to screen for varices. 10 (17.2%) of these patients had a normal platelet count >150x109/L and transient elastography <20kPa and therefore did not require screening. None of these patients were found to have varices. 8 (13.8%) patients had a normal platelet count but had not undergone transient elastography so Baveno VI criteria could not be applied.

Conclusions
Application of the Baveno screening criteria would significantly reduce the endoscopy burden in a Regional Liver Unit.

ABSTRACT 60 (19W156)

CLO And Go, Still A No No

Author(s)
F O'Hara, C Deane, M Anwar
Department(s)/Institutions
Department of Gastroenterology, Our Lady's Hospital, Navan

Introduction
Helicobacter pylori infection is an important pathogen associated with gastritis, peptic ulcers, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue lymphoma. Irish guidelines recommend an endoscope-and-treat strategy in patients at increased risk of gastric cancer.

Aims/Background
A quicktest CLO was recently introduced to OLHN. Anecdotally this has coincided with an increase in false negative rates when compared to histological examination. Our primary aim was to evaluate the accuracy of quicktest CLO. A secondary aim was assessment of the rate of H.pylori infection in our population.

Method
A retrospective analysis of CLO and histological samples taken during routine gastroscopy between September 2018 and July 2019 in OLHN was performed. The sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of the quicktest CLO was compared to histological evaluation.

Results
176 patient procedures were included, 49.4% male (average age of 56 years). 147 (83.5%) procedures had samples taken for both CLO and histological analysis. 29 (20.5%) of procedures had a CLO and go approach. Histological analysis returned a H.pylori infection rate of 23.8% (n=35) in our cohort. Of these 35, quicktest CLO was positive in only 51.4%. This resulted in a sensitivity of 51.4%, specificity of 99.1%, positive predictive value of 94.7% and a negative predictive value of 86.5%.

Conclusions
The rate of H.pylori infection was comparable to previously published Irish data. The low sensitivity (51.4%) and NPV (86.5%) of the

Quicktest CLO confirms that histological evaluation remains key to diagnosing helicobacter during gastroscopy. Following education on the Irish guidelines we intend to reaudit.

ABSTRACT 61 (19W159)

The Value of Repeat QuantiFERON Testing Following an Initial Indeterminate Result in an IBD Population

Author(s)
R SAEIDI, S KELLY, D KEEGAN, G DOHERTY, J SHERIDAN, G CULLEN
Department(s)/Institutions
Gastroenterology department, St. Vincents University Hospital
Introduction
QuantiFERON testing (QT) is widely used to screen for latent TB infection in patients with IBD before treatment with anti-TNF therapy. It occasionally produces indeterminate results, prompting additional testing and potentially delaying therapy initiation.
Aims/Background
Our goal is to evaluate the value of repeat QT in IBD patients following an initial indeterminate result.
Method
We performed a single-centre retrospective study of QT performed in IBD patients attending SVHG between 2013-2018. Quantiferon test results ordered by gastroenterology were identified from the SVHG laboratory system and correlated with the SVHG prospectively maintained IBD database and clinical records.
Results
667 QuantiFERON tests were requested by gastroenterology in SVHG between 2013 and 2018. 35 patients had an indeterminate QuantiFERON result and were included. 72% had UC. 54% were female. Twenty-five patients (71%) had a repeat QT, 16 were started on anti-TNF therapy, 8 didn't start on biological therapy and one was already on anti-TNF therapy. Of the 25 repeat QT tests, 23 were negative and 2 had an indeterminate QT result requiring further testing which was ultimately negative. Four patients were started on biological therapy prior to a repeat QT, five were started on biological therapy without a repeat and in four patient's therapy was delayed pending repeat QT.
Conclusions
This small series suggests that repeating a QT following an initial indeterminate result is of limited value in IBD patients. TB risk factors and chest radiology findings may be more useful in determining the risk of TB reactivation with biologic therapy in those with an indeterminate QT result.

ABSTRACT 62 (19W160)

Surveillance colonoscopy in a high-risk Lynch population: a five year cross-sectional study

Author(s)
N Mehigan-Farrelly, T Ryan, S Foy, P MacMathuna, C Lahiff
Department(s)/Institutions
Gastrointestinal Unit, Mater Misericordiae University Hospital, Eccles Street, Dublin 7
Introduction
Lynch syndrome is the most common form of inherited colorectal cancer. Surveillance colonoscopy using high definition systems is recommended. The Mater Hospital has a dedicated unit for GI familial cancer.
Aims/Background
Our aim was to evaluate endoscopic surveillance for Lynch syndrome from 2014-2019.
Method
This was a retrospective cohort study of patients with Lynch syndrome. Patients were identified from our prospectively-maintained database who underwent surveillance colonoscopy during the study period.
Results
Of 115 patients identified, 83 had undergone colonoscopy at our hospital within the study period. Median age was 44 (range 28-69) and 42% were male. Caecal intubation and rectal retroflexion rates were 100%. Bowel preparation was excellent or adequate in 89%. Median withdrawal was 10 minutes. Twenty-seven polyps were identified in 15 patients. All polyps were diminutive (n=7) or small (n=20). Twenty-six polyps were removed by cold forceps (n=17,65%), cold snare(n=8,31%) and snare diathermy (n=1,4%). Polyps were adenomas (n=6,23%), hyperplastic (n=16,62%) and other (n=4). More adenoma were detected by consultants than by non-consultants (12% vs. 3%,p=0.1). Adenoma were detected more frequently in MLH1 and MSH2 than other genotypes (9% vs. 0,p=0.34). No endoscopically flat (Paris 0-IIb) lesions were detected. Narrow-band imaging was used in 11% while no patients had dye-based chromoendoscopy.
Conclusions
Experienced endoscopists appear to detect more neoplasia, especially in higher-risk Lynch genotypes. Adoption of advanced endoscopic imaging techniques may improve dysplasia yields, including flat lesions which are thought to have greater significance in Lynch syndrome. Larger prospective studies are required to determine whether this has an impact upon interval cancer diagnoses and mortality.

ABSTRACT 63 (19W161)

Hepatitis E Screening in Anti-TNF Therapy

Author(s)
K. Hazel, G. Rothwell-Kelly, A. O'Connor, B. Ryan, D. McNamara, N. Breslin
Department(s)/Institutions
Department of Gastroenterology, Tallaght University Hospital, Dublin 24
Introduction
Hepatitis E virus (HEV) is transmitted through the faecal oral route or haematologically. There are more than 20 million new infections annually, causing over 3 million cases of acute hepatitis and over 55,000 deaths. In Europe, there has been an increase in the number of cases from 514 in 2005 to 5617 in 2015. An Irish study, showed a prevalence 8% in routine testing testing. HEV infection is usually self-limiting and most patients are asymptomatic. Complications include acute hepatic failure, cholestatic hepatitis and chronic HEV infection, particularly in immunocompromised patients. The role of TNFα is currently unknown but case reports have shown severe exacerbations of chronic HEV infection on commencement of anti-TNFα therapy. In vitro data has shown inhibition of HEV replication by TNFα, which could be abolished with the addition of anti-TNFα therapy. We therefore recommend exclusion of HEV infection prior to initiation of TNFα-inhibitor therapy as chronic infection in an immunocompromised host may lead to cirrhosis.
Aims/Background
To audit if HEV testing was performed on patients taking or due to

commence a biologic medication for management of their IBD. We also sought to determine the rate of HEV infection in our IBD cohort.

Method

Retrospective analysis of microbiology results of all patients attending an IBD outpatient clinic in TUH over a four week period. It was noted if HEV was tested for and the result.

Results

Of 105 patients, 36 were on biologic monotherapy; 31 with anti-TNFα, 4 with Ustekinumab and 1 with Vedolizumab. A further 10 patients were on dual immunosuppression with an immunomodulator plus biologic; 7 with anti-TNFα, 2 with Ustekinumab and 1 with Vedolizumab. Only six patients in our cohort were tested for HEV infection. 3 of these were established on anti-TNF therapy, while two were screened prior to commencing Adalimumab. All patients tested were negative for HEV infection.

Conclusions

The prevalence of HEV is increasing in frequency in Ireland and progression to chronic HEV infection is becoming a recognised complication in immunosuppressed patients. As such, we must adapt our practice to ensure HEV is tested for routinely prior to commencing anti-TNFα therapy.

ABSTRACT 64 (19W162)

5-ASA Therapy and Renal Function Monitoring in the IBD Cohort

Author(s)

G. Rothwell-Kelly, K. Hazel, N. Breslin, B. Ryan, A. O'Connor, D. McNamara

Department(s)/Institutions

Department of Gastroenterology, Tallaght University Hospital, Dublin 24

Introduction

5-aminosalicylates (5-ASA), are commonly used in the treatment of Inflammatory Bowel Disease (IBD). Over 10% of patients taking 5-ASAs may experience headache and GI disturbance. Acute interstitial nephritis (AIN) is a rare but serious adverse effect of 5-ASAs with a mean incidence of 0.3% per person-year and presents as an acute kidney injury (AKI). Patients are often asymptomatic but may experience oliguria or anuria, nausea and malaise. AIN is most commonly drug induced (70-75%) with antibiotics, NSAIDs, diuretics, PPIs and 5-ASAs being the most common causative agents.

Aims/Background

Monitoring of renal function is a recognised part of management of patients taking 5-ASAs. The ECCO guidelines recommend 6-monthly renal function monitoring but no guidance is given with regard to acceptable fluctuations in renal function or when 5-ASAs should be stopped. We reviewed our compliance with this guideline using the charts of patients on 5-ASA therapy and whether a deterioration in renal function was noted or acted upon.

Method

A chart review of patients attending the IBD clinic in Tallaght University Hospital was performed over a four week period. Biochemistry results were accessed and the last two eGFRs were recorded. The interval between last two renal profiles was noted as well as change in eGFR over that time.

Results

40 of 105 patients were on 5-ASA therapy. Renal function was recorded in the charts of 19 patients on a 5-ASA (47.5%) compared with 27/65 not on a 5-ASA (41.5%). Renal function had deteriorated in 9 of the 40 patients (22.5%) taking a 5-ASA from the previous measurement (mean change of 7.67 mL/min, median change of 8mL/min, range 2-14 mL/min). Renal function was recorded in three of these nine (33%) patient's charts. There was great variation in the frequency of renal function monitoring (median 3 months, mean 6.56 months, range 0.167-33 months). One patient had never had renal function tested and two patients had only had one previous test.

Conclusions

Renal function was recorded in less than half of our patient cohort on 5-ASA therapy. As AIN is a recognised complication of 5-ASA therapy, more stringent monitoring of renal function should be carried out on all patient's using these agents. Action should also be taken in those with declining renal function while on 5-ASA therapy.

ABSTRACT 65 (19W163)

Exploring Risk of CPE Transmission in a GI Endoscopy unit

Author(s)

S. Sehrish1, A. M Anjum1, J. Powell2, M. Ashraf1, U. Tufail1, N. Shakoor1, S. McDermot1, R. Doyle1, L. Power2, N H O'Connell 2, M. M. Skelly1

Department(s)/Institutions

1. Department of Gastroenterology, University Hospital Limerick. 2. Dept of Microbiology, University Hospital Limerick.

Introduction

Reports associate outbreaks of carbapenemase producing Enterobacteriales (CPE) with GI endoscopy. CPE are highly drug-resistant Gram-negative bacilli causing colonization or infection.

Aims/Background

To explore possible acquisition of CPE from endoscopies at UHL.

Method

A retrospective review of CPE positive patients was cross checked against Unisoft (February 2009 and August 2018).

Results

260 positive CPE patients (px) were detected over 9.5 years. 104 (40%) patients had attended the UHL endoscopy unit. 37 patients were known CPE positive at endoscopy. CPE (+) patients were scoped last on list, isolated in the GI unit and the room was deep cleansed No evidence of cross infection from known CPE (+) px was found. 67 patients (34 female (51%) , median age 75 (25-94yrs)) later confirmed CPE (+) had a variety of endoscopies. Median time from endoscopy to CPE positivity was 61 days (range 2 – 2250 days). Screen swabs (60, 90%), urine (4, 6%), sputum (2, 3%), wound swab (1, 2%). No patients developed bacteremia. 43 of the 67 patients were not known CPE contacts, 12 had negative CPE tests between the scope and testing positive. 3 patient pairs (4 males, 2 females, median age 65, range 41-82) of the 67 were scoped in the same room on the same day with different scopes.

Conclusions

Work is needed to review whole genome sequence of CPE isolates to explore if there is cluster cross transmission in UHL endoscopy.

AWARDED BVBM AWARDED

Amgevita®

awarded best value biosimilar medicine
in a citrate free formulation of adalimumab
by the Medicines Management Programme

AMGEVITA®▼ (adalimumab)

CITRATE-FREE

WHAT'S BEHIND AMGEVITA® MAKES THE DIFFERENCE

Introducing the adalimumab biosimilar from Amgen – with over 35 years of biologics experience and a commitment to the treating of immuno-modulated inflammatory disease

supply reliability consistent quality continuing innovation manufacturing excellence

>35 YEARS BIOLOGICS EXPERIENCE

PRESCRIBE AMGEVITA® BY BRAND NAME

Prescribing information is available on request at the Amgen stand at this meeting.

AMGEN®

UKIE-P-AMG-1018-069192(1)a. Date of preparation: April 2019.

Legal Category: POM. Marketing Authorisation Numbers:

EU/1/16/1164/001 – 1 pack: AMGEVITA® 20 mg solution for injection in pre-filled syringe
EU/1/16/1164/003 – 2 pack: AMGEVITA® 40 mg solution for injection in pre-filled syringe
EU/1/16/1164/007 – 2 pack: AMGEVITA® 40 mg solution for injection in pre-filled pen

Marketing Authorisation Holders: Amgen Europe B.V., Minervum 7061, NL-4817 ZK Breda, The Netherlands.

▼This medicinal product is subject to additional monitoring. Adverse events should be reported directly to 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 Amgen Limited on +44 (0)1223 436441.

Reference: 1. AMGEVITA® (adalimumab) summary of product characteristics.

Prescribing information is available at the stand, at www.medicines.ie or on request.

Indications: AMGEVITA® is indicated for the treatment of rheumatoid arthritis, juvenile idiopathic arthritis, axial spondyloarthritis, psoriatic arthritis, psoriasis, paediatric plaque psoriasis, hidradenitis suppurativa, Crohn's disease, paediatric Crohn's disease, ulcerative colitis and uveitis.

Adult
- Rheumatoid arthritis
- Ankylosing spondylitis (AS)
- Axial spondyloarthritis without radiographic evidence of AS
- Psoriatic arthritis
- Crohn's disease
- Ulcerative colitis
- Psoriasis
- Hidradenitis suppurativa
- Uveitis

Paediatric
- Polyarticular juvenile idiopathic arthritis (from 2 years of age)
- Enthesitis-related arthritis (from 6 years of age)
- Crohn's disease (from 6 years of age)
- Plaque psoriasis (from 4 years of age)
- Uveitis (from 2 years of age)
- Adolescent hidradenitis suppurativa (from 12 years of age)

For full indications and more information, see full Summary of Product Characteristics.

Summer Meeting 2019

Mary Ryan, Deborah Stammers, Maura O'Connor, Jennifer Hewson, Simona Sehrish, Marichu Almazan

Prof Larry Egan, Laragh DeBhulbh AbbVie, Prof Christian Maaser

ABSTRACT 66 (19W164)

Treatment of symptoms in the Absence of INflammation in Inflammatory Bowel Disease (TRAIN-IBD): Initial Results

Author(s)
A.M. Fennessy, S. Sihag, S. Warnock, I. Warnock, M.S. Ismail, K. Hazel, S. Anwar, D. McNamara, B.M. Ryan, N. Breslin, A. O'Connor
Department(s)/Institutions
Gastroenterology Department, Tallaght University Hospital, Tallaght, Dublin 24

Introduction
The prevalence of Irritable Bowel Syndrome (IBS) in Inflammatory Bowel Disease (IBD) has been estimated at 39%. The subset of IBD patients affected by IBS report reduced quality of life with increased anxiety and depression. Studies examining the efficacy of probiotics in IBD have shown mixed results to date, with no trials examining the IBD/IBS overlap subgroup.
Aims/Background
To assess the efficacy of probiotics in reducing IBS symptoms for patients with inflammatory bowel disease in remission.
Method
This is a single-centre, double-blind, placebo-controlled trial. IBD patients recruited had a normal FCP and CRP at week 0, and met Rome IV Criteria. They were randomised to receive either placebo or a probiotic containing L. rhamnosus, E. faecium, L. acidophilus, and L. plantarum. All participants returned after 12 weeks for further assessment of symptoms, repeat CRP and faecal calprotectin.
Results
Eighteen patients have completed 12 weeks of treatment with placebo or probiotic. Baseline data was collected for all patients with follow up data available for 11. Included in this group are two Ulcerative Colitis (UC) patients and nine Crohn's disease (CD) patients. One UC patient had an improved partial Mayo score. Five CD patients had an improved Harvey Bradshaw Index (HBI) score. For two patients, their score did not change, while three patients had a higher score after completion. Eight of the 11 patients reported a reduction in their IBS Severity score at week 12.
Conclusions
These results would suggest possible benefit with probiotic use, however more data is required in order to assess for significance.

ABSTRACT 67 (19W169)

Out of Sight Out of Mind. Faecal Calprotectin Levels in Patients With Endoscopically Quiescent Inflammatory Bowel Disease

Author(s)
C. Clifford, O. Fagan, K. Kennedy, F. MacCarthy, K. Hartery, S. McKiernan, D. Kevans
Department(s)/Institutions
Department of Gastroenterology, St James's Hospital, Dublin 8

Introduction
Endoscopic mucosal healing (MH) is a primary therapeutic goal in inflammatory bowel disease (IBD). Faecal calprotectin (FC) is a reliable surrogate biomarker of colonic inflammation. Studies have shown FC to be useful in patients with clinically inactive disease but its role in patients achieving MH is less certain.
Aims/Background
To explore FC levels and the characteristics of patients with endoscopically quiescent disease.
Method
A retrospective study of patients with endoscopically quiescent disease [endoscopic Mayo subscore 0 or 1, SES CD 0-2] undergoing colonoscopy between August 2015 and August 2018 was carried out. Patients were extracted from our IBD surveillance database. Endoscopy images were reviewed using the ADAM endoscopy software. FC checked within 3 months of their colonoscopy was included. FC >250 was the defined threshold for elevated levels.
Results
A total of 412 colonoscopies were reviewed. 67 patients had endoscopically quiescent disease and a subsequent FC measured. 21 (32%) UC and 46 (68%) CD. 40 (60%) female and 27(40%) male. 26 (38%) had FC >250. 4 (16%) were on aminosalicylate monotherapy, 11(42.2%) biologics only, 8 (26.2%) combination therapy while 1 (5.2%) was on no treatment.
Conclusions
A significant proportion of patients with quiescent IBD had elevated FC despite various treatment regimens. Further work is needed to determine the significance of these high FC levels and whether there is an association with relapse allowing timely escalation or de-escalation of therapy. Analysis of relapse in this cohort of patients is ongoing to establish any clear association.

ABSTRACT 68 (19W170)

An Audit of Hepatocellular Carcinoma Surveillance

Author(s)
E. Leung, P. Singh, R. Al Nabhani, S. Garvey, M. Tayyub, S. Sengupta, J. Keohane
Department(s)/Institutions
Department of Gastroenterology, Our Lady of Lourdes Hospital, Drogheda, County Louth

Introduction
HCC surveillance can lead to early detection of tumors amenable to curative therapy. Studies demonstrate improved survival rates and cost-effectiveness with 6-month intervals compared to annual surveillance. Most guidelines recommend 6-monthly liver ultrasound (the addition of AFP testing is less clear). This is rarely achieved in practice.
Aims/Background
To measure adherence to HCC surveillance guidelines
Method
We identified patients with cirrhosis by searching clinic letters from October 2013 to December 2015. We searched NIMIS and laboratory software for dates of dedicated liver imaging and AFP tests. We calculated the mean interval between tests for each patient. Intervals less than 3 months were not included.
Results
49 patients were examined. 7 never had liver imaging (3 of these had died within 1 year of first surveillance). 4 patients had only 1 liver imaging study (2 died within 1 year). Mean interval between liver imaging was less than 7 months for 4 patients, 7-9 months for 4, 9-12 months for 9, 12-18 months for 15, 18-24 months for 4, and 24-36 months for 2. 5 patients never had AFP tested (3 died within 1 year). 10 patients had AFP tested only once (6 died within 1 year). The mean interval between AFP testing was less than 7 months for 4 patients, 7-9 months for 11, 9-12 months for 10, 12-18 months for 6, 18-24 months for 3.
Conclusions

8% had liver imaging at intervals in line with guidelines. Improved clinician and patient education and creating a surveillance database are interventions that may improve adherence.

ABSTRACT 69 (19W172)

ERCP under General Anaesthesia – A Single Tertiary Centre Experience

Author(s)
B.Christopher1, J.Rasool1, J.Keohane2, S.Sengupta2, D.Cheriyan1, S.Patchett1
Department(s)/Institutions
1Department of Gastroenterology, Beaumont Hospital, Dublin 2Department of Gastroenterology, Our Lady of Lourdes Hospital, Drogheda, Co Louth
Introduction
Endoscopic retrograde cholangiopancreatography (ERCP) is a complex procedure, that in Ireland is typically performed under conscious sedation. ERCP can also be performed under general anaesthesia (GA), which is often standard practice in other countries. Risks associated with conscious sedation include desaturation and premature termination of the procedure due to patient intolerance. Despite this, access to regular ERCP lists with anaesthetic cover remains a challenge.
Aims/Background
The aim of this study was to evaluate patients at a tertiary care referral hospital who have had ERCP under GA and to determine the indication for the procedure with anaesthetic support.
Method
ERCP procedures performed from January 2017 to September 2019 were retrospectively assessed by database search and chart review. All procedures were performed in Beaumont hospital by four experienced consultant gastroenterologists. During the study period, 1114 procedures were performed. Outcomes measured included procedure termination for any reasons, hypoxia (O2 sats < 90%) / hypotensive events (systolic BP < 90mmHg), dose of sedation used prior to GA consideration and usage of reversal agents.
Results
23 patients (2%) of the total 1114, had ERCP performed under GA. Mean age was 64 (25 – 84) with equal gender distribution. The average sedation dose given under conscious sedation before contemplating GA was – Fentanyl 75 mcg, midazolam 5 mg, pethidine 50 mg and diazepam 6 mg. 1 patient received both Flumazenil and Naloxone and 2 others were given one of each reversal agent. The principal indications for GA were patients' intolerance (remained agitated despite safe sedation escalation) in 57% cases (13/23), large biliary stones leading to failed prolonged procedure (n=3), ampullary adenoma resection (n=2), desaturation (n=1) and hypotension (n=1). There were 2 pregnant patients who had ERCP performed under GA. 1 patient was already intubated due to cholangitis.
Conclusions
ERCP cases performed under GA were very selective and all had prior ERCP performed under conscious sedation. The limited access to anaesthetic support remains a challenge. Improvement in availability of GA for ERCP is likely to improve safety and efficiency of our ERCP service.

ABSTRACT 70 (19W173)

Audit of colonoscopies carried out for the indication of abnormal radiological imaging over a 4 year period in St James's Hospital.

Author(s)
RM. Corcoran, S. O'Reilly, BA. Shoukat, K. Hartery, S McKiernan, D. Kevans, F. MacCarthy.
Department(s)/Institutions
Department of Gastroenterology St James's Hospital
Introduction
A frequent indication for colonoscopy referral is abnormal findings on cross-sectional imaging or PET. Colonic abnormalities may also be incidentally detected in patients undergoing imaging for other reasons.
Aims/Background
Our aim was to determine the yield of endoscopy in the investigation of intestinal abnormalities detected on cross-sectional imaging.
Method
Colonoscopy reports from the 1st of July 2015 to the 1st of July 2019 which had 'abnormal imaging' listed as the indication were retrieved from the St James Hospital endoscopy database. 158 patients were identified from this initial search. Duplicates, patients with external imaging, and patients with incomplete colonoscopies were excluded resulting in a final study cohort of 134 patients. Comparison between sensitivity of different cross-sectional imaging modalities was made. P values < 0.05 were considered significant.
Results
40 patients underwent PET-CT and the remainder underwent either CT or MRI. 57% (n=76) of patients had an endoscopic abnormality correlate with abnormal imaging findings. Comparing imaging techniques, 73% (29 / 40) of PET-CT versus 51% (48 / 94) CT / MRI patients had an endoscopic-radiological correlate p= 0.02. 21 colorectal cancers were diagnosed (16%); 3 described as "colonic thickening' with the other 19 described as a "mass / FDG-avid abnormality with lymph nodes or concerning features". Where imaging demonstrated "colitis / fat stranding (n=14)", 36% (n=5) of patients had a correlating finding at colonoscopy. No patients with this CT finding had a colorectal cancer.
Conclusions
Radiological abnormalities are moderately correlated with endoscopic findings. Endoscopy should generally be performed to investigate radiological abnormalities. There is a significantly higher yield for endoscopy performed to investigate PET-CT abnormalities compared abnormalities detected on standard cross-sectional imaging.

ABSTRACT 71 (19W174)

A survey of functional status of IBD patients on Vedolizumab, in MUH.

Author(s)
Dr Naveed khan, Dr Donal Tighe, Dr Luke O'Donnell, Dr Brian Egan.
Department(s)/Institutions
Gastroeneterology, Mayo University hospital Castlebar
Introduction
Vedolizumab is a monoclonal antibody, selective adhesion molecule inhibitor. The aim of this treatment is not only to reduce the frequency

and severity of flare-ups but also to minimize the impact of disease and treatment side effects on daily life.

Aims/Background

The aim of this survey was to find out the functional status of IBD patients pre and post Vedolizumab commencement.

Method

Our Medical day unit infuses 16 patients of IBD with Vedolizumab. 62% are men, 38 % are women. 62% with UC and 38% with CD. 62% had previously other biologic agents and 38 % are Biologic-Naïve due to CI to other agents.50% of the patients had ≥2 biologic agents previously. All patients who attended were asked to fill IBD disk questionnaires and some forms were filled through telephonic interviews. 11 patients completed the questionnaire. All patients had their CRP checked at every visit.

Results

Prior to Vedolizumab treatment the greatest disability was abdominal pain, followed by regulating defecation, Education/work and Energy levels. After Vedolizumab treatment the most common issue was Joints pain, sleep, energy and abdominal pain followed by Emotions and regulating defecation. Nearly 70% patients had most recent CRP <10 and only 2 patients had CRP higher than 50.

Conclusions

The use of IBD disk has the potential to be a valuable tool for use in clinical visit and facilitate assessment of IBD related disability relevant to both physicians and patients. It also gives an opportunity for patients to be more engaged in their care.

ABSTRACT 72 (19W175)

Twenty years of outcomes post Orthotopic Liver Transplant, a retrospective analysis

Author(s)

Armstrong P, Gallagher A, Shanahan W, O'Driscoll P, McCarthy A, Houlihan D

Department(s)/Institutions

Liver Transplant Unit, St Vincent's University Hospital

Introduction

Both elective and emergency Orthotopic Liver Transplant (OLT) has been performed in St Vincent's University Hospital since 1993.

Aims/Background

We analysed twenty years of OLT across two decades, with five year follow up for each group. Outcomes examined; five year survival and retransplant, and presence of intrahepatic malignancy and its effect on survival.

Method

Data was obtained from the National Liver Transplant Registry, and analysed using SPSS. Patients were divided into decade one (1/1/1994-31/12/2003) and decade two (1/1/2004-31/12/2013). Outcomes were compared between these decades.

Results

There were in total 228 patients in decade one and 476 in decade two. Survival was increased in decade two, although not statistically significant. There was a statistically significant increase in transplants for malignancy in the second decade compared to the first, $p<0.0001$, [1.75-4.79] and their survival outcomes were improved compared to the first decade, using a Kaplan Meier Curve. Over the entire twenty years of the study, we saw a reduced survival rate in malignant cases compared to non-malignant, $p<0.0001$, [0.26-0.61]. There was no significant difference between the rate of retransplant in decade one and decade two.

Conclusions

Increasing numbers of OLT are being performed in SVUH, with statistically significant improved survival rates across decades shown for those in the malignant cohort.

ABSTRACT 73 (19W176)

A review of inpatient OGDs in St James Hospital

Author(s)

L Coffey, E Connolly , R Varley ,L Piggott, , F MacCarthy , D Kevans , S Mc Kiernan, K Hartery

Department(s)/Institutions

Gastroenterology Department ,St James Hospital

Introduction

Upper GI bleeding is a common cause of admission to hospital. It is associated with significant morbidity and mortality.

Aims/Background

Endoscopy services are under significant pressures from inpatient and outpatient referrals. Bleeding from the upper GI tract is a common indication for inpatient endoscopy.

Method

A retrospective analysis of all OGDs performed in the endoscopy suite at a tertiary centre with the indication of haematemesis, malaena and anaemia in the time period October 2018 to August 2019 was performed using the endoscopy software ADAM. Relevant clinical covariates, endoscopic findings, and outcomes were collected by review of the electronic medical record.

Results

A total of 793 upper GI endoscopic procedures were reviewed over a 22 month time period. 250(31.5%) were inpatient upper GI endoscopies. Indications for endoscopy included haematemesis n=51(6.4%), maleana n=73 (9.2% and anaemia n=126(15.8%). 33(1.2%) patients were on DOAC, 14(1.8%) patients were on warfarin therapy and 52(6.5%) patients were on aspirin alone or dual anti-platelet therapy. Mean Blatchford score was 7.5 and the mean haemoglobin at the time of endoscopy was 8.9g/L.

Conclusions

The study demonstrates the utilisation of inpatient endoscopy for investigation of upper GI bleeding in the investigation of our cohort of patients. *Correlations between endoscopy findings can be presented at the Winter meeting

ABSTRACT 74 (19W178)

A Single Centre Retrospective Audit of Utility of Ultrasound Surveillance in Haemochromatosis .

Author(s)

A.Tony, D.Poynton, M.Callghan, S.Ryan, J.O'Connell, M.Hanly, F.Toor, C.Smyth, O.Kelly, B.Hall, RJ.Farrell.

Department(s)/Institutions

Department Of Gastroenterology, Connolly Hospital, Blanchardstown. Royal College of Surgeons of Ireland .

Introduction

Haemochromatosis patients with cirrhosis have a 100-fold increased chance of developing hepatocellular carcinoma (HCC) (EASL Clinical Practice Guidelines 2018). Recent meta-analysis reported a 1.2% incidence of HCC in hemochromatosis patients with cirrhosis.1 HCC in non-cirrhotic patients is very rare and it is unclear if screening for HCC is necessary in this group with no established optimum surveillance interval guidelines published.

Aims/Background
The aim of our study was to retrospectively assess the interval of ultrasound (USS) examination in haemochromatosis patients at our centre and to determine its yield and utility for HCC surveillance. Among the 173 patients included in our study, the interval between USS varied from 6 months t
Method
All haemochromatosis patients in our venesection database were included. Data was collected from the NIMIS radiology and lab system. This study excluded patients with no genotype or USS results.
Results
Among the 173 patients included in our study, the interval between USS varied from 6 months to 6 years, with a mean interval of 2.7 years. Out of the 173 patients, 94 (54.3%) showed hepatic steatosis, 51 (29.4%) had a normal study, 28 (16.2%) showed hepatic cysts and 3 had cirrhosis. Among the 173 patients who had USS, 18 (10.4%) had USS six monthly, 31(17.9%) had yearly and 22(12.7%) had eighteen monthly. However, 88 (50.8%)of patients had USS done at an interval more than 2 years and 14 never had USS in the past in our system . Interestingly, out of the 3 patients with established cirrhosis (1.7%), 1 developed a HCC, who had an USS surveillance scan performed 13 months earlier.
Conclusions
USS surveillance among the haemochromatosis patients without cirrhosis should be limited to an interval of every 18 months or more as the yield in detecting HCC is very low. However, haemochromatosis patients with cirrhosis should have USS and AFP every six months for early detection of HCC with low threshold for MRI liver if suspicious liver lesions are detected on USS. Adoption of uniform surveillance USS intervals for haemochromatosis patients with and without cirrhosis would have significant cost savings as the vast majority of patients do not have cirrhosis and do not warrant frequent surveillance USS. References 1. Tarao, K. et al. (2019). Real impact of liver cirrhosis on the development of hepatocellular carcinoma in various liver diseases—meta-analytic assessment. Cancer Medicine, 8(3), pp.1054-1065. 2. European Association for the study of the Liver. EASL clinical practice guidelines for HFE hemochromatosis.J Hepatol(2010) doi: 10.1016/j.jhep.2010.03.001. Epub 2010 Apr 18.

ABSTRACT 75 (19W179)

A Snapshot of Ustekinumab Use for Crohn's Disease in Ireland

Author(s)
McShane C (1), Gracias CS (1), Keogh A (2), O'Donovan H (2), O'Hara F (3), Slattery E (2), Boland K (3), O'Toole A (3), Keohane J (1), Sengupta S (1)
Department(s)/Institutions
1. Our Lady of Lourdes Hospital, Drogheda. 2. Galway University Hospital, Galway. 3. Beaumont Hospital, Dublin.
Introduction
Ustekinumab is a human monoclonal antibody targeting IL-12 and IL-23 which was approved for treating Crohn's Disease (CD) in 2016.
Aims/Background
To describe the experience to date of Ustekinumab in treating CD since its approval in 2016 in an Irish setting.
Method
A retrospective study was performed across 3 centres throughout Ireland. Patients commencing Ustekinumab treatment for CD (2016-present) were identified. Demographic, clinical and biochemical data were collected.
Results
The cohort comprised of 61 patients. Baseline characteristics; Gender - 67.2% female; Age at diagnosis (median) - 29.07yrs; CD classification - L1 14.8%, L2 18%, L3 60.7%, L2+L4 1.6%, L3+L4 4.9%, B1 33.9%, B2 22%, B3 44.1%, perianal 20%; Previous treatments - immunomodulators 66.7%, Anti-TNF 91.7%, Vedolizumab 15%, Resection 51.7%; Alternative Rheumatalogical/ Dermatological indication - 21.7%. Characteristics at induction; Age - 41.69yrs, Corticosteroid use - 25%; Intravenous induction - 85.2%. Outcomes; Mean follow-up – 435d (IQR 127-608.5); Respective wk0, wk12 and wk44 results - Harvey Bradshaw Index (7, 3.57, 4), Faecal Calprotectin (846, 204, 245) and CRP (8.02, 5.07, 5.01mg/L); 13.2% required dose escalation; 11 patients discontinued treatment with a mean duration of treatment of 238d (IQR 15.5-407) (4 allergic reaction, 1 primary LOR, 5 secondary LOR, 1 social reasons). Pregnancy occurred in 1 patient. 4 patients had adverse infective reactions.
Conclusions
This study demonstrates that Ustekinumab has a durable response and a good safety profile in an Irish treatment refractory CD population. A high percentage of patients were found to have a Rheumatological/ Dermatological co-morbidity, suggesting that Ustekinumab is being selected to treat both indications.

ABSTRACT 76 (19W180)

Significant Correlation between Adenoma and Serrated Lesions Detection Rates at Colonoscopy

Author(s)
P. McDonagh, E.H.D Wouda, J. O'Connell, S. McKiernan, F. MacCarthy, D. Kevans, K. Hartery
Department(s)/Institutions
Department of Gastroenterology, St James's Hospital, Dublin 8
Introduction
Sessile serrated lesions (SSL) have in recent years been identified as important precancerous lesions, accounting for between 15-30% of interval colorectal cancers (CRC). Adenoma Detection Rate (ADR) is a powerful quality indicator that has proven to be directly related to interval CRC. Little is known about the correlation between ADR and SSL-Detection Rate (SSL-DR).
Aims/Background
Our primary objective was to assess correlation between ADR and SSL-DR.
Method
Retrospective study analysing electronic endoscopy database from an academic teaching hospital from January 1st to December 31st, 2018. Average-risk screening colonoscopies were analysed. Endoscopists were stratified by high and low ADRs (>/=25%, <25%). SSL-DR defined as any serrated lesion of any size proximal to sigmoid colon divided by number of surveillance colonoscopies. Exclusion criteria: FAP/HNPCC, IBD, diagnostic colonoscopy, patient <50years of age, incomplete colonoscopy or failure due to poor prep. Endoscopists who performed <20 colonoscopies were excluded from the final analysis.
Results
830 procedures by 22 endoscopists were analysed, comprising of 7 consultants and 15 trainees. The overall ADR and SSL-DR were 37% and 17% respectively. There was a statistically significant correlation between ADR and SSL-DR (r=0.711, n=22, p <0.05).

Endoscopists with an ADR >25% had a significantly higher SSL-DR (19% vs 10%).

Conclusions

Detection of SSLs at colonoscopy is important. Endoscopists with higher ADRs have higher SSL-DR. SSL-DR may have a use as a marker of endoscopist's performance.

ABSTRACT 77 (19W181)

The effectiveness of patient information leaflets provided by a Clinical Nurse Specialist on disease related knowledge in Inflammatory Bowel Disease (IBD)

Author(s)

Cathy Walsh

Department(s)/Institutions

Letterkenny University Hospital

Introduction

Inflammatory Bowel Disease is a chronic debilitating relapsing remitting inflammatory bowel condition which predominately affects a young adult population. The management of complex needs in chronic illness is one of the biggest challenges for health care professionals. Education and knowledge are requirements for chronic health management. Patients are required to be knowledgeable on various aspects of their condition, in particular complex medication management. The effects of poor knowledge can lead to poor quality of life with repeated hospital admissions and risk for surgery.

Aims/Background

The study aim was to explore the effectiveness of patient information leaflets provided by a clinical nurse specialist on disease related knowledge in an Irish University Hospital

Method

A cross sectional, survey design methodology using a convenience sample of participants with a diagnosis of Inflammatory bowel disease. The study design implemented was quantitative by means of a self-administered questionnaire. Descriptive data and inferential statistics were generated to from the data collected.

Results

Wide variations in knowledge needs have reported in multiple international studies. Similar findings were demonstrated in this study regarding knowledge needs. Significant new findings related to age as a factor for poor knowledge and duration of disease demonstrated that newly diagnosed had better knowledge of the condition.A significant statistical finding is that patient information leaflets are only moderately effective for knowledge needs in IBD patients.

Conclusions

This is the first Irish study to assess disease related knowledge using the Crohns and Colitis knowledge score (CCKNOW) developed by Eaden et al, 1999. Unreported information regarding patient information leaflets has been demonstrated. Disease related knowledge has been reported as moderate and less than adequate. Patient information leaflets are not meeting the knowledge needs for IBD patients.It illustrates the need for further education programmes for IBD patients

ABSTRACT 78 (19W183)

Identification And Correction Of Iron Deficiency Anaemia In Newly Diagnosed IBD Patients

Author(s)

M. Muzammil, M. Jawad, B. Egan, A. Petrie

Department(s)/Institutions

Mayo University Hospital Castlebar Co mayo.

Introduction

One of the most frequent complication of IBD is anaemia (Hb<13g/dL for men and <12g/dL for women), which may affect patient's quality of life and should hence be evaluated at initial diagnosis. Microcytic anaemia is usually most common type of anaemia in IBD, which usually indicates iron deficiency anaemia.

Aims/Background

Adherence to ECCO-anaemia guidelines for identification and correction of iron deficiency anaemia in newly diagnosed IBD patients in Mayo University Hospital Castlebar Co Mayo

Method

Retrospective study involving 47 newly diagnosed IBD patients from June 2018-June 2019.

Results

Iron studies were done on 37 out of 47 (78.72%) newly diagnosed IBD patients from June 2018 to June 2019.23 out of 47 patients (48.9%) were found to be iron deficient and out of which 16 (69.5%) were found to have anaemia with iron deficiency and 7 patients (30.5%) had iron deficiency but no anaemia.12 out 23 (52.1%) Iron deficient IBD patients had Iron replacement (IV or oral) done while 11 out of 23(47.8%) did not have any Iron replacement.

Conclusions

All newly diagnosed IBD patients should have iron studies done after confirmation of diagnosis. Iron replacement is recommended for prevention of anaemia in such patients.

ABSTRACT 79 (19W184)

An audit assessing clinical practice for suspected irritable bowel syndrome (IBS) in patients presenting to gastroenterology clinic in Tallaght University Hospital (TUH)

Author(s)

D. Molloy1,2, S. Sihag1,2, Neary E 3, Gill S 3, N Breslin 2, B. Ryan2, D. McNamara1,2 A.O'Connor 1,2

Department(s)/Institutions

1. Trinity Academic Gastroenterology Group, Trinity College Dublin 2. Department of Gastroenterology, Tallaght University Hospital, Tallaght, Dublin 24 3 Department of Nutrition & Dietetics, Tallaght University Hospital, Tallaght, Dublin 24

Introduction

The aim of the audit was to evaluate clinical practice for patients presenting with symptoms suggestive of IBS preceding the introduction of an IBS pathway. This baseline audit will form the basis of re-audit following the implementation of the IBS pathway.

Aims/Background

The objectives were to determine if appropriate clinical investigations were completed at first time presentation to clinic, assess time to diagnosis and baseline rates of colonoscopy use in these patients

Method

80 patients were identified for inclusion in the study from referrals

to the dietitian for IBS management. A retrospective review of electronic records were viewed to obtain blood tests (full blood count, CRP, thyroid function tests (TFT's) and anti-tTG and faecal calprotectin. The number of patients who proceeded to colonoscopy was obtained.

Results

78% (62/80) were female. Mean age 39 years (17-85). 36% (29/80) attended ≥3 clinics before diagnosis of IBS. Mean number of clinic appointments 4.72 (1-24). 93% (74/80) had FBC, 76% (61/80) had TFT's, 79% (63/80) had CRP, 69% (55/80) had anti-tTG antibodies checked on first clinic appointment. 29 % (23/80) had faecal calprotection done. 60% (48/80) had colonoscopies with 27% (13/48) colonoscopies occurring prior to clinic consultation. 56% (27/48) were <45 years undergoing colonoscopy

Conclusions

This baseline audit has highlighted that appropriate investigations were not being performed in all patients presenting to clinic with IBS symptoms. A re-audit since the introduction of IBS pathway should now be performed to evaluate if suitable investigations are completed and if number of clinic appointments and colonoscopies are reduced since its introduction.

ABSTRACT 80 (19W185)

Real World Experience with Tofacitinib for Moderate to Severe Ulcerative Colitis (UC)

Author(s)

R SAEIDI, A YADAV, C ROWAN, G CULLEN, J SHERIDAN, E SLATTERY, L EGAN, A O'TOOLE, C O'MORAIN, GA DOHERTY

Department(s)/Institutions

Centre for Colorectal Disease, St. Vincent's University Hospital/ UCD Medical School, UCHG and NUI Galway, Beaumont Hospital/ RCSI, Trinity College Dublin/Beacon Hospital On behalf of the INITIative network

Introduction

Tofacitinib, an oral pan-JAK inhibitor with short half-life, was recently approved for induction and maintenance of remission in UC. Tofacitinib has been linked to several adverse effects including higher infection risk, VZV re-activation, hyperlipidaemia and PE.

Aims/Background

The aim of our study was to assess the safety and efficacy of tofacitinib in real world Irish practice.

Method

We performed a retrospective multi-centre study through the INITIative IBD network. Anonymised demographic data was collected. Non-response was defined as permanent discontinuation due to lack of efficacy, need for colectomy or adverse effects.

Results

Total of 18 patients were included with median therapy duration of 25 weeks, seventeen of which were on anti-TNF therapy prior to tofacitinib. Twelve (67%) were male. 12/18 patients (67%) responded to therapy, of which one discontinued therapy due to pregnancy. Median treatment duration was 31 weeks in responder group 6/18 (33%) patients were non-responders to therapy after a median of 17 weeks, 4 of whom underwent colectomy and 2 were referred for a surgical approach. 9/18 patients (50%) had concomitant maintenance medication(s); 2 of whom were on vedolizumab, 1 on methotrexate and the remainder on either oral 5-ASA or topical steroid/5-ASA, alone or in combination. There were 5 episodes of infection in 3 patients which required total of 38 days of therapy interruption. No other documented adverse effects of tofacitinib were recorded.

Conclusions

In our study majority of UC patients in real world Irish practice responded to tofacitinib. Further long term safety and efficacy registry of this medication would be beneficial.

BSTRACT 81 (19W186)

Risk assessment and management of non-variceal upper-GI-bleed, how are we doing? Real world observational study in a single tertiary centre

Author(s)

R Saeidi, S Shahsavari, J Sheridan, G Cullen, Ga Doherty

Department(s)/Institutions

St. Vincent's University Hospital and UCD Medical school

Introduction

UGIB is a common medical emergency with a reported mortality of 2-10%. Patients with low risk of needing an emergent intervention can be managed as outpatients. Patients with a higher risk should undergo endoscopy within 24-hours.

Aims/Background

Risk assessment and management of patients were compared to NICE guidelines.

Method

A prospective study of inpatient referral to endoscopy unit in SVUH with suspected UGIB for one month duration (August 2019) was performed.

Results

Total of 41 patients were included in the study with male predominance of 61% (25). Total of 48 procedures were carried out. Three cases (7%) had a recorded Glasgow Blatchford score (GBS) pre-endoscopy. Thirty six (88%) were already started on PPI prior to endoscopy. Thirty four (83%) procedures were carried out within 24 hours from referral time, 20 of which were within 12 hours. Major reasons for delayed procedures included patient's fasting status, bed management issues and late referrals. Most common abnormal findings were Peptic ulcers disease (34%). Four patients required repeat endoscopies with total of 11 procedures. To achieve haemostasis a combination of adrenaline and endoclip(s) were used in 5 procedures, endoclip(s) alone in two, endoclot in one and OTSC in one case. No patient required interventional radiology or surgical interventions and no fatal cases occurred pre and post endoscopy. No patient had post-endoscopy Rockall-score documented.

Conclusions

The risk assessment quality does not meet the accepted standards and makes evaluation of quality of care difficult in this study, however endoscopic managements were according to guidelines and there were no serious outcomes.

ABSTRACT 82 (19W187)

Comparison Of Potentially Curative Therapies In Hepatocellular Carcinoma – Ireland's Experience

Author(s)

B. Layard, M. Bourke, D. Houlihan

Department(s)/Institutions

The Liver Transplant Unit, St. Vincent's University Hospital, Dublin

Introduction

Hepatocellular carcinoma (HCC) is a primary aggressive liver tumour. There are multiple treatment modalities, including resection,

liver transplant, locoregional therapy and systemic chemotherapy. Transplant is deemed the most superior treatment, with 5-year survival rates being quoted in the region of 80%.

Aims/Background

Assess and compare survival of patients undergoing potentially curative therapies for HCC - resection, liver transplantation and radiofrequency ablation (RFA).

Method

We retrospectively analysed data collated from a prospectively maintained database, at a National Tertiary Referral centre in Ireland, over 5-years. We assessed patients who had resection, RFA or transplant as treatment for HCC, from 01/01/2014 – 31/12/2018. Patient demographics, background liver disease, date of diagnosis, mode of treatment, and date of death were analysed.

Results

162 patients identified. 55 underwent resection and 39 underwent RFA as primary treatment for HCC. 68 patients were listed for transplant. 80% were male. Majority were 60-69 years. 90% had cirrhosis. A Kaplan-Meier curve demonstrates a drop-out of 10-15% in the liver transplant group at 1-year, compared to an almost 100% survival at 18 months for those undergoing RFA or resection. 5-year survival on the curve is 71% for RFA, 61% for transplant and 58% for resection.

Conclusions

Careful patient selection is key to achieve optimal results in each treatment modality. In patients meeting criteria for transplant, consideration must also be given to RFA, or resection if suitable, which can provide patients with similar or better outcomes, but without risk of drop-out at 1 year. This also allows donor grafts to be utilised for other patients in need.

ABSTRACT 83 (19W188)

Prevalence and Trends of Helicobacter Pylori Diagnosis at University Hospital Kerrya

Author(s)

Amad U H Bhatti, S. Sharma, M. MKarimi, C.K. Shahzad, E. Myres, B. Waldron, I Un Nabi

Department(s)/Institutions

University Hospital Kerry

Introduction

Helicobacter Pylori is a gram-negative bacterium that colonizes gastric epithelium with manifestations including asymptomatic, acute or chronic gastritis, ulceration, and gastrointestinal lymphoma. It is thought to be the most common bacterial infection, affecting 50% of the world. A number of non-invasive and endoscopic investigations exist for diagnosis, including the biopsy urease test (CLO test).

Aims/Background

To determine the age related prevalence of H. Pylori diagnosed by CLO testing during upper GI endoscopy at University Hospital Kerry from 2015 to 2019

Method

9552 Upper GI endoscopies (OGD's) were performed between January 2015 and August 2019. 9051 of these patients had CLO test during the procedure.501 patients did not have a CLO test. Results from these were analysed by age groups to determine the frequency of CLO positivity. Age-based and overall prevalence of H. pylori was calculated.

Results

9051 CLO tests were performed, 1013(11.19%) were positive (n= 9051), of these, 17 (0.19%) were up to 20 years old, 91(1%) were between 21-30years, 175(1.93%) 31-40 years, 192 (2.12%) 41-50 years, 185(2.0%) 51-60 years, 186 (2%) 61-70 years, 138 (1.52%) 71-80 years and 29(0.32%) 81-90 years.

Conclusions

Prevalence of H. Pylori diagnosis using CLO test was found to be 11.19 %. The highest age-related prevalence was found in the 41 - 50 year old age group at 2.12%, followed by the 61 – 70 years at 2% and 31 – 40 years age group at 1.93%. Overall it appears from these data that there is no much difference in age related prevalence of helicobacter pylori positivity in this population of patients.

ABSTRACT 84 (19W189)

A Rare Case of Two Synchronous Gastrointestinal Stromal Tumours (GIST) of the Stomach

Author(s)

J.Steen, C.J.Park, E. Wiseman

Department(s)/Institutions

Department of Gastroenterology, Ryde Hospital, Sydney, NSW 2122

Introduction

We present a 73 yo female referred with a 6 month history of worsening cyclical diarrhoea and severe abdominal cramps to a point of sweating. Past medical history includes hypertension, colonic polyps, obesity, non-smoker, no family history of GI malignancy.

Method

CT abdomen pelvis highlighted 2 gastric lesions. These were further clarified at OGD as: 1. An ulcerated submucosal 3x2cm lesion projecting from the lesser curvature of the gastric body. 2. A large antral submucosal lesion measuring approximately 6x3cm

Results

Histology from EUS samples confirmed both lesions as GISTs and following review by Upper GI surgery she underwent partial gastrectomy with lymph node dissection due to the size and location of the tumours as well as the presence of a serosal nodule on the external surface of the stomach identified on CT scan (? Bilobed tumour, local lymph node or transmural extension). She is currently being considered for adjuvant therapy with Imatinib pending specimen histopathological analysis.

Conclusions

While GISTs are the most common mesenchymal tumours of the GI tract, they are largely considered to be solitary tumours and the presence of multiple primary lesions is very rare out of the context of familial/genetic conditions such as NF1 or Carney's syndrome. Furthermore, despite their malignant potential, metastatic GISTs favour deposition in the peritoneum or liver rather than other sites within the GI tract. This case reports the very rare phenomenon of two synchronous GISTs occurring within the stomach and highlights the issue of distinguishing synchronous pathology from GI tract metastases.

Prof Larry Egan, Jayne Doherty 3rd Oral prize & Todd Manning AbbVie

ABSTRACT 85 (19W192)

New oral anticoagulant use and upper gastrointestinal bleeding, a single centre retrospective study.

Author(s)
L Coffey, E Connolly , R Varley , L Piggott, , D O Toole, S Mc Kiernan, F MacCarthy , D Kevans , K Hartery
Department(s)/Institutions
Department of Gastroenterology, St. James's Hospital, Dublin 8

Introduction
Upper gastrointestinal (GI) bleeding is a common cause of admission to hospital, and is associated with significant mortality. Glasgow Blatchford Score (GBS) is a risk scoring tool used to predict the need to treat patients presenting with upper GI bleeding. Use of new oral anticoagulants (NOAC) is becoming increasingly more common in our ageing co-morbid population.

Aims/Background
Here in, we review outcomes in patients admitted with upper GI bleeding over a 10 month period in our centre.

Method
Retrospective study analysing electronic endoscopy database from an academic teaching hospital from October 2018 to August 2019. All OGDs performed due to the indication of haematemesis, melaena and anaemia analyzed. Patients were excluded if procedure was performed as an outpatient. Clinical data and endoscopy reports were obtained from patient's electronic health record.

Results
251 inpatient upper GI endoscopies were performed for the indication of haematemesis (n=59), meleana (n=77) and anaemia (n=159). 48 (18.7%) patients were on NOAC, of which 27% (n=13) were also on concomitant antiplatelet therapy. In our cohort, GBS correlated with need for transfusion (p=0.001) and endoscopic intervention (p=0.03). NOAC use was associated with higher GBS score (8 vs 7, p <0.05). There was a significant association between combined NOAC and antiplatelet use and severity of haemorrhage assessed by transfusion requirement (p=0.04). This was not observed with in NOAC alone (p=0.21).

Conclusions
The study further validates the use of GBS in clinical setting. Combined NOAC and antiplatelet use was associated with a higher transfusion requirement. Rationalisation of combined NOAC and antiplatelet use should be considered, where possible.

FUTURE MEETINGS
Dates to Remember

Friday 27 March 2020
USG Spring Meeting
Park Ave Belfast

Thursday 23 April 2020
ESGE Days- Symposia
Dublin Convention Centre

24 & 25 April 2020
ESGE Days
Dublin Convention Centre

2 - 5 May 2020
DDW
Chicago

14 & 15 May 2020
Joint ISG / Coloproctology Meeting
Killashee Hotel, Naas


Prof Larry Egan, Jacinta Walsh 1st Oral prize & Todd Manning AbbVie


Prof Larry Egan, Helen O'Donovan 2nd Oral prize & Todd Manning AbbVie

Summer Meeting 2019

Dr Patrick Allen

Eabha Ring and Sile Kelly

Abrar Ahmed Ansari, Muteeb Ashraf, Chuhadry Khuram Shahzad

Gareth Horgan, Sharon Hough, Ashraf Monged

Prof Fank Murray & Dr John Lennon

ISG Meeting Winter, 2019 Exhibitors

AbbVie Limited

Merck Sharp & Dohme

Norgine Pharma Ltd

Takeda Products Ireland Ltd

Pfizer

Janssen Cilag Ltd

Alimentary Health Ltd

Amgen Ireland Ltd

Ardmore Healthcare Ltd

Biogen

Boston Scientific Ltd

Cook Medical

Dr. Falk

Echosens

Ferring Pharma Ltd

Fleetwood Healthcare Ltd

Fresenius Kabi Ltd

Gilead Sciences Ltd

Hospital Services Ltd

KeyMed (Ireland) Ltd

Medtronic

Mylan IRE Healthcare Ltd

Symprove

Sword Medical Ltd

Tillotts

Vifor Pharma UK Ltd

The above Sponsors have supported this meeting through a payment to exhibit a stand and have no involvement in any other aspect of this meeting.

Summer Meeting 2019

Johnny Cash, Grant Caddy and Tony Tham

Niamh Mehigan, Helen O'Donovan, Mark Kielty, Rory MCGuinness

Stelara®
(ustekinumab)

MISSION: STEROID–FREE REMISSION[1]

FOR STELARA® THE MISSION FOR ULCERATIVE COLITIS (UC) PATIENTS IS STEROID-FREE REMISSION[1]

STELARA® NOW LICENSED IN ULCERATIVE COLITIS[2,3]

STELARA® 45 mg and 90 mg solution for injection and 130 mg concentrate for solution for infusion PRESCRIBING INFORMATION. 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 TNFa antagonist or have contraindications to such therapies. **Ulcerative colitis:** Treatment of adult patients with moderately to severely active ulcerative colitis who had an inadequate response with/lost response to/were intolerant to either conventional therapy or a biologic 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/ulcerative colitis. 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 up to and including 100kg, 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Patients greater than 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 under 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 greater than 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 greater than 100 kg. Consider discontinuation if no response after 28 weeks. Crohn's disease and ulcerative colitis: 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 16 weeks after the IV induction dose or 16 weeks after switching to the 8-weekly maintenance dose. Immunomodulators and/or corticosteroids may be continued but consider reducing/discontinuing corticosteroids if responding to Stelara. In Crohn's disease, if therapy interrupted, resume s.c. every 8 weeks if safe/effective. ***Children: under 12 years*** - Not recommended for psoriasis. ***under 18 years*** - Not recommended for psoriatic arthritis, Crohn's disease and ulcerative colitis. ***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, sinusitis, 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 children 12 years and over 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 and ulcerative colitis: concomitant immunosuppressive or corticosteroid therapy did not appear to affect STELARA. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** Prescription Only Medicine (POM). **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 Sciences Ireland UC, Barnahely, Ringaskiddy, IRL - Co. Cork, P43 FA46. **Prescribing information last revised:** 07/2019 (CHMP opinion).

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events via: HPRA Pharmacovigilance, Earlsfort Centre, Block A, Earlsfort Terrace, 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 Sciences Ireland UC on 1800 709 122 or at dsafety@its.jnj.com.

Corticosteroid-free remission (defined as clinical remission Mayo score ≤2 points, with no individual subscore >1) and not receiving corticosteroids at Week 44 out of all randomized patients in each treatment group.

REFERENCES:

1. Sandborn WJ, *et al.* 14th Congress of ECCO; March 6-9, 2019; OP37
2. Stelara® 130 mg concentrate solution for infusion Summary of Product Characteristics, available at www.medicines.ie.
3. Stelara® 90 mg and 45 mg solution for injection Summary of Product Characteristics, available at www.medicines.ie.

janssen Immunology

PHARMACEUTICAL COMPANIES OF Johnson & Johnson

CP-110580 | Date of preparation: September 2019

MAVIRET®
glecaprevir/pibrentasvir

8 WEEKS
12 WEEKS

FOR TREATMENT-NAÏVE, NON-CIRRHOTIC PATIENTS

WITH MAVIRET[1]

AN 8-WEEK DURATION ACROSS ALL GENOTYPES[1*†]

NOW INDICATED FOR

8-WEEK DURATION FOR TREATMENT-NAÏVE, COMPENSATED CIRRHOTIC HCV PATIENTS ACROSS GT 1, 2, 4–6†

TREATMENT-NAÏVE PATIENTS

NON-CIRRHOTIC	COMPENSATED CIRRHOTIC‡	
8 WEEKS		GT 1, GT 2, GT 4, GT 5, GT 6
	12 WEEKS	GT 3

TREATMENT-EXPERIENCED PRS† PATIENTS

NON-CIRRHOTIC	COMPENSATED CIRRHOTIC‡	
8 WEEKS	12 WEEKS	GT 1, GT 2, GT 4, GT 5, GT 6, GT 3
16 WEEKS		

ONCE DAILY

STRAIGHTFORWARD ONCE-DAILY REGIMEN[1]

- No baseline resistance or viral load testing required
- 0.1% discontinuation of treatment due to adverse reactions
- The most common adverse reactions (≥10% of patients) were headache and fatigue
- When given the choice between a shorter duration and less tablets ONCE daily, 87% will choose the therapy with shorter duration[2]

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 and in adolescents aged 12 to <18 years.
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:** *Adults and adolescents aged 12 to <18 years:* 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, 2, 4, 5, 6): **No cirrhosis:** 8 weeks. **Cirrhosis:** 8 weeks. (GT 3): **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 dose adjustment required in adolescents aged 12 to <18 years. The safety and efficacy of Maviret in children aged less than 12 years have not yet been established. Diabetic Patients: Diabetics may experience improved glucose control, potentially resulting in symptomatic hypoglycaemia, after initiating HCV direct acting antiviral treatment. Glucose levels of diabetic patients initiating direct acting antiviral therapy should be closely monitored, particularly within the first 3 months, and their diabetic medication modified when necessary.
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. Frequency not known (cannot be estimated from the available data): pruritus.
▼ 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; website: www.hpra.ie. Suspected adverse events should also be reported to AbbVie Limited on 01-4287900.
LEGAL CATEGORY: POM(S1A). **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:** July 2019. PI/1213/007.

* Refers to genotypes 1–6.
† The recommended duration of MAVIRET is 12 weeks in liver or kidney transplant recipients with or without cirrhosis.
‡ Cirrhotic refers to compensated cirrhotic (Child-Pugh A).
† pegIFN + RBV ± S OF or SOF + RBV failures

For full prescribing information please refer to the Maviret Summary of Product Characteristics, available at www.medicines.ie

REFERENCE: 1. MAVIRET Summary of Product Characteristics, available on www.medicines.ie **2.** Welzel T, et al. Assessing Patient Preferences for Treatment Decisions for New Direct Acting Antiviral (DAA) Therapies for Chronic Hepatitis C Virus Infections, Adv Ther 2019, published online June 25 2019. https://doi.org/10.1007/s12325-019-01012-6.

IE-MAVI-190043 **Date of Preparation:** September 2019

abbvie