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Irish Society of Gastroenterology

Summer Meeting

30-31 May 2019

Galmont Hotel, Galway

MSD

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NORGINE

INTRODUCING
THE FIRST ORAL JAK INHIBITOR
APPROVED FOR ULCERATIVE COLITIS[1]

MADE IN IRELAND

RAPID AND SUSTAINED EFFICACY[2,3]

A MARK OF XELJANZ▼

When your UC patients have failed conventional therapy or a biologic agent, you can choose XELJANZ *[1]

XELJANZ®
(tofacitinib citrate)

Rapid improvement of symptoms seen as early as 3 days‡[2]
Sustained steroid-free remission as well as mucosal healing†[1,3]
A well characterised safety profile[1,4]

XELJANZ*▼ (tofacitinib) Prescribing Information:
Please refer to the Summary of Product Characteristics (SmPC) before prescribing XELJANZ 5 mg or 10 mg film-coated tablets. **Presentation:** Film-coated tablet containing tofacitinib citrate, equivalent to 5 mg or 10 mg tofacitinib. **Indications:** In combination with methotrexate (MTX) for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying antirheumatic drugs. Can be given as monotherapy in case of intolerance to MTX or when treatment with MTX is inappropriate. In combination with MTX for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior disease modifying antirheumatic drug (DMARD) therapy. For the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic agent. **Dosage:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition for which tofacitinib is indicated. Tofacitinib is given with or without food. ***RA and PsA:*** The recommended dose is 5 mg administered orally twice daily. ***UC:*** The recommended dose is 10 mg given orally twice daily for induction for 8 weeks and 5 mg given twice daily for maintenance. For patients who do not achieve adequate therapeutic benefit by week 8, the induction dose of 10 mg twice daily can be extended for an additional 8 weeks (16 weeks total), followed by 5 mg twice daily for maintenance. Tofacitinib induction therapy should be discontinued in any patient who shows no evidence of therapeutic benefit by week 16. For some patients, such as those who have failed prior tumour necrosis factor (TNF) antagonist therapy, consideration should be given to continuation of the 10 mg twice daily dose for maintenance in order to maintain therapeutic benefit (see SmPC section 5.1). Patients who experience a decrease in response on tofacitinib 5 mg twice daily maintenance therapy may benefit from an increase to tofacitinib 10 mg administered twice daily. It is recommended not to initiate dosing in patients with an absolute lymphocyte count (ALC) less than 0.75 x 10^3/l, an absolute neutrophil count (ANC) less than 1x10^3 /l or in patients with haemoglobin less than 9 g/dL. ***Renal impairment:*** No dose adjustment is required in patients with mild or moderate renal impairment. Patients with severe renal impairment the dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal renal function is 5 mg twice daily. Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal renal function is 10 mg twice daily. Patients with severe renal impairment should remain on a reduced dose even after haemodialysis. ***Hepatic impairment:*** No dose adjustment is required in patients with mild hepatic impairment. Patients with moderate hepatic impairment dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal hepatic function is 5 mg twice daily.Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal hepatic function is 10 mg twice daily. Tofacitinib should not be used in patients with severe hepatic impairment. ***Elderly:*** No dose adjustment is required in patients aged 65 years and older. Use with caution as increase risk and severity of adverse events. ***Drug-drug Interactions:*** XELJANZ dose should be reduced to 5 mg once daily in patients receiving potent inhibitors of cytochrome (CYP) P450 3A4 (e.g., ketoconazole). XELJANZ dosage should be reduced to 5 mg once daily in patients receiving one or more concomitant medicinal products that result in both moderate inhibition of CYP3A4 as well as potent inhibition of CYP2C19 (e.g., fluconazole) Coadministration of XELJANZ with potent CYP inducers (e.g., rifampicin) may result in a loss of or reduced clinical response. Coadministration of potent inducers of CYP3A4 with XELJANZ is not recommended. **Contraindications:** Hypersensitivity to any of the ingredients, active tuberculosis (TB), serious infections such as sepsis, or opportunistic infections, severe hepatic impairment, pregnancy and lactation. **Warnings and Precautions:** Tofacitinib should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition for which tofacitinib is indicated. Patients treated with tofacitinib should be given a patient alert card. There was a higher incidence of adverse events for the combination of tofacitinib with MTX versus tofacitinib as monotherapy in RA clinical studies. Tofacitinib should be avoided in combination with biologics and potent immunosuppressants such as azathioprine, 6-mercaptopurine, ciclosporine and tacrolimus. ***Infections:*** Serious and sometimes fatal infections have been reported in patients administered tofacitinib. Rheumatoid arthritis patients taking corticosteroids may be predisposed to infection. Patients should be closely monitored for infections, with prompt diagnosis and treatment. Treatment should be interrupted if a serious infection develops. Use carefully in elderly or patients predisposed to, or with a history of infection (e.g. diabetes). ***Tuberculosis:*** Patients should be evaluated for both active and latent TB prior to being treated with tofacitinib, patients who test positive for latent TB should be treated with standard antimycobacterial therapy before administering tofacitinib. ***Viral Reactivation:*** In clinical studies viral reactivation and cases of herpes zoster have been observed. Screening for viral hepatitis should be performed in accordance with clinical guidelines prior to starting therapy with tofacitinib. The impact on chronic viral hepatitis is not known. ***Vaccinations:*** Prior to initiating tofacitinib, it is recommended that all patients be brought up to date with all immunisations in agreement with current immunisation guidelines. Live vaccines should not be given concurrently with tofacitinib. ***Malignancy:*** Lymphomas and other malignancies have been observed in patients treated with tofacitinib. Patients with highly active disease may be at higher risk than the general population. The effect of tofacitinib on the development and course of malignancies is not known. NMSCs have been reported, the risk of NMSC may be higher in patients treated with tofacitinib 10 mg twice daily than in patients treated with 5 mg twice daily. Periodic skin examination is recommended in patients at increased risk. ***Interstitial lung disease:*** Caution is recommended in patients with a history of chronic lung disease as they may be more prone to infection. Asian patients are known to be at higher risk of ILD caution should be exercised with these patients. ***Gastrointestinal perforations:*** Tofacitinib should be used with caution in patients who may be at increased risk e.g. diverticulitis or concomitant use of corticosteroids or NSAIDs. ***Cardiovascular risk:*** Risk factors should be managed as part of usual standard of care. ***Hypersensitivity:*** Cases of drug hypersensitivity associated with tofacitinib administration have been reported. Allergic reactions included angioedema and urticaria; serious reactions have occurred. If any serious allergic or anaphylactic reaction occurs, tofacitinib should be discontinued immediately . ***Laboratory Parameters:*** Increased incidence of lymphopenia and neutropenia have been reported and decreases in haemoglobin and should be monitored in accordance with the SmPC. Monitor ANC and haemoglobin at baseline, 4-8 weeks and 3 monthly, ALC at baseline and 3 monthly. Tofacitinib has been associated with increases in lipid parameters maximal effects are observed at 6 weeks. Monitoring should be performed 8 weeks after initiation and managed according to hyperlipidemia guidelines. Increases in liver enzymes greater than 3x ULN were uncommonly reported, use caution when initiating with potential hepatotoxic medicinal products. **Pregnancy & Lactation:** Use of tofacitinib during pregnancy and breast-feeding is contraindicated. **Side Effects:** The most common serious adverse reactions were serious infections; pneumonia, cellulitis, herpes zoster, UTIs, diverticulitis, appendicitis and opportunistic infections. The most commonly reported adverse reactions during the first 3 months in controlled clinical trials were headache, upper respiratory tract infections, nasopharyngitis, diarrhoea, nausea and hypertension. The most commonly reported adverse reactions in patients receiving tofacitinib 10 mg twice daily in the induction studies were headache, nasopharyngitis, nausea, and arthralgia. Commonly reported adverse reactions (≥1/100 to <1/10), were pneumonia, influenza, herpes zoster, urinary tract infection, sinusitis, bronchitis, nasopharyngitis, pharyngitis, anaemia, headache, hypertension, cough, abdominal pain, vomiting, diarrhoea, nausea, gastritis, dyspepsia, rash, arthralgia, pyrexia, oedema peripheral, fatigue, blood creatine phosphokinase increased. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** S1B. **Marketing Authorisation Number:** EU/1/16/1178/003 – 5 mg (56 film-coated tablets); EU/1/16/1178/007 – 10 mg (56 film-coated tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at EUMEDINFO@pfizer.com. ***For queries regarding product availability please contact:*** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

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

Last revised: 11/2018.

Ref: XJ 6_0.

* XELJANZ is indicated for patients with moderately to severely active UC who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic agent.
‡ In a post-hoc analysis of data from phase 3 trials of induction therapy with tofacitinib in patients with UC.
† Sustained steroid-free remission: remission and using no corticosteroids for at least 4 weeks prior to the visit at both Week 24 and Week 52. Improvement of endoscopic appearance of the mucosa (mucosal healing) was defined as a Mayo endoscopic subscore of ≤1 at Week 8 for induction and Week 52 for maintenance.

References:
1. XELJANZ Summary of Product Characteristics. **2.** Hanauer S et al. Poster presented at: World Congress of Gastroenterology at the American College of Gastroenterology Annual Scientific Meeting; October 13–18, 2017; Orlando, FL, USA. **3.** Sandborn WJ et al. N Engl J Med 2017; 376(18): 1723–1736. **4.** Sandborn WJ et al. Gastroenterology [Safety manuscript].

PP-XEL-IRL-0387 | Date of preparation: March 2019

Welcome Message

Dear Colleagues,

It is my great pleasure to welcome you to the Summer ISG Meeting 2019.

For this year's meeting we have a number of very exciting invited presentations along with the best of the original research abstracts that have been submitted to the meeting. As ever, the Irish Society of Gastroenterology Meetings are a great forum for young researchers in gastroenterology and hepatology to present their findings to an interested and enthusiastic audience. This year the twelve best abstracts are going to be presented as oral free papers and we will also have four clinical case presentations on Friday morning. Poster presentations will be available for viewing throughout the meeting and I strongly encourage you all to visit the posters and engage with the poster presenters.

At this year's meeting we have a significant focus on inflammatory bowel diseases. At the cutting edge of inflammatory bowel disease we have Professor William Faubion from the Mayo Clinic giving an update on his work in the use of mesenchymal stromal cells for the treatment of perianal fistulas in Crohn's disease and Professor Severine Vermeire from Leuven in Belgium who will give an update on the use of JAK inhibitors in IBD. Professor Hugh Mulcahy from St Vincent's University Hospital in Dublin will present his pioneering work on acceptance and commitment therapy in IBD. On Friday afternoon we have a special session on the use of ultrasound in IBD meeting with a hands on course led by Professor Christian Maaser from Lueneburg, Germany. This section could be particularly attractive to trainees who might consider developing ultrasonography skills.

Alcohol related liver problems continue to be a major scourge in this country and around the world. We are delighted to welcome Professor Philippe Mathurin and Professor Eilish Gilvarry who will speak on aspects of related liver disease and alcohol addiction.

Turning to the practice of gastroenterology in Ireland, the interim director of bowel screen Professor Padraic MacMathuna will give an update. Professor Deirdre McNamara will provide a lecture on *H.pylori* infection in Ireland - an important topic in view of emerging antimicrobial resistance. Gastroenterologists up and down the country, both north and south continue to debate the future of general internal medicine in gastroenterology training and practice. The results of a survey of ISG members on their views about general internal medicine and how it impacts on their day to day work life and clinical practice will be presented followed by a panel discussion of some key leaders in Gastroenterology in Ireland.

I sincerely hope that you enjoy the meeting this year and that you have a chance to get out and enjoy my home town of Galway.

Yours sincerely,
Prof. Laurence Egan
President ISG

It Began With... Entyvio®

(vedolizumab)

Give your UC and CD patients outcomes that matter

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

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

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

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

Entyvio® vedolizumab

BEGIN THE CHANGE

Entyvio® (vedolizumab) PRESCRIBING INFORMATION
Refer to the Summary of Product Characteristics (SmPC) before prescribing.
Presentation: 300 mg powder for concentrate for solution for infusion. **Indication:** Adult patients with moderately to severely active ulcerative colitis(UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist. **Dosage & Administration:** Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn's disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. Ulcerative colitis: Recommended dose regimen 300mg administered by intravenous infusion over 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 Summer Meeting
30-31 May 2019 Galmont Hotel, Galway

Thursday May 30th

09.10 **Official Opening by Prof Larry Egan, President ISG.**

09.15 Oral Free papers (1 – 6)

10.15 **Upper GI**

Prof Deirdre McNamara,
Consultant Gastroenterologist,
Tallaght University Hospital, Dublin
"Update on H. Pylori in Ireland"

11.00 Coffee break, Poster viewing and meet the Industry

11.30 **IBD Session**

Prof William Faubion,
Specialist in pediatric and adult Gastroenterology
Mayo Clinic, Minnesota, USA
"Autologous MSCs applied in a seton for perianal fistulas in Crohn's disease

Prof Severine Vermeire,
Professor of Medicine
KU Leuven, Belgium
"JAK inhibitors in IBD – where are we in 2019?"

13.00 Lunch, view posters and meet the Industry

14.00 **Oral free papers (7- 12)**

15.00 Coffee break, Poster viewing and meet the Industry

15.30 **Liver Session**

Prof Philippe Mathurin,
Prof of Hepatology,
University Hospital of Lille. France
"Alcohol related Hepatitis"

16.15 **Prof Eilish Gilvarry,**
Clinical Director of Specialities and
Forensic Services Northumberland,
Tyne & Wear NHS Foundation Trust. UK
"Managing Alcohol Addiction".

17.00 ISG AGM

20.00 Conference Dinner

Friday May 31st

09.00 **4 Clinical Case Presentations**

10.00 **BowelScreen Update**

Prof Padraic MacMathuna,
Interim Director BowelScreen
Mater Misericordiae University Hospital, Dublin,
"BowelScreen update 2019"

10.45 Coffee Break, Poster viewing and meet the Industry.

11.15 **IBD Session**

Prof Hugh Mulcahy,
Consultant Gastroenterologist,
St Vincent's University Hospital, Dublin
"Psychological disability in IBD: Where the brain meets the bowel"

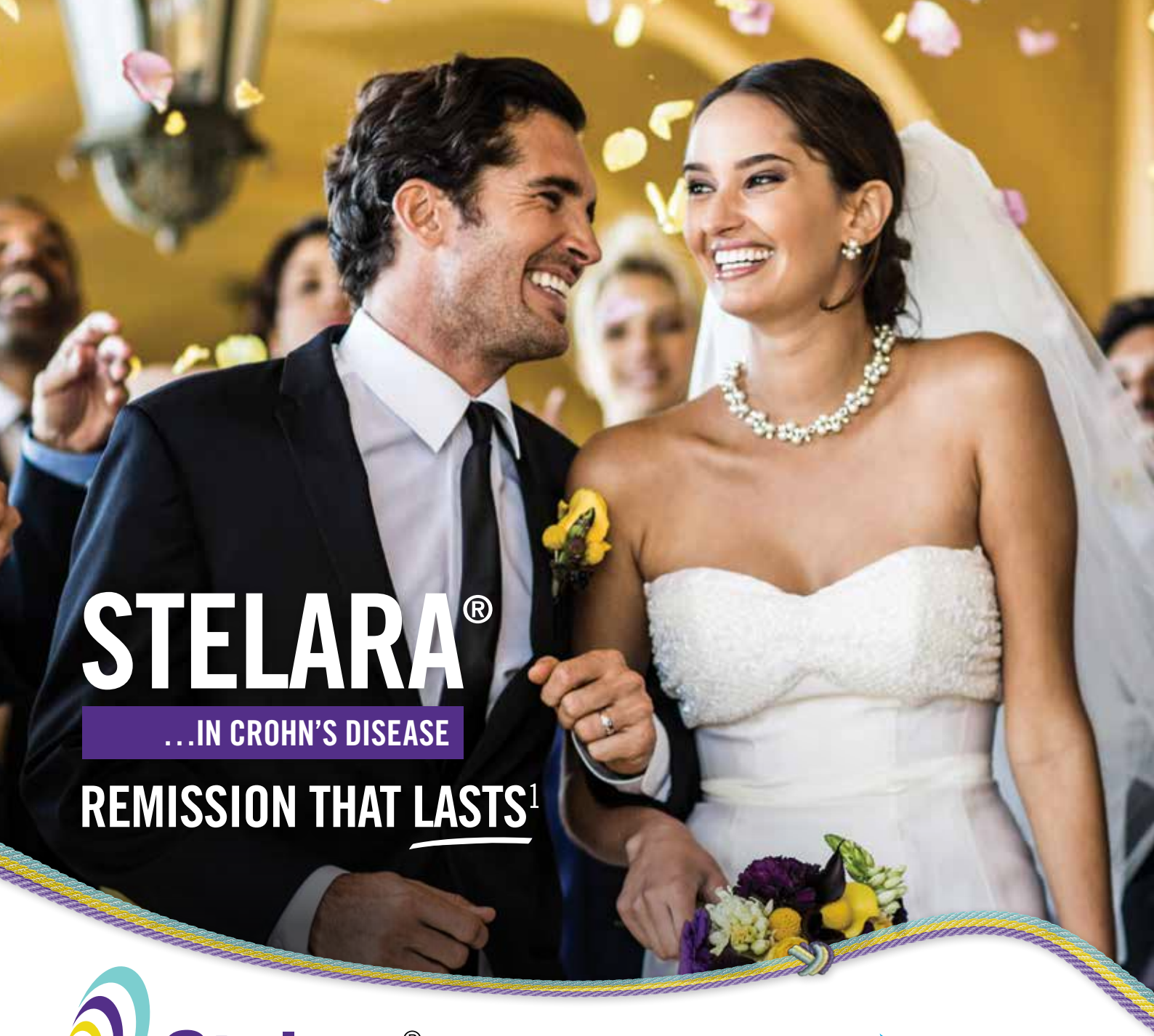
12.00 ***'Panel Discussion - The future of General Internal Medicine (GIM) in Gastroenterology Training and Practice'***

Featuring:
Professor Laurence Egan
President ISG
Prof Glen Doherty,
Training Lead for Endoscopy.
Dr Tony Tham,
Incoming President ISG.
Dr Jan Leyden,
National Specialty Director.
Prof Garry Courtney,
Consultant Gastroenterologist.
Prof Frank Murray,
National Doctors Training and Planning.

13.00 Presentation of Awards

13.15 Close of Morning Session

14.00 **Ultra Sound Special Meeting – Invited attendance**
Prof Christian Maaser,
Consultant Gastroenterologist.
Klinikum, Hospital Lueneburg, Germany.
"Hands on IBD ultrasound course"



Stelara® (ustekinumab)

Janssen Immunology

PHARMACEUTICAL COMPANIES OF Johnson & Johnson

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 TNFα antagonist or have contraindications to such therapies. **DOSAGE & ADMINISTRATION:** ***Adults:*** Under guidance and supervision of a physician experienced in diagnosis and treatment of psoriasis/psoriatic arthritis/Crohn's disease. **Psoriasis or psoriatic arthritis:** Subcutaneous (s.c.) injection. Avoid areas with psoriasis. Self-injecting patients or caregivers ensure appropriate training. Physicians are required to follow-up and monitor patients. **Plaque psoriasis, adults & elderly:** Patients < 100kg, 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Patients >100 kg, 90 mg at week 0 followed by a 90 mg dose at week 4, then every 12 weeks (45 mg was less effective in these patients). **Plaque psoriasis paediatrics (12 years and older):** Patients <60 kg, 0.75 mg/kg at week 0, followed by 0.75 mg/kg at week 4 then every 12 weeks thereafter. Patients ≥60 - ≤100kg, 45 mg at week 0 followed by 45 mg at week 4, then every 12 weeks. Patients >100 kg, 90mg at week 0, followed by 90mg at week 4, then every 12 weeks. **Psoriatic arthritis, adults & elderly:** 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Alternatively, 90 mg may be used in patients with a body weight >100 kg. Consider discontinuation if no response after 28 weeks. **Crohn's Disease:** Initial single intravenous infusion dose based on body weight (260 mg or 390 mg or 520 mg) diluted in sodium chloride solution and given over at least one hour. At week 8 after intravenous dose, 90 mg s.c. dose is given; followed by every 12 weeks (or 8 weeks based on clinical judgement). Consider discontinuation if no response at 16 weeks. Immunomodulators and/or corticosteroids may be continued but consider reducing/discontinuing corticosteroids if responding to Stelara. If therapy interrupted, resume s.c. every 8 weeks if safe/effective. ***Children:*** **<12 years** - Not recommended for psoriasis. **<18 years** - Not recommended for psoriatic arthritis and Crohn's disease. ***Renal & Hepatic impairment:*** Not studied. **CONTRAINDICATIONS:** Hypersensitivity to product; clinically important, active infection. **SPECIAL WARNINGS & PRECAUTIONS:** ***Infections:*** Potential to increase risk of infections and reactivate latent infections. Caution in patients with a chronic infection or history of recurrent infection, particularly TB. Patients should be evaluated for tuberculosis prior to initiation of STELARA. Consider anti-tuberculosis therapy prior to initiation of STELARA in patients with past history of latent or active tuberculosis. Patients should seek medical advice if signs or symptoms suggestive of an infection occur. If a serious infection develops, closely monitor and STELARA should not be administered until infection resolves. ***Malignancies:*** Potential to increase risk of malignancy. No studies in patients with history of malignancy or in patients who develop malignancy while receiving STELARA. Monitor all patients, in particular those older than 60, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment for non-melanoma skin cancer. ***Concomitant immunosuppressive therapy:*** Caution, including when changing immunosuppressive biologic agents. ***Hypersensitivity reactions:*** Serious hypersensitivity reactions (anaphylaxis and angioedema) reported, in some cases several days after treatment. If these occur appropriate therapy should be instituted and STELARA discontinued. ***Latex sensitivity:*** Needle cover contains natural rubber (latex), may cause allergic reactions. ***Immunotherapy:*** Not known whether STELARA affects allergy immunotherapy. ***Serious skin conditions:*** Exfoliative dermatitis reported following treatment. Discontinue STELARA if drug reaction is suspected. **SIDE EFFECTS:** ***Common:*** upper respiratory tract infection, nasopharyngitis, dizziness, headache, oropharyngeal pain, diarrhoea, nausea, vomiting, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, injection site pain. ***Other side effects:*** cellulitis, serious hypersensitivity reactions (including anaphylaxis, angioedema), skin exfoliation, exfoliative dermatitis, lower respiratory tract infection. Studies show adverse events reported in ≥12 year olds with plaque psoriasis were similar to those seen in previous studies in adults with plaque psoriasis. **Refer to SmPC for other side effects. FERTILITY:** The effect of ustekinumab has not been evaluated. **PREGNANCY:** Should be avoided. Women of childbearing potential: Use effective contraception during treatment and for at least 15 weeks post-treatment. **LACTATION:** Limited data in humans. **INTERACTIONS:** *In vitro,* STELARA had no effect on CYP450 activities. ***Vaccinations:*** Live vaccines should not be given concurrently with STELARA, and should be withheld for at least 15 weeks after last dose of STELARA. STELARA can resume at least 2 weeks after such vaccinations. No data on secondary transmission of infection by live vaccines in patients receiving STELARA. ***Concomitant immunosuppressive therapy:*** Psoriasis: Safety and efficacy of STELARA in combination with other immunosuppressants, including biologics, or phototherapy have not been evaluated. Psoriatic arthritis: concomitant MTX did not appear to affect STELARA. Crohn's disease: concomitant immunosupressive or corticosteroid therapy did not appear to affect STELARA. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** Prescription Only Medicine. **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S):** 45 mg, 1 x vial, EU/1/08/494/001. 45 mg, 1 x 0.5 ml pre-filled syringe, EU/1/08/494/003. 90 mg, 1 x 1.0 ml pre-filled syringe, EU/1/08/494/004. 130 mg, 1 x vial, EU/1/08/494/005. **MARKETING AUTHORISATION HOLDER:** JANSSEN-CILAG INTERNATIONAL NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen-Cilag Limited, 50 – 100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK. Prescribing information last revised: 09/2017

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events via: HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2, Tel: +353 1 6764971, Fax: +353 1 6762517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie. Adverse events should also be reported to Janssen-Cilag Limited on +44 1494 567447 or at dsafety@its.jnj.com.

References: 1. Sandborn WJ *et al.* Aliment Pharmacol Ther2018; 48:65-77.

CP-86922 I Date of Preparation: April 2019

Irish Society of Endoscopy Nurses
Agenda
Friday 31 May 2019

08.30	Registration…. Tea/ Coffee & scones/pastries
09:00	**Devika Ghosh** The new committee ***Let us introduce ourselves***
09:15	**Fiona Spellman** **Vijay Amarseda** Welcome to Galway
09.30	**Glenda Hahn** **Deepa Malini** ANP Gastroenterology Mater Miscordiae ***Bowel screening and its implications in Irish healthcare***
10:20	**Liz Waters** **Dr Chris Steele** Gastroenterologist ***JAG***
11:00	COFFEE
11.30	**Devika Ghosh** **Rosaleen White** ANP Sligo General Hospital ***Pre-assessment***
12.20	**Liz waters** Open Forum ***Issues in endoscopy*** ***"Have your say"***
13:00	LUNCH
14:00	**Bridget Meehan** **Prof Humphrey O'Connor** Gastroenterologist Clane General Hospital ***IBS Gut / Brain Connection***
15.00	**Sinead Foley** **Dr Eoin Slattery** Gastroenterologist/UCHG ***EMR***
15:50	Glenda Hahn Liz waters ***New website and educational opportunities***

Winter Meeting 2018

Professor Paud O'Regan & Pricscilla Lynch Med Indo

Dr Barra Neary Video Clips Presentation

Biographical Sketches

Prof William Faubion
Specialist in pediatric and adult Gastroenterology
Mayo Clinic, Minnesota, USA

William Faubion is a Professor in the Departments of Internal Medicine, Immunology and Pediatrics at Mayo Medical School and Director of the Pediatric Inflammatory Bowel Disease Center at Mayo Clinic. He is the principal investigator of the T32 training grant and Vice-Chair of Research for the adult GI division. A graduate of the University of Texas Health Science Center in Houston, he has authored more than 130 papers and articles in peer-reviewed journals including the Journal of Clinical Investigation, Journal of Experimental Medicine, Nature Immunology, Journal of Immunology, and Gastroenterology. He also has an active clinical trails program, steers the translational IBD research group, and an NIH funded mucosal immunology labratory focused on immuno-epigenetics.

Prof Severine Vermeire
Professor of Medicine
KU Leuven, Belgium

Séverine Vermeire obtained her MD degree at the Catholic University of Leuven in 1995 and a PhD at the same University in 2001 on "Genetic Polymorphisms and Serologic Markers in Inflammatory Bowel Disease". Part of her training was done at the Universidad Nacional de Asuncion, Paraguay (1993), at the Wellcome Trust Centre for Human Genetics , University of Oxford (1997-1998) UK and at the Montreal General Hospital (McGill University), Montreal, Canada (2000–2001). Since 2003 she has been a full staff member at the Gastroenterology Department of the University Hospital Leuven and is appointed Professor of Medicine at the Catholic University of Leuven. Since 2016 she is Head of the Department of Chronic Diseases, Metabolism & Ageing (CHROMETA) at the KU Leuven.
Dr Vermeire is actively involved as principle investigator in RCTs with new therapeutic compounds and has been lead investigator on several of these programs.
Her scientific work resulted in more than 400 peer-reviewed articles so far and focussed on the role of the microbiome and genetic susceptibility in IBD and on identifying predictive signatures of treatment response.
She is Past-President of the European Crohn's and Colitis Organisation (ECCO) and was awarded an Advanced ERC Grant from the EU in 2016.

Prof Philippe Mathurin
Prof of Hepatology,
University Hospital of Lille. France

Philippe Mathurin is Professor of Hepatology and Head of the research program on liver disease in the Department of Hepatology and Gastroenterology at the University Hospital of Lille, in France. After completing his medical training and achieving his PhD, he undertook a research fellowship in Professor Tsukamoto's laboratory at the USC School of Medicine in Los Angeles, USA, between 1997 and 1999. He has been associate editor of the Journal of Hepatology since 2009. Philippe Mathurin has published more than 250 articles in prominent journals including the New England Journal of Medicine, JAMA, Gastroenterology, Hepatology, Gut and the Journal of Hepatology. His main research interests are alcoholic liver disease, viral hepatitis, non alcoholic fatty liver disease and hepatocellular carcinoma.

Prof Eilish Gilvarry
Clinical Director of Specialities and Forensic Services Northumberland,
Tyne & Wear NHS Foundation Trust. UK

Eilish Gilvarry is a Consultant Psychiatrist in Addictions at Newcastle Addictions Service, Professor of Addiction Psychiatry at the University of Newcastle upon Tyne, and has been involved with UK addictions services over many years. She has been Clinical Director of Specialist Services 2016 at Northumberland Tyne and Wear NHS Foundation Trust (NTW) and currently is Deputy Medical Director for Appraisal and Revalidation at NTW.
She chaired the Executive Committee of the Royal College of Psychiatrists Addictions Faculty (2004-08), was involved with a number of working parties: member of the National Institute for Clinical Excellence (NICE) guidelines on opiate detoxification (2007), NICE guidelines on clinical management of alcohol related physical complications (2010-11), NICE guidelines on management of alcohol harm and dependence (2011), Chair of standards for treatment for adolescent Drug Use 2012, Member of the review of 'Orange' clinical management guidelines with the Department of Health and Public Health England (PHE) published 2017. She is Chair of the review of the "Blue Book" - Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management (2017-2019). In 2009 she chaired a review of injectables treatment for drug users. She also reviewed deaths in prison (2011-13), this review of practice standards in prisons informed the review of the section on custodial care included in "Orange" guidelines. She has a particular interest in young people and use of substances and has been involved in research and lecturing on this subject.
Chair of the Secretary of State for Transport's Advisory

Committee on drugs and alcohol and a member of the expert panel which produced the report "Driving Under The Influence Of Drugs" (2013), Eilish continues to advise on this issue. She has edited a number of books, published widely in scientific journals and is currently involved in research, eg buprenorphine depot and brief interventions for alcohol misusers. She is also an Assessor and Medical Supervisor with the General Medical Council and other regulatory authorities.

Prof Hugh Mulcahy
Consultant Gastroenterologist,
St Vincent's University Hospital, Dublin

Hugh Mulcahy is a Professor of Clinical Medicine at University College Dublin and Director of Gastroenterology at St Vincent's University Hospital Dublin. He Qualified from The Royal College of Surgeons in Ireland and trained in Dublin, Ireland, London, England and Charleston, SC, USA. He is a Fellow of the Royal College of Physicians in Ireland and a member of National and International Gastroenterology societies. His primary research interests are in the inflammatory bowel diseases, colorectal cancer and screening, interventional endoscopy and the development of novel endoscopic techniques and devices.

Dr Jan Leyden
National Specialty Director

Dr Leyden is a graduate of UCD and has been a Consultant Gastroenterologist in the Mater Misericordiae University Hospital, Dublin since 2009.
He has been one of the RCPI Gastroenterology National Speciality Directors since 2015.

Prof Garry Courtney
Consultant Gastroenterologist

Professor Garry Courtney was born in Omagh, Co. Tyrone and graduated in Medicine from Trinity College, Dublin University. He trained in General Medicine and Gastroenterology in Dublin and London and was appointed a Consultant Physician and Gastroenterologist in St. Luke's Hospital, Kilkenny in 1996. Other appointments include Clinical Director in St. Luke's Hospital Kilkenny, National Clinical Co-Lead of the Acute Medicine Programme, Clinical Professor of Medicine at the Royal College of Surgeons in Ireland and College Tutor at the Royal College of Physicians of Ireland. He was a member of the working groups which established Clinical Directorates in 2008 and the Acute Floor Programme in 2017.
Clinical Interests include Acute Medicine, Viral Hepatitis, Interventional Endoscopy and Inflammatory Bowel Disease.

Prof Frank Murray
National Doctors Training and Planning

Prof Frank Murray is Consultant Physician/ Gastroenterologist at Beaumont Hospital, Dublin and Associate Professor of Medicine at the Royal College of Surgeons in Ireland.
Professor Murray graduated from University College Dublin in 1980 and trained in Dublin, Boston USA, and Nottingham, England. He was a Consultant Gastroenterologist in Ninewells Hospital and Medical School, Dundee, Scotland.
Prof Frank Murray became a Member in 1982, a Fellow of the Royal College of Physicians of Ireland in 1994, was elected to the Council in 2002, and was appointed Registrar in 2007. He was the 141st President of the Royal College of Physicians of Ireland from 2014-2017. Prof Murray is also the former chair of both the Basic Specialist Training Committee and the Irish Committee on Higher Medical Training.
He is a founding member and Co-Chairman of the RCPI/ HSE EQUALS Initiative, a partnership which sources decommissioned medical equipment in Irish hospitals to send to hospitals in less developed countries and is partnering the development of Post-graduate Training in Zambia.
Prof Murray is Chairman of the RCPI Policy Group on Alcohol, and Chairman of Alcohol Health Alliance Ireland. He has played a prominent role in highlighting alcohol harm in Ireland and supported the introduction of evidence-based counter-measures, such as those in the Public health Alcohol Bill.
Prof Murray has recently been appointed Director, National Doctors Training and Planning (NDTP), HSE.

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.

ISG Board Members

Professor Laurence Egan,
President ISG
NUI Galway

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

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

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

Dr Manus Moloney
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 Tony C.K. Tham
Consultant Gastroenterologist
Ulster Hospital, Dundonald, Belfast

Dr Tham qualified in 1985 from Queen's University of Belfast. 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 1995 - 6.
He has been Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast since 1997. During this time, he has developed gastroenterology services in the Ulster Hospital, especially in therapeutic endoscopy and ERCP.
He has more than 70 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" which has been published as a 3rd edition and translated into Polish. He has contributed to several other book chapters. He was the Guidelines Editor for Gut. He is on the International Editorial Board of 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 and Gut.
He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency (deanery) and is currently Training Program Director for Internal Medicine. He is the Deputy Chair of the Specialist Advisory Committee for internal medicine at the Joint Royal Colleges of Physicians Training Board.
He is the President -elect of the Irish Society of Gastroenterology. He is the Chair of the British Society of Gastroenterology (BSG) Clinical Services and Standards Committee. He was formerly the Quality Improvement and Guidelines lead of the BSG. He is an examiner for the Royal College of Physicians of Edinburgh and Queen's University.
Specialties: Oesophagogastroduodenoscopy, colonoscopy, endoscopic retrograde cholangiopancreatography, therapeutic endoscopy, inflammatory bowel disease, pancreatobiliary disorders, irritable bowel syndrome

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

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

Dr Paul Lynch
Consultant Gastroenterologist
Antrim Area Hospital

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

Professor Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin

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.

Prof Padraic MacMathuna,
Interim Director BowelScreen
Mater Misericordiae University Hospital, Dublin.

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

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.

FUTURE MEETINGS
Dates to Remember

Saturday 12 October 2019
IBD Study Day
Galway

Friday 18 October 2019
USG Autumn Meeting
Park Ave Belfast

21 & 22 November 2019
ISG Winter Meeting
Killiney Castle Hotel

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

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Professor of Pharmacology

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Consultant Gastroenterologist

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Consultant Gastroenterologist

Dr Susanne O'Reilly
Gastroenterology SpR

Dr Paul Lynch,
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Consultant Gastroenterologist

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Consultant Gastroenterologist

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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.)

Inaugural Liver Disease Symposium

On Dec 7th 2018, South Tipperary General Hospital (STGH) hosted the inaugural Liver Disease Symposium. The meeting attracted over 150 attendees from Medicine / Surgery / Radiology / Nursing and Allied Health Care Professionals. A recently opened Liver Ward at STGH has highlighted the burden of Liver Disease which is reflected nationally. The aim is to optimise management of these patients locally while working in conjunction with Specialist centres.

High calibre speakers on the day included Dr Orla Crosbie, Consultant Hepatologist CUH, Mr Criostoir O' Suilleabhain, Consultant Hepatobiliary Surgeon MUH, Prof Aiden McCormick, Consultant Hepatologist SVUH, Dr Kieran Moriarty, Consultant Gastroenterologist Royal Bolton Hospital, London.
The Symposium was very well received and proved educational, stimulating and constructive with many interesting discussions.

Sponsors on the day included Norgine, Echosens, Ferring and Intercept.

Oral Presentations - ISG Winter Meeting

Abstract No.	Time:	Ref:	Title of Paper	Author
1	9.30	19S140	Review of RANP Gastroenterology/Colorectal Endoscopist in Republic of Ireland	Eddie Myers
2	9.40	19S144	First do no harm: A Single Centre Analysis on Endoscopy Referrals	Charlene Deane
3	9.50	19S151	The Impact of a Prebiotic mix, FOS-Inulin, on Hepatic Drug-Metabolising Enzymes	Jacinta Walsh
4	10.00	19S155	The impact of a dedicated clinical assessment and dietetic intervention strategy at improving symptom response and reducing unnecessary endoscopy in patients with... symptoms	Grainne Holleran
5	10.10	19S145	Endoscopic Band Ligation or Argon Plasma Coagulation for the Treatment of GAVE: Which Results in Better Outcomes?	Helen O'Donovan
6	10.20	19S141	Single centre comparison of FIB-4 score and Fibroscan as marker of liver fibrosis in HCV infection.	Farid Ahmad Toor
7	14.00	19S156	A high burden of polyps on index screening colonoscopy contributes to Endoscopist fatigue and subsequent missed polyps.'	Mark Kielty
8	14.10	19S187	Strictureplasty versus bowel resection for the surgical management of fibrostenotic Crohn's disease	Eanna J. Ryan
9	14.20	19S122	Sustainability of biologic therapies is less in UC than Crohns Disease patients independent of prior biologic experience	Jayne Doherty
10	14.30	19S147	All-Ireland experience of Endoscopic Full Thickness for Colonic Non-lifting polyps and early Colorectal Cancer	Patrick Allen
11	14.40	19S118	Development of a new pathway for patients attending gastroenterology with Iritable Bowel Syndrome (IBS)	Sarah Gill
12	14.50	19S115	The Correlation of Fit Levels with Pathology Results in a National Colorectal Cancer Screening Programme	Susanne O'Reilly

ORAL PRESENTATIONS

ABSTRACT 1 (19S140)

Review of RANP Gastroenterology/Colorectal Endoscopist in Republic of Ireland

Author(s)
J. Hewson., E Myers. & Society of Irish Gastrointestinal Nurse Endoscopists ,I Un Nabi

Department(s)/Institutions
Department of Endoscopy, University Hospital Kerry, Tralee, Co. Kerry

Introduction
The introduction of the Bowel Screen Programme in 2013 in Ireland saw a proliferation of nurse endoscopists. Prior to this time there were 2 nurses performing endoscopy procedures. Of the 17 RANPs 11 are involved with the Bowel Screen programme and the remaining work with symptomatic services.

Aims/Background
A review of the role of the RANP Gastroenterology/Colorectal Endoscopist in the Republic of Ireland

Method
Survey questionnaire distributed to 17 Nurse Endoscopists in Republic of Ireland looking at their practises within the gastroenterology/ colorectal field.

Results
Response rate was 88%. 73.3% have 0-5 years experience. 15 RANPs perform up to 69 endoscopy sessions per week (mean 4.3) overall carrying out over 10,000 procedures per year. 50% of RANPs carry out > 300 colonoscopies and > 300 OGDs per year. 100% of endoscopists have CIR >85% and 75% have CIR > 90%. 87.5% have polyp detection rate >30%. 64% of respondents are involved with the Bowel Screen Programme and of which 62% had no assistance with programme administrative work. 62.5 % have informal reflective time with their mentor each month. 90% of RANPs are happy with their role and autonomy was the most positive aspect and heavy workload identified as a negative aspect. The majority of RANPs envisage an increased number of nurse endoscopists within the next 5 years and see their scope of therapeutic intervention expanding. The main intervention carried out by 8/15 RANPs is APC.

Conclusions
Review of role shows overall satisfaction with some variances in practices. It is envisaged that there may be an increase in numbers of RANPS to meet the increasing endoscopy demand.

ABSTRACT 2 (19S144)

First do no harm: A Single Centre Analysis on Endoscopy Referrals

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

Introduction
Referrals for endoscopy have surged in recent years however not all referrals are appropriate. Inappropriate referral not only subjects patients to an unnecessary procedure it also delays the timely intervention of patients who require endoscopy. Validation of endoscopy lists is one way to improve efficiency & efficacy of the system.

Aims/Background
The aim of this study was to audit what percentages of patients in our hospital are listed for endoscopy in accordance with current best practice guidelines.

Method
A list of indications was created taking guidance from the BSG, the conjoint board of the RCPI & RCSI and the NICE guidelines. All referrals received for listing by the endoscopy secretary over a 2 week time period in March 2019 were audited.

Results
122 approved referrals were made in the outlined time period. Only 60% fit the above criteria. 82%were referred to a surgical endoscopy list, 18% to a medical. The majority of referrals came from GPs (59%), followed by 24% from outpatient clinics, 10% from ED & 8% were inpatient referrals. 51% of requests were for OGDs, the most common reason for referral was dyspepsia or reflux however 75% of referral letters failed to mention duration of symptoms, trial of PPI or results of helicobacter pylori detection test (i.e. stool antigen or breath test). 47% of requests were for colonoscopies, 2% for flexible sigmoidoscopy. 67% of all appropriate referrals for colonoscopy were for the indications of iron deficiency anaemia & altered bowel habit. 29% of referrals that did not fit criteria for a full colonoscopy were indicated to have a flexible sigmoidoscopy instead.

Conclusions
A significant proportion of referrals do not meet the criteria for endoscopy. Reflux and dyspepsia were the most common referrals for OGD however the majority of patients did not appear to have an appropriate trial of treatment, duration of symptoms or investigation with breath test or stool antigen test before referral. Colonoscopy referrals with 'family history of colorectal cancer' as the indication frequently did not specify the age of diagnosis of the relative or the relationship of the family member to the patient in the referral form (e.g brother, aunt, etc.). This audit identifies areas of intervention for us including; GP feedback, education around indications for endoscopy & a change in our current referral form to allow more appropriate triage of endoscopy requests.

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ABSTRACT 3 (19S151)

The Impact of a Prebiotic mix, FOS-Inulin, on Hepatic Drug-Metabolising Enzymes

Author(s)
Walsh, J 1,5; Lynch, N 2; Boehme, M 3,5; Cryan, JF 3,5; Dinan, TG 4,5; Griffin, BT1,5; Hyland, NP 2,5 and Clarke, G 4,5

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

Introduction
The cytochrome P450(CYPs) enzyme superfamily and multidrug-resistance protein 1(MDR1) play important roles in age-related variability in drug pharmacokinetics. We and others have previously demonstrated, using germ-free animals, that the microbiome can influence the expression of these genes. However, the effects of more clinically relevant microbiota-directed interventions, such as prebiotics, are less clear.

Aims/Background
Our aim was to investigate whether fructooligosaccharide (FOS)-inulin could alter hepatic CYP and MDR expression and whether this treatment effect was age dependent.

Method
Mice (2- and 10-months old) were fed FOS-Inulin (92%-8%) supplemented chow for 14weeks. Control mice received standard chow (n=9-10). Mice were euthanised by decapitation and total RNA was isolated from harvested liver tissue. Reverse-transcriptase PCR was employed to compare the mRNA expression of CYPs and MDR1. Data was analysed by two-way ANOVA and Bonferroni's multiple comparisons test.

Results
Age affected the response to prebiotics on CYP2a4 gene expression which was significantly up-regulated in young versus middle-aged mice ($P<0.01$). A significant prebiotic effect on CYP3a13 was only observed in young mice characterised by decreased gene expression ($P<0.05$). Interestingly, the age-related impact on MDR1a was opposite to the treatment-induced effect; significantly decreased expression of MDR1a in young versus middle-aged mice was accompanied with a FOS-inulin induced significant upregulation in young mice ($P<0.05$). A significant down-regulation of MDR1b gene expression was observed with increasing age ($P<0.05$) whilst the expression of CYP2b10 and CYP3a11 were not affected by either age or prebiotic.

Conclusions
Our data illustrate that both age and prebiotics may differentially affect the expression of hepatic CYP genes and MDR1. This study highlights that prebiotics can indirectly impact the expression of hepatic enzymes important for the metabolism of a range of commonly used drugs and provides the impetus to consider prebiotics as a potential source of variation in drug response in patients of specific age groups.

ABSTRACT 4 (19S155)

The impact of a dedicated clinical assessment and dietetic intervention strategy at improving symptom response and reducing unnecessary endoscopy in patients with functional gastrointestinal symptoms

Author(s)
Grainne Holleran, Eilish Joyce, Sandra Brady, Karen Hartery, David Kevans, Finbar MacCarthy, Susan McKiernan

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Introduction
Functional disorders account for 40% of gastroenterology referrals. The NICE guidelines recommend Rome IV criteria and non-invasive tests to facilitate diagnosis and avoid unnecessary endoscopy. First-line management involves dietary education/intervention provided by experienced Dieticians, providing adequate symptom relief in 80%. This pathway is rarely followed and patients undergo reassuringly negative endoscopies but are sent back to the GP without symptom resolution.

Aims/Background
In patients <50 years referred for colonoscopy+/-OGD for the investigation of diarrhoea+/-constipation at St James's Hospital, we aimed to assess the impact of a dedicated clinical/dietetic review on 1) symptom relief, and 2) reducing colonoscopy numbers

Method
Patients underwent blood (FBC/electrolytes/CRP/TSH/tTG) and stool (C&S/Calprotectin) tests before attending a medical assessment. Patients fulfilling a diagnosis of IBS then underwent dietetic intervention (1st line-education +/-2nd line-FODMAPs) with a senior Dietician. Response was assessed using a symptom survey pre and post-intervention. Those with an inadequate response underwent medical re-evaluation.

Results
Of the 105 patients who have completed the pilot so far, 75(71%) were referred to Dietetics, 24(23%) required endoscopy, and 6(6%) required no intervention. A further 26 are pending clinical assessment, and 15 are awaiting dietetic referral pending normal stool results. To date, 47 patients have completed dietary intervention. Of these, 44(93.6%) were discharged following adequate symptom relief (74%-1st line and 26%-2nd line intervention), and 3 patients were referred for endoscopy. This has led to the avoidance of 78 colonoscopies and 23 gastroscopies so far, equating to an 80% reduction in endoscopy requirement.

Conclusions
The implementation of a dedicated clinical diagnostic and dietetic management service has significantly reduced the number of unnecessary endoscopic procedures and facilitated the discharge of these patients following adequate symptom relief.

ISG SpR Training Day February 2019

30 Sp R's attended a Hepatology Training day in Dublin on 15 February at Radisson Blu Hotel Golden Lane. The theme of the meeting was "Liver disease in the Clinic, sponsored by Takeda Ltd.

Expert presentations were given by Dr Stephen Stewart, Mater Mis University Hospital,

Dr Diarmaid Houlihan, St Vincents University Hospital and Dr John Ryan, Beaumont Hospital.

The main sessions were on **NAFLD, Iron Disorders & Liver Disease & Hepatocullular Carcinoma** with Interactive Cases associated with all Presentations.

Ger Lawlor & Declan Ruth

Dr John Ryan

Dr Diarmaid Houlihan

Dr Stephen Stewart

ABSTRACT 5 (19S145)

Endoscopic Band Ligation or Argon Plasma Coagulation for the Treatment of GAVE: Which Results in Better Outcomes?

Author(s)
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Introduction
Gastric antral vascular ectasia (GAVE) is a rare acquired vascular malformation located in the antrum. The commonest presentation is with iron deficiency anaemia (IDA). Endoscopic therapy is the mainstay of treatment. Argon Photo Coagulation (APC) has been the standard of care; however Endoscopic Band Ligation (EBL) is increasingly used. There is no consensus regarding optimal treatment modality.

Aims/Background
To assess whether Endoscopic Band Ligation or Argon Plasma Coagulation for the treatment of GAVE at index treatment results in better outcomes.

Method
A retrospective study was performed of all patients with an endoscopic diagnosis of GAVE from 04/2013 to 11/2018. Patients receiving endoscopic therapy were included. Demographic data, indication, number of sessions and pre/post procedure haemoglobin (Hb) levels were collected.

Results
In total, 117 patients were diagnosed with GAVE. Of these, 62 patients (53%) required treatment, with female preponderance (n=39, 58%) and mean age of 74.1 (range 44-92). A total of 218 procedures were performed, with an average 4.84 treatment sessions per patient (range 1-20). IDA (76%) was the commonest indication with melaena (13%), varices (7%) and haematemesis (4%). APC was more frequently employed (n=161, 74%) compared with EBL (n=57, 26%). Patients treated with EBL as index treatment required a mean of 2.7 subsequent treatments, compared to 3.9 treatment sessions for APC. The mean rise in Hb was higher in the EBL group (1.7g/dL vs 1.0 g/dL, p=0.27), and in those receiving EBL post APC (2.0 g/dL vs. 1.2g/dL, p=0.14).

Conclusions
APC was the commonest treatment modality employed. Patients treated with EBL at index treatment required fewer subsequent treatment sessions and had greater mean rises in Hb post treatment, suggesting EBL as initial treatment may lead to better outcomes.

ABSTRACT 6 (19S141)

Single centre comparison of FIB-4 score and Fibroscan as marker of liver fibrosis in HCV infection.

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Introduction
In Hepatitis C virus (HCV) infection, non-invasive tests have replaced liver biopsy in the staging of disease. These include the FIB-4 score, which combines age with biochemical values (AST, platelet count, ALT), and liver stiffness measurement (LSM) by transient elastography (Fibroscan®), both of which can reliably exclude advanced fibrosis.

Aims/Background
To compare the agreement of FIB-4 scoring with Fibroscan® in the staging of fibrosis in HCV patients pre-treatment.

Method
We evaluated 50 HCV patients referred to Beaumont Hepatology Unit for treatment. The FIB-4 score (calculated using an online calculator) and LSM by Fibroscan® were performed as part of their standard clinical care. A FIB-4 score <1.45 has a negative predictive value of 90%, and >3.25 a specificity of 92%, for advanced fibrosis. LSM values of <7.0kPa and ≥12.5kPa were deemed to indicate an absence of significant fibrosis, and advanced fibrosis, respectively.

Results
Of the 50 patients, 24(48%) were male and 26(52%) female. The age range was 33-78 years. Of the 50 HCV patients, 13 (26%) had a FIB4 score <1.45, while 13 patients (26%) had a score >3.25. The remaining 24 (48%) fell in between. In the 13 patients with a FIB-4 score <1.45, the mean (+/-SD) LSM was 5.4kPa (+/-1.5), with a LSM 7.1-8.1kPa in only 2 of the 13 patients. Patients with a FIB-4 >3.25 had a mean (+/-SD) LSM of 17kPa (+/-9.7); of these, 2 patients had a LSM <7kPa, 3 were between 9.2-11kPa, and the remaining 8 had LSM values between 12.4-33kPa. The LSM values for the 24 patients with FIB-4 scores between 1.45 and 3.25 ranged from 4 to 25kPa. A modest correlation was seen between LSM and FIB-4 scores in the overall cohort (rho=0.48, p=0.0004).

Conclusions
In this single centre study of HCV patients, FIB-4 scoring demonstrated good utility for ruling out significant fibrosis and for ruling in advanced fibrosis as indicated by Fibroscan®. However, FIB-4 score was unreliable in 52% of cases, highlighting the need for a second non-invasive test to appropriately stage liver disease in the majority of patients.

ABSTRACT 7 (19S156)

'A high burden of polyps on index screening colonoscopy contributes to Endoscopist fatigue and subsequent missed polyps.'

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Introduction
It has been suggested that endoscopists' vigilance may diminish when polyp burdens are high. The more polyps encountered on a colonoscopy, the more likely it is for an endoscopist to miss further polyps as fatigue sets in.

Aims/Background
To assess whether high polyp burden on index screening colonoscopy affects endoscopist performance resulting in missed polyps, detected at follow-up colonoscopy.

Method
A retrospective review of NCSS BowelScreen colonoscopies performed between March 2013 and October 2018. Index colonoscopies included had ≥5 polyps. Data including number, size and histology of polyps as well as sedation rates and quality of bowel preparation were recorded. The presence of polyps on follow up colonoscopies 11-13 months post index colonoscopies was recorded.

Results
A total of 1906 colonoscopies were performed during the study period, with 13.4% (n=255) noted to have ≥ 5 polyps on index (range 5-10). Of these, 31.7% (n=81) have had follow up colonoscopies within 11-13 months. Mean caecal withdrawal time on index was 23.5 minutes (range 3-98). On repeat colonoscopy, 72.8% (n=59) had at least 1 polyp (range 1-14) with a mean polyp size of 4.3mm (range 1-14mm). Of these, 96.4% (n=55) displayed low grade dysplasia, 1.7% (n=1) high grade dysplasia and 1.7% (n=1) invasive adenocarcinoma.

Conclusions
A high burden of polyps on index screening colonoscopy is associated with a high rate of polyps on surveillance colonoscopy. While some may represent interval de novo development of polyps, a significant number represent missed polyps. These procedures are often longer and require more patient sedation, which contributes to endoscopist fatigue.

ABSTRACT 8 (19S187)

Strictureplasty versus bowel resection for the surgical management of fibrostenotic Crohn's disease

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Introduction
Strictureplasty (SPX) may conserve bowel and minimise the risk of developing short gut syndrome in Crohn's disease (CD). However, SPX may be associated with a higher risk of recurrence compared to bowel resection (BR).

Aims/Background
We sought to compare morbidity and recurrence following SPX and BR in patients with fibrostenotic CD.

Method
A systematic review was performed according to PRISMA and MOOSE guidelines. Observational studies that compared outcomes of CD patients undergoing either SPX or BR were identified. Log hazard ratios (InHR) for recurrence free survival (RFS) and their standard errors were calculated from Kaplan–Meier plots and pooled using the inverse variance method. Dichotomous variables were pooled as odds ratios (OR) using the Mantel-Haenszel method. Quality assessment of the included studies was performed using the Newcastle-Ottawa Scale (NOS).

Results
14 studies of 1593 CD patients (SPX n=545, 34.21%; BR with or without SPX n=1048, 65.79%) were eligible for inclusion. The median NOS score was 8 (range 5-9). There was an increased likelihood of disease recurrence with SPX than with BR (OR 1.61 95% Confidence interval [95% CI]: 1.03, 2.52, p=0.04, I^2=0%). Patients who had a SPX alone had a significantly reduced RFS than those who underwent BR (HR 1.36, 95% CI: 1.02, 1.81; p=0.04, I^2=0%). There was no difference in morbidity between the groups (OR 0.63; 95% CI: 0.28, 1.44; p=0.27, I^2=0%).

Conclusions
SPX should only be performed in those patients with Crohn's strictures that are at high risk for short gut and intestinal failure; otherwise BR is the favoured surgical technique for the management of fibrostenotic CD.

ABSTRACT 9 (19S122)

Sustainability of biologic therapies is less in UC than Crohns Disease patients independent of prior biologic experience

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Introduction
Treatment of Inflammatory Bowel Disease (IBD) with biologics is usually effective but may be discontinued due to inadequate response or adverse effects. Few studies have examined what determines the sustainability of treatment in a real-world setting.

Aims/Background
To determine the factors which determine sustainability of biologics therapy

Method
We performed a single centre retrospective study of a prospectively maintained database. Our primary end-point was time to discontinuation of a biologic (due to inadequate response or adverse effects) in biologic-naive (Group 1) and biologic-experienced patients (Group 2) depending whether they had UC or CD. The impact of immunomodulator co-therapy and other disease characteristics was examined.

Results
A total of 946 patients were identified with complete data. Group 1: 700 patients were biologic-naive. 331 (47.3%) received infliximab, 334(47.7%) adalimumab, 32(4.6%) golimumab and 3(0.4%) ustekinumab. 250(35.71%) had UC. 255(36.43%) patients discontinued their biologic. Median time to discontinuation was 2.94 years in UC which was significantly shorter than in CD patients with median time to discontinuation of 3.96 years (p = 0.000). Group 2: 246 patients were biologic-experienced. 83(33.7%) received infliximab, 57(23.2%) adalimumab, 39(15.9%) vedolizumab, 26(10.6%) golimumab and 41(16.7%) ustekinumab. 98(39.84%) had UC. 97(39.43%) patients discontinued their biologic. Median time to discontinuation in UC was 2.58 years compared to 3.8 years in CD (p = 0.010). No significant differences in time to biologic discontinuation were observed between biologic-naive and biologic-experienced treatments.

Conclusions
Our real-world data indicates the sustainability of biologic treatment is less in UC than in CD and is not strongly determined by prior biologic exposure. These findings are important in determining how biologic therapies are employed in both IBD sub-types and suggest the need for new non-biologic/small molecules to demonstrate their relative sustainability as IBD therapies.

ABSTRACT 10 (19S147)

All-Ireland experience of Endoscopic Full Thickness for Colonic Non-lifting polyps and early Colorectal Cancer

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Introduction
Endoscopic full thickness resection (EFTR) has been shown to be also effective for the treatment of benign non-lifting colorectal lesions. Current international Endoscopy Guidelines recommend endoscopic resection for T1 colorectal cancer (CRC) with histological low risk features and oncologic resection for those at high risk of lymphatic metastases. Accurate risk stratification is important to avoid under or over treatment for these colorectal lesions.

Aims/Background
This All-Ireland multicentre retrospective study aimed to evaluate efficacy, ease of application, safety and clinical success of EFTR for these colonic lesions.

Method
The records of all patients undergoing EFTR for various indications at 4 centres were screened for eligibility. The endpoints for this study were technical success, R0 resection, adverse events and whether patients required surgery.

Results
There were 18 patients included in the study, 6/18 were female (33 %), the mean age was 72 yrs (range 53-86 years). The indication was : non-lifting sign in 10 patients ; likely early cancer in 5 patients, 2 patients had carcinoid tumours and appendiceal orifice location in 1 patient. Technical success was achieved in 100% of patients. R0 resection was achieved in 15/18 (83%), of this 2 patients had small residual adenoma which were managed endoscopically, and one patient had a positive pathological margin. In total 6 out of 18 patients had upstaged pathology after FTR was performed (LGD to HGD n=1; HGD to cancer n=5) There was one delayed perforation at 72 hrs in a patient who had an appendiceal orifice adenoma that required surgery. There were no other adverse events. In total 2/18(11 %) of patients required oncologic resection due to high risk features, one patient required surgery for a delayed perforation whereas 15/18 (83%) of patients were followed endoscopically.

Conclusions
In non-lifting benign colorectal polyps and early colorectal cancer , EFTR is technically feasible and safe in our experience. It appears to allow better accuracy for histological risk stratification and can assist with decisions for endoscopic surveillance versus oncologic resection. Further prospective studies are required to evaluate the long-term accuracy and success of this procedure in early colorectal cancers.

ABSTRACT 11 (19S118)

Development of a new pathway for patients attending gastroenterology with Irritable Bowel Syndrome (IBS)

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Introduction
25-50% of patients attending gastroenterology out-patient clinics have a Functional Gastrointestinal Disorder (FGID) such as Irritable Bowel Syndrome (IBS) There was no clinical pathway for patients with IBS attending TUH, leading to delayed diagnosis, a revolving door of appointments and investigations, and poor patient outcomes. Clinical evidence supports the use of dietary intervention as first line treatment for IBS

Aims/Background
• Reduce waiting times for gastroenterology appointments • Reduce unnecessary investigations • Improve time to diagnosis, patient outcomes and satisfaction for IBS patients

Method
A quality improvement project was undertaken using PDSA cycle. A new patient pathway was developed and piloted which identifies and fast tracks IBS patients to a dietitian led clinic

Results
• 18% of patients attending gastro OPD had a diagnosis of IBS • IBS patients had on average 4 appointments and 1.5 scopes each (cost of €1,301 pp) • In 6 months 80 patients have been redirected to dietitian led clinics thereby avoiding long gastroenterology waiting lists. A further 82 patients are seeing both disciplines. • Patients can now be diagnosed and access dietitian within 4 months of GP referral • Patient satisfaction has improved, 100% of patients attending the dietitian led service would recommend it. Previously 41% of patients reported not being at all satisfied with services for IBS.

Conclusions
Patients with IBS now have timely access to effective and quality care. Further promotion within the gastroenterology department to optimise referral and discharge rates is needed. Clinical outcomes are being recorded and will be reported as patients complete their dietetic intervention.

ABSTRACT 12 (19S115)

The Correlation of Fit Levels with Pathology Results in a National Colorectal Cancer Screening Programme

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Introduction
Faecal Immunochemical Testing (FIT) has replaced guaiac-based stool testing in many countries as the gold standard for colorectal cancer (CRC) screening. Its correlation with the pathology detected at subsequent colonoscopy remains unknown.

Aims/Background
To examine the correlation between FIT levels and pathology identified in the Irish national CRC screening programme with particular reference to right sided and sessile serrated polyps.

Method
FIT levels of 9,271 patients were analysed and correlated with patient demographics and pathology identified at colonoscopy. Pathology examined included adenomas, sessile serrated lesions, number of polyps, polyp size, and presence of dysplasia. Levels were divided into two categories: A 'high' FIT was defined as a FIT level above the median of 479 ng/ml, and 'low' was any score below the median. Binary logistic regression multivariate analysis was performed.

Results
The median FIT level was 479 ng/ml. 8084 clients attended for colonoscopy. On multivariate analysis, those aged under 65 years of age (OR 1.267, 95% CI 1.107-1.45, p=0.001), those with a polyp over 10mm (OR 1.736, 95% CI 01.512-1.991, p<0.001) and left sided polyps (OR 1.484, 95% CI 1.266-1.74, p <0.001), had higher FIT levels (table 1). Cancers (OR 2.8, 95% CI 2.09-3.75, p<0.001) and high-grade dysplasia (OR 1.356, 95% CI 1.08-1.7, p=0.008) were also more likely to have higher FIT level than low grade or benign polyps, but levels varied greatly. FIT was likely to be higher if there was a polyp present than if colonoscopy was normal. Number of polyps was not significant. Individuals with right sided polyps had lower FIT levels, regardless of the presence or absence of left sided polyps (OR 0.867, 95% CI 0.75-0.99, p=0.048).

Conclusions
In this study, FIT levels were high for left sided and large polyps, suggesting that FIT is less useful for the detection of diminutive and right sided neoplasia. FIT levels had no significant association with gender and declined with age. FIT levels vary greatly even in those with advanced neoplasia and therefore FIT is unlikely to be useful as a risk stratification tool.

POSTER PRESENTATIONS

ABSTRACT 13 (19S102)

Evaluation of Iron Deficiency Anemia In Female Patients under Age of 50 Attending Endoscopy Unit

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Introduction
Iron Deficiency Anemia (IDA) occurs in 2-5% of adult men and postmenopausal women in the developed world and is a common cause of referral to gastroenterologist (4-13% of referrals). While menstrual blood loss is the most common cause of IDA in premenopausal women, blood loss from the GI tract is the most common cause in adult men and postmenopausal women(1).

Aims/Background
To ensure that Females less than 50 years old presented with symptoms and signs suggestive of iron deficiency anemia are managed in accordance with the British Society of Gastroenterology guideline.

Method
Data were obtained from patient health records, retrospectively in Endoscopy unit by the audit leaders.

Results
Total of 21 patients had been referred to Endoscopy unit by their general practitioners for investigation of iron deficiency anemia. . Nine patients out of twenty one had significant history of gynecological disease i.e (endometriosis, endometrial cancer or history of Menorrhagia), that would explain anemia. .Thirteen patients out of twenty one patients underwent Gastroscopy and tested for H.Pylori, with only six patients turned to be positive for H.pylori and received treatment. .Only two patients out of nine patients with significant gynecological disease showed positive CLO test for H.pylori. This might explain multi factorial causes for anemia. .Ten patients out of the total number had undergone colonoscopy for evaluation of anemia with all patients turned to have negative colonoscopy.

Conclusions
Giving the above data and from medical literature, we recognized that the commonest cause of iron deficiency anemia in females of this age group is gynecological diseases. .Proper clinical history including gynecological history and clinical examination remain the cornerstone for identifying the possible cause of iron deficiency anemia at this age group. .Giving the long waiting time for outpatient gastroscopy and colonoscopy services at University Limerick Hospital Group, trial of raising the awareness of following the BSG guidelines for management of iron deficiency anemia among medical staff, nursing staff and general practitioners to reduce the number of patients referred/admitted to hospital for scopes.

ABSTRACT 14 (19S103)

Patients' Compliance With Venesection Protocol For Haemochromatosis

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Introduction
Haemochromatosis is a chronic, hereditary disorder characterized by a systemic iron overload. Both national and international guidelines recommend venesections as the treatment of choice for the management of haemochromatosis. The protocol used in the selected department advises patients to undergo weekly venesections until their ferritin level is <250ug/L. Monthly venesections are to continue thereafter until their target ferritin level (50-100ug/L age dependent) is achieved.

Aims/Background
The aim of this audit is to assess patients compliance with the venesection protocol.

Method
This is a retrospective audit. It focused on a 15 week period in a venesection outpatient clinic and centered on 10 patients who matched the qualifying criteria. The qualifying criteria included a diagnosis of homozygous haemochromatosis with a ferritin level >250ug/L.

Results
No patient was 100% compliant with the venesection protocol. All patients attended 5 or more weeks during the 15 week period. All patients who attended the clinic experienced a reduction of some degree to their ferritin level. This audit demonstarted those with the highest attendance records had the greatest response to reduction in their serum ferritin.

Conclusions
To help increase compliance level to the venesection protocol, education sessions with patients during/prior to their first venesection appointment, focusing on the importance of attending their appointments and about their condition is recommended. How appointments are made should be reviewed and altered if necessary to encourge better compliance with the protocol. A re-audit should be carried out in a years time for comparison.

ABSTRACT 15 (19S104)

Use of Endoscopic Classifications Amongst Trainees in Ireland

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Introduction
Use of classifications to describe endoscopic findings in a standardised fashion is recommended. Their use is advocated for both upper and lower endoscopy. Incorporating them into routine practice is advised but requires education and initiative.

Aims/Background
Establish if Irish trainees are incorporating standardised classifications and scoring systems into endoscopy reports.

Method
A survey was distributed to gastroenterology trainees working in Ireland over a four week period. Routine incorporation of Mayo Endoscopic Score, NICE, Paris and Prague classifications into endoscopy reporting was established.

Results
There were 31 respondents; 29 were included for analysis. Among respondents 60% were male and the median age 31.5 years (range 28-43). Responses were identified from 10 of the 16 hospital sites surveyed. Only 48% of trainees have a formal training list and 52% have been scoping for 4 years or more. To describe polyps 50% of trainees typically use the Paris Classification; 18% never use it. Among non-users, 31% don't find it useful and 31% forget to use it. Typically 29% use the NICE Classification. Of those who don't use the NICE classification 37% forget to use it and 26% don't find it useful. Notably 11% are not sure what the NICE classification is. When reporting IBD findings 85% always use standardised reporting scores. Among non-users, 67% report that they forget to use them and 33% report it takes too much time. The majority at 96% always use the Prague Classification to describe Barrett's.

Conclusions
Frequently trainees don't utilise endoscopic classifications. Improved education and awareness will help improve current practice.

ABSTRACT 16 (19S105)

Keeping up with the Times: Use of Adjuvant Technology by Irish Gastroenterology Trainees.

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Introduction
Use of accessory devices and additional techniques in upper and lower endoscopy is always evolving. Incorporating this equipment into routine practice requires initiative often depending on the budget of the unit and the endoscopy department itself.

Aims/Background
Establish the availability and use of specialised equipment and accessory devices among trainees in Ireland.

Method
A survey was distributed to gastroenterology trainees working in Ireland over a four week period. Use of foot pump, scope guide, CO2, simeticone, endocuff, cap, NBI, and chromo-endoscopy was explored in addition to patient repositioning.

Results
There were 31 respondents; 29 were included for analysis. Responses

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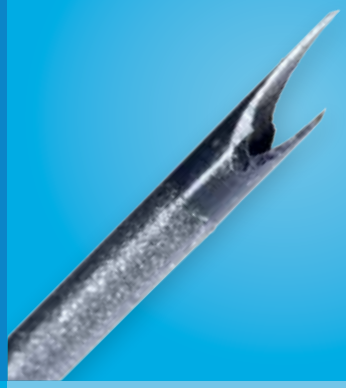

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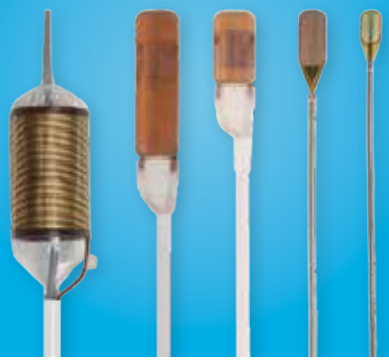

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were identified from 10 hospitals. Typically 39% of trainees use a foot pump and 38% use a scope guide for colonoscopy. Lack of availability (82%, 47% respectively) was frequently cited among non-users. Only 38% typically use CO2 during colonoscopies while just 10% use simeticone. 78% reported CO2 wasn't always available to them, whereas trainees don't find simeticone useful (35%). To aid polyp detection 68% typically reposition the patient. Trainees that don't report they don't find repositioning useful (56%). Almost two thirds of trainees typically use NBI. Those who don't report lack of confidence (33%). 18% typically use a cap for polypectomy. Among non-users, 35% haven't been taught how to use it. Only 11% typically use Endo-cuff and 26% use chromo-endoscopy (methylene blue/acetic acid).

Conclusions
Many newer accessory devices and equipment are not utilised among trainees mainly due to lack of availability or training. Addressing these issues may improve quality of endoscopy training in Ireland.

ABSTRACT 17 (19S106)

Establishing a Barrett's Oesophagus Surveillance Service in an acute hospital setting

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Introduction
Barrett's Oesophagus (BO) is a precancerous condition and has been recognised as a precursor to oesophageal adenocarcinoma. There are 430 new oesophageal cancer cases diagnosed in Ireland annually. A dedicated surveillance programme is recommended and has shown to improve assessment and management of BO. University Hospital Kerry had no uniform surveillance programme, assessment or follow-up regime prior to 2017.

Aims/Background
Establish a BO surveillance programme in University Hospital Kerry. Implement clinical guidelines and dedicated endoscopy lists following recognized protocols in order to establish a clear patient pathway.

Method
A working group was established to audit practice and implement a surveillance program. One list per month was established and dedicated to BO surveillance. This surveillance list would be undertaken by only a senior endoscopist. The Prague reporting protocol was implemented with the Seattle sampling system used for endoscopic assessments. The British Society of Gastroenterology guidelines were used for follow up of all patients.

Results
Analysis of the UHK Endoscopy waiting list identified 270 patients with a potential BO. Further analysis of the waiting list identified approximately 80 patients a year would be due surveillance. Between May 2017 and December 2018, a total of 129 patients attended for surveillance. 40 patients who underwent surveillance did not have BO and were removed from the waiting list, giving an overall reduction of 31%.

Conclusions
The introduction of a structured surveillance programme reduced the number of inappropriate procedures performed. The Prague protocol and Seattle sampling system allowed a uniform approach in undertaking BO surveillance. The establishment of a clear patient pathway allowed accurate and appropriate follow up of patients. The implementation of a structured BO surveillance programme in UHK has provided a streamlined evidence based service.

ABSTRACT 18 (19S107)

Patient's Satisfaction With A Nurse/Pharmacist Led Hepatitis C Pre Treatment Education Clinic

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Introduction
In 2017 a nurse\pharmacist led pre-treatment education clinic (PTEC) for patients with Hepatitis C (HCV) was established in CUH. At the time of this study 171 patients had attended this clinic. The nurse and the pharmacist play a pivotal role in preparing patients with HCV for treatment. Data on the satisfaction of patients attending a nurse\pharmacist led PTEC is scarce.

Aims/Background
To determine patient satisfaction with a nurse\pharmacist led Hepatitis C PTEC and identify any potential changes to improve patient experience.

Method
Patients were requested to complete a questionnaire retrospectively. The questionnaire was composed of a combination of Likert-scale questions and three open ended questions. Inclusion criteria required patients to have attended the PTEC and SVR 12 clinic. Patients were randomly selected to complete the questionnaire via post. Patients who attended a HCV clinic during the data collection period were also asked to complete the questionnaire. A qualitative thematic analysis was used for the open-ended survey questions.

Results
A response rate of 56% was achieved (n=50). Participants were very satisfied with the information they received and with how their questions were answered. Participants found both the nurses and the pharmacist were extremely helpful, polite, caring and professional. 98% of participants felt that the pre-treatment clinic was of benefit to them. Some participants requested an increased number of clinics, reduced waiting time and remote sites.

Conclusions
This study identified that the PTEC is of benefit to patients undergoing treatment for Hepatitis C. It also identified areas of change in order to improve patient experience.

ABSTRACT 19 (19S108)

To investigate the prevalence of anxiety and depression in Irritable Bowel Syndrome (IBS)

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Introduction
Irritable Bowel Syndrome (IBS) has been widely associated with psychological disorders, specifically anxiety and depression. The Hospital Anxiety and Depression Scale (HADS) is a reliable self-reporting scale that screens for anxiety and depression in IBS individuals.

Aims/Background
To look at the HADS scores of IBS individuals, to see how many had abnormal HADS scores, to in turn showcase the prevalence of anxiety and depression in Irritable Bowel Syndrome (IBS)

Method
Between 2013-2019, patients referred to TUH dietitians, with IBS were sent screening forms which consisted of the HADS. HADS score of the returned forms was calculated based on the patient's answers to the questionnaire. The percentage of patients that fell into the abnormal category (a score of 11-21) for HADS-A and then HADS-D was calculated.

Results
258 patients had returned their form at the time of analysis. 65 of these respondents were culled (because HADS was incorrectly completed or had some missing answers). 193 respondents remained. Of these 83 (43%) were found to have abnormal HADS-A scores, 47 (24%) were found to have abnormal HADS-D scores and 39 (20%) were found to have both abnormal HADS-A and HADS-D scores. An abnormal HADS score dictates an individual has a 'probable presence of mood disorder' in question.

Conclusions
The results show that there is a prevalence of psychological disorders in IBS. A high proportion of the individuals have a probable presence of both anxiety and depression. There is a higher prevalence of anxiety in IBS than there is depression.

ABSTRACT 20 (19S109)

An audit of Coeliac screening practices in a cohort of patients with IBS type symptoms

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Introduction
A coeliac screen is recommended when triaging patients with IBS type symptoms. Screening involves the measurement of serological markers - Immunoglobulin A (IgA), tissue Transglutaminase (tTg) +/- Endomysial antibody (EMA) - while consuming a gluten containing diet. If a screen is positive, patients should then proceed to duodenal biopsy for confirmation of diagnosis.

Aims/Background
To audit the practice and validity of coeliac screening undertaken in a cohort of patients with IBS type symptoms attending a tertiary hospital (n=350)

Method
The presence of coeliac serology and/or D2 biopsy was recorded at the time of referral to the dietitian-led Functional Gastrointestinal Disorders service

Results
Results show that D2 biopsy alone was completed in 104 (30%), serology and D2 in 95 (27%), and serology and IgA in 94 (27%). An incomplete screen, tTg without IgA, was ordered in 23 cases (10%). No screen appeared to have been ordered in 34 cases (6%). IgA deficiency was noted in 1 patient (0.3%) requiring IgG serology. The use of endoscopy to investigate this cohort cost an estimated €116,803.05.

Conclusions
Results suggest current practices are not compliant with clinical guidelines. The majority of patients with IBS type symptoms underwent endoscopy and duodenal biopsy, with or without serology, to out rule coeliac disease. This practice is costly and unnecessary for most patients. Inconsistency in the definition and components of serological screening was also noted. Only 27% were adequately screened according to criteria. The complete omission of a coeliac screen in 6% is a concern at a time when coeliac disease remains under-diagnosed.

ABSTRACT 21 (19S110)

Retrospective Analysis of Referrals for Endoscopy for Iron Deficiency Anaemia : Are we getting it right ?

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Introduction
Iron deficiency anaemia(IDA) occurs in 2-5% of adult men and postmenopausal women in the developed world. True IDA will require gastroscopy with or without colonoscopy after all preliminary test had been done to investigate IDA.

Aims/Background
To identify compliance of referrals for endoscopy in University Hospital Limerick(UHL) for IDA.

Method
A retrospective review of endoscopy performed between June and September 2018 for anaemia was conducted. Inclusion criteria included both gender, patients age ≥16 years, inpatients and outpatients referrals and iron deficiency anaemia using red cell indices, ferritin and serum iron studies. Exclusion criteria excluded diagnosed malignancy, abnormal imaging, and documented bleeding episodes.

Results
Only 41/66(62.1%) had confirmed IDA on blood tests in the preceding 12 months prior to endoscopy. The rate of ferritin, B12, folate, iron studies, and anti-TTG completed were 34/41(82.9%), 30/41(73.2%), 30/41(73.2%), 37/41(90.2%) and 15/41(36.6%) respectively. Only 15/41(36.6%) had all non-invasive tests done prior to endoscopy. Both gastroscopy and colonoscopy were performed in 21/41(51.2%), while 13/41(13.7%) had gastroscopy alone and 7/41(17.1%) had colonoscopy only. Among all the patients who had colonoscopy, 25/28(89.3%) had complete colonoscopy and 11/25(44.0%) had terminal ileum intubation. Duodenal biopsy to confirm coeliac disease was performed in 26/34(76.5%).

Conclusions
The British Society of Gastroenterology(BSG) guidelines for investigations of IDA highlighted that patients with IDA should be screened for coeliac disease, gastroscopy and colonoscopy should be performed. Ferritin is the study of choice for IDA especially in the absence of inflammation. We need to better improve awareness towards investigations of IDA to increase the quality of referral for endoscopy.

ABSTRACT 22 (19S111)

Complications Post-Band Ligation of Oesophageal Varices

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Introduction
Endoscopic variceal ligation (EVL) is an effective treatment however may be associated with complications of post banding ulceration and haemorrhage, stricture formation and rarely perforation.

Aims/Background
To assess the rate of complications post band ligation of oesophageal varices including bleeding due to post banding ulceration, stricture formation and perforation.

Method
A retrospective audit of the hospital endoscopy data base (PROCREP), electronic results program iSOFT and medical notes was performed on all patients undergoing band ligation from January 2013 until December 2017. Patients were classified according to whether they had band ligation to treat acute bleeding, for primary prophylaxis or secondary prophylaxis after a bleeding episode.

Results
185 EVL procedures performed in 75 patients (56 male and 19 female) from January 2013 to December 2017. There were 69 EVL procedures for acute bleeding and 116 elective EVL procedures (primary and secondary prophylaxis). Overall, 5 patients died within 30 days of the acute bleeding episode. There were 6 cases (3.24%) of post-EVL ulcer related bleeding of which 4/69 (5.79%) occurred following EVL for acute bleeding, compared to 2/116 (1.72%) that occurred after primary or secondary prophylaxis. There were no perforations or deaths due to post-banding ulcer haemorrhage.

Conclusions
Our complication rate post band ligation of oesophageal varices is similar to other published series. In our cohort, post band ulcer bleeding was mild and no patients required balloon tamponade or TIPS procedure. Band ligation is a safe procedure with a low rate of complications in what is a high-risk group of patients with significant co-morbidities of cirrhosis.

ABSTRACT 23 (19S112)

Colon Cleansing Efficacy And Safety Of 1L NER1006 In Patients With Mild To Moderate Renal Impairment: Post Hoc Analysis Of Randomised Phase 3 Clinical Trials

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Introduction
Only polyethylene glycol (PEG) bowel preparations are recommended for patients with renal failure.

Aims/Background
This post hoc analysis of randomised phase 3 clinical trials assessed the colon cleansing efficacy of the first 1L PEG, NER1006, in renally impaired versus non-renally impaired patients.

Method
Patients received split dosing regimens of NER1006, either day-before (PM/PM), overnight (PM/AM), or morning-only (AM/AM). Cleansing efficacy was assessed by treatment blinded central readers using the Harefield Cleansing Scale (HCS). The efficacy analysis included patients with a documented renal status and colonoscopy data. Patients were stratified into creatinine clearance rate (CrCl) groups: normal renal function (≥90 mL/min), mild renal insufficiency (≥60 to < 90 mL/min), or moderate renal insufficiency (≥30 to < 60 mL/min). Patients with severe renal insufficiency were excluded.

Results
Among 1134 randomised patients, 1016 were assessed for efficacy (renal status; 692 mild/moderate, 324 normal). No significant difference was observed in the overall cleansing success rates in mild and moderate versus normal. Safety was assessed in 1028 patients. The types of TEAEs were generally consistent between mild and moderate and normal. The most common TEAEs in all patient groups were gastrointestinal i.e. nausea, vomiting and dehydration. There were numerically more TEAEs in patients with moderate renal insufficiency versus normal. However, this may reflect the patients' disease state.

Conclusions
The current efficacy and safety findings support the use of NER1006 (PLENVU®) as a bowel preparation in patients with mild to moderate renal impairment.

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ABSTRACT 24 (19S113)

Plasma Electrolyte Concentrations After The Use Of 1L Polyethylene Glycol Bowel Preparation NER1006: Post Hoc Analysis Of Randomised Clinical Trials

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Introduction
Bowel preparations contain electrolytes to maintain electrolyte homeostasis after diarrhoea.

Aims/Background
This post-hoc analysis of randomised, Phase 3 clinical trials assessed plasma sodium concentrations following treatment with the 1L NER1006.

Method
The safety of NER1006 was assessed in the studies NOCT, MORA and DAYB. This analysis included patients whose plasma sodium concentrations shifted from normal at baseline to above upper limit normal (ULN) at any subsequent visit. ULN was defined locally and ranged from 143-148mmol/L. Timing of blood sample collection was determined by the dosing schedule. Samples were collected at 4 visits: at baseline (1), day of colonoscopy (2), 1-4 days (3) and 8-10 days (4) post-colonoscopy.

Results
Among 1134 randomised patients, 1028 had evaluable sodium data and 214 were included in this analysis. A transient shift around 5mmol/L occurred predominantly at Visit 2, with 96.4-99.6% patients returning to normal levels by visit 3. More patients in NOCT compared to MORA and DAYB experienced elevated sodium levels. However, in NOCT the baseline value was high with >50% patients at >142mmol/L. For such patients, minor shifts of only 2-3mmol/L would exceed ULN. There were 4 reported cases of mild hypernatremia across the studies, all of which were considered treatment-related by investigator. No hyponatraemia was observed with NER1006. Across all three studies the median changes in plasma electrolyte levels were transient and not considered clinically significant.

Conclusions
Mild, transient increases in plasma electrolyte levels were observed with NER1006 (PLENVU®) on visit 2, these were not clinically significant.

ABSTRACT 25 (19S114)

High-Quality Colon Cleansing Improves Real-World Identification Of High-Risk Patients: Post Hoc Analysis Of Randomised Clinical Trials Using Two Validated Cleansing Scales

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Introduction
Clinical guidelines classify colonoscopy patients with three or more detected adenomas as being high risk for advanced neoplasia. These patients have a recommended follow-up after 3 years.

Aims/Background
Our post hoc analysis of three phase 3 randomised clinical trials assessed whether increased colon cleansing quality could improve real-world identification of high-risk patients.

Method
Three similarly designed phase 3 trials assessed the efficacy and safety of 1L NER1006 (PLENVU®) versus standard bowel preparations. Polyps were detected by site endoscopists as per local practice. Cleansing quality was assessed by treatment-blinded central readers using the validated Harefield Cleansing Scale (HCS) and Boston Bowel Preparation Scale (BBPS). This pooled analysis assessed the identification of high-risk patients with three or more adenomas versus attained colon cleansing quality.

Results
A total of 1749 patients were included. Three or more adenomas/patient were observed more frequently when the overall cleansing quality increased from failure to high-quality (HCS grade A vs C: 8.7% vs 3.9%; P=0.022, and BBPS overall score 7-9 vs 0-5: 8.6% vs 4.6%; P=0.013). When the cleansing quality improved from adequate to high, a numerical trend towards increased detection was observed with both scales, and statistical significance was established with BBPS 7-9 vs 6 at 8.6% vs 5.6%; P<0.001.

Conclusions
With high- versus adequate only colon cleansing quality, more patients were identified as being at high-risk for advanced neoplasia. This trend was numerically consistent across both HCS and BBPS, but reached statistical significance with the more balanced sample sizes in the BBPS analysis.

ABSTRACT 26 (19S116)

Endoscopist-Related Factors Influencing Polyp Detection Rate In A National Colorectal Cancer Screening Programme

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Introduction
Endoscopist-related factors are known to influence the rate of polyp detection at colonoscopy. Previous studies have shown significant inter-endoscopist variability in polyp detection rates, withdrawal times and caecal intubation. Females and gastroenterologists have been shown to have a higher adenoma detection rate (Mehrota et al GIE 2018).

Aims/Background
Our aims were to assess endoscopist-specific factors associated with polyp detection rate, and particularly right sided pathology.

Method
Data from The Irish National Colorectal Cancer Screening Programme, 'BowelScreen' between November 2012 and December 2016 were collated. , BowelScreen was introduced in 2012, offering free Faecal Immunochemical Test (FIT)-based screening to men and women aged 60-69. Variables examined included FIT score, patient gender and age, date of colonoscopy, endoscopy centre, endoscopist, polyps identified, method of polypectomy, pathological findings per polyp and cancer pathology. FIT score and years of scoping experience were divided into categories for the purposes of statistical analysis. Endoscopists who had performed <50 colonoscopies during the period studied were excluded. Chi square tests were employed to compare gender, age and endoscopist groups. Multivariate analysis was performed for all polyps, right sided polyps and polyps >2cm, using binary logistic regression.

Results
Almost half a million people were screened, of whom 5% were positive. 8084 clients were deemed suitable for colonoscopy and attended for their test, yielding 113,785 polyps in total, with 414 cancers. 43 endoscopists were included in analysis (73% male, 47% gastroenterology consultants). Mean adenoma detection rate was 58.5%. Median years scoping post-specialist training were 6.4 (range 2.3-26). Gastroenterologists ($p < 0.001$, OR 1.42, 95% CI 1.25-1.62), and those with more experience ($p<0.001$, OR 1.37, 95% CI 1.18-1.57) were more likely to find any polyp, right sided pathology alone, and tumours. There were no differences between male and female endoscopists. Patients were more likely to have a polyp identified on a Tuesday ($p < 0.001$, OR 1.31, 95% CI 1.15-1.50) and less likely on a Friday ($p=0.003$, OR 0.83, 95% CI 0.73-0.94). The only significant factor associated with SSL detection (n=324) was day of the week was again significant here, with Tuesdays yielding more SSLs ($p<0.001$, OR 1.16, 95% CI 1.05-1.31) and Fridays yielding less ($p=0.005$, OR 0.83, 95% CI 0.73-0.95).

Conclusions
Gastroenterologists and experienced endoscopists were more likely to identify any pathology, as well as right sided polyps and tumours. Endoscopist gender had no effect on polyp detection, but day of the week was a significant factor.

ABSTRACT 27 (19S117)

Clinical outcomes following dietitian led group education on 1st line diet and lifestyle management of Irritable Bowel Syndrome

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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.

Aims/Background
• Improve clinical outcomes among patients with IBS attending dietetic led group education sessions.

Method
Patients were referred to a dietitian for group information sessions on 1st line dietary and lifestyle management of IBS. Patients completed a symptom evaluation questionnaire at baseline and at 3 month telephone review which included the Global Symptom Question (GSQ) and IBS Symptom Severity Score (IBSSSS).

Results
• 114 patients attended the 1st line group session and were followed up by telephone. • 44 (38.6%) had a significant (>50 point IBSSS reduction) improvement in their IBSSS on review, 24 (21.2%) were discharged with satisfactory symptom control (GSQ). • 67 (58.7%) did not have a significant improvement but have opted to remain in the dietetic led clinic for further first line advice or to advance to a low FODMAP diet. 3 patients opted out of the dietetic led clinic and were referred back to gastroenterology for further management. • 4 patients (3.5%) had no improvement in their symptoms and opted to be referred back to gastroenterology for further medical management. 3 of these 5 also had comorbidities which may have been affecting their symptoms.

Conclusions
First line dietary intervention is effective in improving symptoms in 38.6% of IBS patients and should be tried prior to the low FODMAP diet. This shows that alternative models of care such as groups and scheduled telephone reviews can be effective and efficient.

ABSTRACT 28 (19S119)

The Use Of Critical Flicker Frequency In The Assessment Of Hepatic Encephalopathy In Patients With Cirrhosis

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Introduction
Hepatic encephalopathy (HE) is a widely recognized complication in patients with liver cirrhosis. Critical Flicker Frequency (CFF) is an increasingly recognized method of assessing HE, but its diagnostic accuracy is still poorly understood in the clinical setting.

Aims/Background
To assess the accuracy of Critical Flicker Frequency as a diagnostic tool in determining the presence of HE in a cohort of Hepatology inpatients with known cirrhosis at the Royal Victoria Hospital, Belfast.

Method
A random sample of 20 inpatients with confirmed cirrhosis, were selected between September and November 2018. This included patients both with and without a diagnosis of HE. These patients underwent CFF testing, and the results compared to recent EEG findings, ammonia levels and clinical assessment for encephalopathy.

Results
Of the 20 patients, 8 had previously confirmed HE, via clinical assessment, EEG and ammonia levels, and 12 had no current clinical suspicion of HE. In the study group CFF distinguished between patients with and without HE with 37.5% sensitivity, and 92% specificity. Positive and negative predictive values were 75%, and 69% respectively.

Conclusions
Critical flicker frequency distinguished between patients with

confirmed HE, and those without, with high specificity and low sensitivity. When correlated with ammonia levels, EEG and clinical assessment, critical flicker frequency is a reliable method in distinguishing the presence or absence of overt HE in cirrhosis patients. Using critical flicker frequency as a single diagnostic method for HE is unlikely to be sufficient, given the low sensitivity. However, further analysis is required to determine its efficacy in these cases.

ABSTRACT 29 (19S120)

An Educational Intervention Improves Foundation Doctors' Confidence In The Management Of Patients With Ascites

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Introduction
Ascites has a mortality rate of 48% at one year, and can have life-threatening complications such as spontaneous bacterial peritonitis. Direct observation in our unit suggested that Foundation doctors were not confident in the management of patients with ascites.
Aims/Background
To investigate the impact of an educational intervention on Foundation doctors' confidence in the management of ascites.

Method
19 Foundation doctors (14 Foundation year one (F1), and 5 Foundation year two (F2)) in a district general hospital completed a 13-question survey to assess their confidence in the management of patients with ascites. Each question asked them to rate their confidence on a scale from 0 to 10. Following completion of this survey, an interactive teaching session was delivered. Following the teaching session, the Foundation doctors completed the same survey. A paired t-test compared the average score for each Foundation doctor pre-teaching and post-teaching.

Results
An average pre-teaching and post-teaching confidence score was calculated for each Foundation doctor. The mean average pre-teaching score was 2.77 (2.13 for F1, 4.57 for F2), and the mean average post-teaching score was 7.68 (7.24 for F1, 8.91 for F2). The average post-teaching confidence score for each Foundation doctor was compared to the corresponding average pre-teaching confidence score using a paired t-test. There was a statistically significant improvement following the teaching session, with $p < 0.0001$.

Conclusions
A focused educational intervention improved Foundation doctors' confidence in the management of ascites. Future work could incorporate similar presentations into local trust induction for the Foundation doctors.

ABSTRACT 30 (19S123)

A Quality Improvement Project to Implement Use of Mayo and Rutgeerts Scoring in Endoscopy Reporting in Cork University Hospital

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Introduction
The goal of therapy in inflammatory bowel disease (IBD) is to modify disease course to improve quality of life and avoid disability. The Mayo Endoscopic score (MES) and Rutgeerts Score (RS) represents valuable endoscopic tools for scoring severity of disease in IBD especially in an era where we are focusing on a treat to target approach.

Aims/Background
Improve use of both MES and RS in endoscopy reporting in CUH.

Method
We audited the use of MES and RS in endoscopy reports on outpatients in CUH and found use of these tools to be minimal. Informative charts were subsequently hung in each endoscopy room in our unit outlining the MES and RS and how to use these tools. We re-audited their use after 3 months.

Results
69 endoscopy reports were reviewed in our re-audit. Median age was 45.91 years. 38(56.52%) patients were male. 57 patients had a diagnosis of ulcerative colitis and 12 a diagnosis of Crohns Disease with a previous ileo-colonic resection. We found use if MES scoring increased from 22.61% prior to our intervention to 42.10% post. Use of RS improved from 31.57% to 50%. We found endoscopists were more likely to use MES in patients with active disease as opposed to patients with endoscopic remission (MAYO 0). Out of 31 patients with endoscopic remission only 6 (19.4%) patients had MES reported as opposed to 18 (69.2%) of 26 patients with active disease ($p = 0.000$).

Conclusions
Use of disease activity scores improved by nearly 50% after informative posters were placed in our department. However, to increase further use of these tools we need to promote their use in educational teaching sessions along with continuing to promote their use in endoscopy and re-audit the results in a year.

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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. Hogehilweg 7, 1101 CA Amsterdam ZO, 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/XIF5/0119/0477
Date of preparation: January 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

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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

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UK/XIF5/0219/0487

Date of preparation: February 2019.

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ABSTRACT 31 (19S124)

Acute Tubular Necrosis in Critically Ill Patients with Cirrhosis Who Meet Criteria for Hepatorenal Syndrome

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Introduction
Recognition of acute tubular necrosis (ATN) as a form of acute kidney injury is very important on the background of cirrhosis as ATN predicts the poorer outcome. Patients with ATN are more likely to require renal replacement therapy than patients with HRS.

Aims/Background
We aimed to investigate the risk factors of ATN in critically-ill patients with cirrhosis who meet criteria of HRS in hospital

Method
This was a retrospective study of 142 hospitalized patients with cirrhosis (City Hospital's medical records). All of them had died of cirrhosis complications from 2008 to 2010.Total 142 patients with histologically confirmed cirrhosis were included (male 64%). Median age was 53 years (range 19-80). Mostly alcohol induced cirrhosis.

Results
ATN at autopsy among 142 patients was found in 70 hospital cases (49.3%; 95%CI:40.8-57.8). Among 142 hospitalized patients antemortem conditions were as follows: 53 met criteria of type 1 HRS (37.3%; 95%CI:29.4-45.3) and 11 met criteria of type 2 HRS (7.8%;95%CI:3.9-13.4). In fact, it is interpretation of serum creatinine increase in the absence of morphological examination of kidneys. For patients the length of stay (LOS) of ATN group was higher than in the group without of ATN: median 7 (IQR 2–12) days vs. 4 (1–10) days, respectively (p=0.044). In our study infectious complications (mostly pneumonia, pyelonephritis, sepsis) were associated with 4.8-fold increase in the odds ratio of ATN (95%CI:2.6-8.6; p<0.001). Among infections only pneumonia was associated with 5.4-fold increase in the odds ratio of ATN (95%CI:2.8-10.4; p<0.001). The frequency of upper gastrointestinal bleeding in patients with ATN was significantly less than in group without ATN (31.3% vs. 48.3%, respectively, p=0.017). Among 142 patients pre-existing chronic kidney diseases were not significantly associated with ATN (OR=2.5;95%CI:0.8-7.2; p=0.108).

Conclusions
Risk factors of ATN in critically ill patients with cirrhosis were infections, in particular pneumonia. ATN was associated with increase of LOS.

ABSTRACT 32 (19S125)

Endoscopic Papillary Large Balloon Dilatation – Has It Made A Difference?

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Introduction
Endoscopic papillary large balloon dilatation (EPLBD) has been shown to be an effective technique for clearance of common bile duct stones (CBDS). It is unclear if EPLBD reduces numbers referred for CBD exploration.

Aims/Background
To compare CBD clearance, mechanical lithotripsy use and referral for CBD exploration between patients undergoing sphincterotomy alone (ES) vs. EPLBD.

Method
A single-centre retrospective study. Data was extracted from the endoscopic reporting system for ERCPs performed from September 2013 to January 2019. Inclusion criteria: ERCP performed for CBDS; failed CBD clearance at index case. Exclusion criteria: unsuitable for definitive CBD clearance due to coagulopathy. Difficult stones were defined as stones ≥20mm, ≥5 stones or tapering distal CBD.

Results
117 patients included for analysis, 48 with ES alone, 69 with EPLBD. Demographics were similar between the two groups with 48% aged ≥70 with ES vs. 52% with EPLBD. CBD clearance was eventually achieved in 38% with ES vs. 88% with EPLBD (p <.001). When excluding those lost to follow-up or not for definitive clearance due to co-morbidity, 69% with ES achieved CBD clearance vs. 98% with EPLBD (p <.001). ML was used in 31% with ES vs. 20% in EPLBD (p 0.18). 17% with ES were referred for CBD exploration vs. 1% with EPLBD (p 0.002). 54% with ES had difficult stones vs. 33% with EPLBD. Difficult stone clearance was achieved in 27% with ES vs. 70% with EPLBD (p 0.003).

Conclusions
EPLBD leads to improved CBD clearance, reduced use of ML and reduced referral for CBD exploration.

ABSTRACT 33 (19S126)

Temporary Loop Stomas; Ileostomy Or Colostomy That Is The Question

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Introduction
The creation of a loop ileostomy is a technique to defunction the bowel that has now largely replaced loop colostomies. We pose the question- is the gulf between the two procedures as wide as is thought?

Aims/Background
Surgical implications following closure of de-functioning stomas remains a common surgical problem. Loop ileostomies are now thought to be the preferred surgical option with probable fewer complications to loop colostomy. However few studies have shown such benefits.

Method
We reviewed all stomas performed over a ten year period from a

single surgeon dedicated colo-rectal database. This resulted in the formation of a one-hundred and nine stomas of which fifty-two were temporary loop colostomies.

Results
Fifty of fifty-six (89.2%) of the temporary stomas were reversed over a period of 2-14 months (mean; 5.1, median;3). At follow up over a period of one month to ten years (median; 6 months), seven of fifty (14%) reversed developed symptomatic incisional hernias . Three other stoma patients had incisional hernias seen on follow up CT but were clinically insignificant and asymptomatic.

Conclusions
Temporary loop colostomy is still a safe and effective method of de-functioning the large bowel and is associated with little morbidity and complications. It is also associated with fewer incisional hernias and other complications following closure when compared to closure of loop ileostomies.

ABSTRACT 34 (19S127)

Making An Impact Early: Evaluation Of The Early Management of Decompensated Cirrhotic Patients Against A Standardised Evidence Based "Care Bundle"

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Introduction
Decompensated cirrhosis is a common presentation to Emergency departments and carries a high in-house mortality (10%-20%). The importance of optimal initial management of these patients was reflected in the design of a standardised evidence-based care bundle by the British Society of Gastroenterology (BSG)/British Association for the Study of the Liver (BASL) 2016.

Aims/Background
To compare the early (first 24 hours) management of decompensated cirrhotic patients presenting to an Irish regional hospital against the BSG/BASL Care Bundle.

Method
We reviewed medical admissions to Naas General Hospital with suspected decompensated liver failure during the period 2017-2018. 54 admissions were identified. 23 admissions were excluded due to the absence of known cirrhosis and evidence of decompensation. Patient records were then examined to evaluate the initial 24-hour management.

Results
31 admissions with decompensated liver failure were identified with GI bleeding (29%) and ascites (26%) the most common presentations. 31% of ascites admissions had a diagnostic tap within 24 hours while in those with suspected spontaneous bacterial peritonitis, 20% received nil antibiotics. For those cirrhotic patients with GI bleeding, 9% had prophylactic antibiotics and 18% received Terlipressin. Of the patients who presented with evidence of kidney injury or hyponatremia, 38% had nephrotoxics held and 54% received fluid resuscitation. Where not contraindicated, 20% received DVT prophylaxis.

Conclusions
This data highlights the variability of early medical management of decompensated cirrhosis within a single centre and the need for adherence to a standardised evidence-based protocol to ensure each patient has the right interventions early.

ABSTRACT 35 (19S129)

Colorectal Cancer of the Young: A local Perspective

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Introduction
Colorectal Cancer is one of the most common cancers and is a leading cause of cancer deaths in the developed world. Recently there have been rising number of reports about young patients being diagnosed with colorectal cancer.

Aims/Background
In our study our aim was to analyse the characteristics of young patients of colorectal cancer in the north-eastern county Louth of Ireland.

Method
Retrospective review of charts of patients diagnosed with colorectal cancer, aged 50 or less, in the last 10 years at Our Lady Of Lourdes Hospital; Drogheda

Results
A total of 55 patients were included in the study. The mean age in our study was 43.39±4.461 years. We noted a higher number of male patients at 61.8% (n=34) as compared to the female patients 38.2% (n=21) in our study. The most involved site was found to be the rectum with 45.5% of the patients having rectal cancer. More than a quarter of the patients (27.3%, n=15) had Dukes stage C, at the time of diagnosis. The most common Primary symptom at presentation was Bleeding per-rectum at 25.5% (n=14). 16.4% (n=9) of patients were found to have genetic mutations predisposing them to colorectal cancer. 10 patients (18.2%) passed away during the course of 10 years with the mean age at death being 47.67±3.122 years. 3.6 % (n=2) patients had Ulcerative Colitis while 12.7% (n=7) were smokers.

Conclusions
We found a predominant number of young male patients presenting with CRC. A quarter of our patients had fairly advanced disease.

ABSTRACT 36 (19S130)

Vaccination routines during Anti TNF treatment in IBD patients attending St Luke's Hospital Kilkenny. A completed audit cycle

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

Aims/Background
To find out whether there has been any improvement in number of vaccinated IBD patients after a 3 month period of OPD education regarding vaccination.

Method
IBD patients frequently visiting Gastroenterology outpatients and infusion unit were educated regarding vaccination particularly against flu and pneumonia especially those on Anti-TNF therapy in specially designed education sessions. After 3 month period, an audit was conducted to find out an improvement in number of vaccinated IBD patients.

Results
68 patients (39 M, 29 F) were audited. Median age of responders were 32.5 yr (15yrs to 72yrs). 51/68 (75%) were on Adalimumab. 11/68 (16%) were on Infliximab, 3/68 (4.4%) on Vedolizumab and 3/68 (4.4%) on Ustekinumab. 47 out of 68 (69.1%) received at least one vaccine. Out of which, 34 (72.3%) received TIV only, 8 (17%) received TIV plus Pneumococcal, 5 (10.6%) received TIV + pneumococcal and Hep B vaccines. Main reasons not to receive vaccination included time constraints, active infection followed by no appointment available with GP.

Conclusions
This manuscript represents completion of audit cycle with successful implementation of educating IBD patients who are on anti-TNF therapy and performing repeat audit to ensure a positive outcome. Further plan is to formulate an information leaflet specifically made for IB patients on anti-TNF therapy to further consolidate the basic concept.

ABSTRACT 37 (19S131)

Endoscopic Gastrointestinal (GI) Stenting: A Single Centre – 8 Years Experience

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Introduction
Stenting has become an optimal option for the treatment of gastrointestinal malignant and benign diseases, which plays a vital role in alleviating obstructive symptoms such as dysphagia, pain and improving patients' quality of life.

Aims/Background
In this review, indications, clinical outcomes and any complications of stenting and sedation used are discussed.

Method
All inserted enteral stents were recorded in a database. ENDORAAD reporting system was used in our department from 2014 onwards and the details from ENDORAAD reports were reviewed.

Results
There were 86 total GI stents placed from January 2011 to February 2019 in our department. There were 47 males and 39 females with average age of 73.2 years (40-93). In terms of anatomical stents placement, there were 44 oesophageal, 31 colonic, 8 duodenal and 3 gastric. Indications include palliation for oesophageal carcinoma (56.9%), palliation for colorectal carcinoma (36%), 4 cases (4.7%) for recurrent benign oesophageal strictures after failed repeated CRE balloon dilatation, 1 patient (1.2%) for oesophageal perforation and 1 patient (1.2%) extrinsic oesophageal compresssion from metastasis. The average sedation used was midazolam 3mg, fentanyl 50 mcg, pethidine 37.5mg and buscopan 20mg. The average Gloucester Comfort score was 1.5 Endoscopic success rate is excellent, with all the cases (100%) had stents placed in intended position.

Conclusions
Endoscopic stenting is currently the most common modality for palliation of symptoms in patients with un-resectable upper and lower GI cancer. Endoscopic stenting is less invasive and leads to shorter hospital stay and lower cost compared to surgery. This review performed seemed to be favourable in our department in terms of expected clinical outcome for stents placement with no major procedure-related complications.

ABSTRACT 38 (19S132)

Cardiovascular Risk and Statin Use in Patients with Non-Alcoholic Fatty Liver Disease

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Introduction
Non-alcoholic fatty liver disease (NAFLD) is associated with ischemic heart disease (IHD). In addition to lifestyle modification the American Heart Association recommends moderate or high intensity statin therapy in patients with known IHD, patients aged 40-75 with DM with LDL greater than 1.8 and those aged 40-75 with a 10-year cardiovascular risk (CVR) greater than 7.5%.

Aims/Background
We assessed CVR and statin therapy in patients with NAFLD to identify potential interventions to reduce the risk of IHD.

Method
We identified patients referred to a tertiary hepatology centre aged 40 to 75 with NAFLD. We assessed their comorbidities, 10-year CVR, cardiovascular risk factors and the use of statins.

Results
55 patients were identified, 30 (55%) were female, 9 (16%) had an additional hepatological condition. 10 had IHD, of whom 8 (80%)

The Humira Family[1]

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.

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FOOTNOTES

* Comparing the HUMIRA 80mg Pen to the HUMIRA 40mg Pen in indications with a loading dose of 80mg or 160mg.

^ In indications that are approved for 40mg EW dosing either as the standard regimen or as a dose increase regimen.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

REFERENCES

1 HUMIRA SmPC. Available on www.medicines.ie
2 Commission implementing directive 2012/52/EU of 20 December 2012
3 Medicinal Products (Prescription and Control of Supply) (Amendment) (No.2) Regulations 2014. SI No. 504 2014

Uveitis, adults: For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be 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: April 2019, IE HUM 190021

were taking statins. 13 had DM with LDL greater than 1.8. 11 (85%) were taking statins. 5 had DM with LDL lower than 1.8. All were taking statins. 27 had neither IHD nor DM. 12 (44%) had a 10-year CVR greater than 7.5%. Of those with elevated risk 6 (50%) were taking statins. 15 (56%) had a 10-year CVR lower than 7.5%. 5 (33%) were taking statins.

Conclusions
Statins are used routinely in patients with NAFLD with IHD or with DM. Statins are only used in 50% of patients without IHD or DM with a CVR greater than 7.5%. In addition to lifestyle interventions these patients may benefit from the introduction of statins to reduce their CVR.

ABSTRACT 39 (19S133)

Post-colonoscopy Colorectal Cancer Rates in A N. Ireland Trust

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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 standardized 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.

ABSTRACT 40 (19S134)

Vedolizumab Therapy in Ulcerative Colitis in the Mid West – Real World Experience

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Introduction
Vedolizumab is a humanized monoclonal antibody that inhibits α4β7-integrin heterodimer. The GEMINI 1 study showed that vedolizumab was more effective than placebo as induction and maintenance therapy for ulcerative colitis (UC).

Aims/Background
We aimed to report the efficacy and safety of the use of vedolizumab in UC in the Mid West.

Method
A retrospective study was performed across the University Limerick Hospital Group. Patients with UC who were treated between January 2015 and July 2018 were identified.

Results
19 patients with UC were identified within the 43-month time frame. The majority were male(63%). The median age was 49[IQR 31–57 years]. The distribution of UC was extensive in 6/19(32%), left-sided in 8/19(42%) and 5/19(26%) were confined to the rectum. 3/19(16%) were biologic naïve, 9/19(47%) had previously been on one biologic and 7/19(37%) had been on two or more biologics. The median duration of treatment with vedolizumab was 9[1-42] months. 50% of those discontinued from vedolizumab started on a different biologic agent, 20% had surgery, 30% had neither. At 3 months, 14/19(74%) remained on vedolizumab, with 12 free from steroid and physician global assessment of disease indicated satisfactory response. At 6 months, 12/19(63%) patients remained on vedolizumab of whom one had required steroids. At 12 months, 9/19(47%) remained on vedolizumab and 7 were steroid-free for the entire study period. There were no observed cases of upper aerodigestive tract infections or gastrointestinal infections.

Conclusions
Vedolizumab was an effective means of achieving clinical response and steroid-free remission in a group of majority biological-failure patients with ulcerative colitis.

ABSTRACT 41 (19S135)

Vedolizumab Therapy in Crohn's Disease in the Mid West – Real World Experience

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Introduction
Vedolizumab is a humanized monoclonal antibody that inhibits α4β7-integrin heterodimer.

Aims/Background
We aimed report the efficacy and safety of the use of vedolizumab in Crohn's Disease (CD) in the Mid West.

Method
A retrospective study was performed across the University Limerick Hospital Group. Patients with CD who were treated with vedolizumab between January 2015 and July 2018 were identified.

Results
21 patients with CD were identified who were treated within the 43-month time frame. The majority were male(57%). The median age was 49[IQR 27 – 48.5 years]. Of these, 4/21(19%) had perianal disease and 17/21(81%) had confined ileocolonic disease. 4/21(19%) were biologic naïve, 5/21(24%) had previously been on one biologic and 12/21(57%) had been on two or more biologics. The median duration of treatment with vedolizumab was 8[1-38] months. 58% of those who stopped vedolizumab were started on a different biologic agent, 25% had surgery, and 17% had neither. At 3 months, 16/21(76%) remained on vedolizumab, 15 free from steroid and physician global assessment of disease indicated satisfactory response. At 6 months, 13/21(62%) patients remained on vedolizumab of whom one had required steroids. At 12 months, 7/21(33%) remained on vedolizumab and 4 were steroid-free for the entire study period. There were two potentially significant adverse effects, a miscarriage at 20 weeks and a new diagnosis of myasthenia gravis in a 78 year old man.

Conclusions
Vedolizumab was an effective means of achieving clinical response and steroid-free remission in a group of majority biological-failure patients with CD.

ABSTRACT 42 (19S136)

Pregnancy Outcomes in Patients with Inflammatory Bowel Disease: A Single Centre Experience

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Introduction
IBD is increasing in prevalence and frequently affects women of childbearing age. It is important to manage disease activity and risks during the perinatal period.

Aims/Background
To examine current management and pregnancy outcomes in our cohort of IBD patients.

Method
Following ethical approval, known IBD patients with at least one pregnancy were recruited. Using a self-assessment questionnaire, demographic and clinical data were recorded including medications and perinatal IBD activity and pregnancy outcomes, complications and delivery mode.

Results
30 patients, 20 CD, 9 UC and 1 Indeterminate (ID) were recruited since February 2019. Mean age 29.6 years at diagnosis. There were 78 pregnancies, 65 live births and 13 miscarriages (17%). Most attended routine combined GP and Maternity services. Only 5 (17%) attended a high risk Maternity clinic. Overall 4 (13%) smoked and 2 (6%) drank alcohol during their pregnancy. Biologic use was similar pre, during and post pregnancy; 6 (20%), 7 (23%) and 9 (30%). Reported flares were less frequent during pregnancy 40% (n=12) versus pre-60% (n=18) and post-partum 70% (n=21), $p<0.04$, OR 0.28. There were 49 vaginal and 16 (25%) caesarean sections (CS). CS rates did not differ by disease, UC 4/9 & CD 12/20, p=0.3. There were 3 (10%) preterm deliveries, 2 with low birth weights. No congenital abnormalities were recorded. Breast feeding rates were 36% (n=11).

Conclusions
Our pilot study found less disease activity during pregnancy, miscarriage rates consistent with the national average and substantial breast feeding rates in our cohort; the majority of whom did not attend a tailored pregnancy service.

ABSTRACT 43 (19S137)

Focussed Endoscopic Ultrasound Results in Patients with Unexplained Dilatation of Common Bile Duct and or Pancreatic Duct

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Introduction
Unexplained dilation of the common bile duct (CBD) and/or pancreatic duct (PD) on abdominal imaging are among the most common indications for endoscopic ultrasound (EUS).

Aims/Background
To investigate if derangement of liver function tests (LFTs) is associated with positive findings on EUS to explain the cause for the dilated ducts

Method
Patients referred for EUS for dilated CBD and/or PD from 2012 to 2016 for whom LFTs were available, were included in the study. CBD dilatation was defined as CBD diameter greater than 7 mm at any place while PD diameter more than 4 mm in the head and 3 mm in the body and tail was considered dilated.

Results
We examined a total of 2179 EUS procedures, of which 404 patients met the study criteria. 293/404 had elevated LFTs [defined as elevation of one of these: bilirubin, ALT, ALKP or GGT] and 111/404 had normal LFTs. 74% patients had more than one imaging modality prior to the EUS. EUS found a cause of dilated duct in >50% of cases in both the groups. In patients with CBD dilatation alone, elevated bilirubin was associated with finding a significant finding on EUS ($p<0.027$) (66%). In those with CBD and PD dilatation, raised bilirubin ($p<0.022$) and Alkaline Phosphatase ($p<0.018$) were associated with positive findings (39% and 62%).

Conclusions
The presence of raised bilirubin +/- concurrent ALKP rise was statistically more likely to have a cause found for the dilated duct on EUS. EUS detected undiagnosed pathology in unexplained duct dilation even in the presence of normal LFTs. We recommend early access to a diagnostic EUS in the diagnostic pathway of patients with dilated CBD and or PD.

ABSTRACT 44 (19S138)

The CIDS Score, A Benchmark Of A Thorough Endoscopist?

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Introduction
ESG guidelines recommend photo documentation of caecal intubation for a high-quality colonoscopy. Caecal intubation documentation scores (CIDS) have been suggested as a marker for a thorough procedure.

Aims/Background
Our primary objective was to assess the purported relationship between improved CIDS and higher polyp detection rates (PDR). Secondary objectives were to compare CIDS with comfort scores and withdrawal times.

Method
We carried out a retrospective analysis of electronic database records from colonoscopies performed by experienced gastroenterologists at a major tertiary teaching hospital from May 1st – June 30th 2018. Images were reviewed by two independent observers. CIDS was applied; 0, no image; 1, unclear image; 2, clear image; 3, clear labelled image. Mean CIDS ≥2 was considered to be evidence of meticulous endoscopy.

Results
449 procedures, completed by 11 endoscopists were reviewed. The mean unit CIDS score was 2.10. 86% of procedures had a CIDS score ≥2 . Four endoscopists had a CIDS score >2 (160 procedures). Endoscopists with a CIDS score >2 had a higher PDR (43.85% vs 38.25%), lower comfort score (1.93 vs 1.99) and slightly longer withdrawal time (13.66 vs 11.85). Reviewing the images identified 23 procedures with no clear documentation of caecal intubation. This corresponds to 5.2% of all procedures performed.

Conclusions
Endoscopists with a CIDS score >2 have a demonstrated higher PDR and lower comfort scores. CIDS potentially has a role in benchmarking endoscopist performance similar to traditional KPIs.

ABSTRACT 45 (19S139)

A Single Centre Study On The Uptake Of Cervical Cancer Screening In Patients With Inflammatory Bowel Disease

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Introduction
In Ireland, cervical cancer is the second most common cancer in women aged 25-39 years. Screening in Ireland is coordinated by CervicalCheck, the national cervical screening programme. ECCO guidelines and several others strongly recommend regular cervical screening for women with inflammatory bowel disease(IBD), especially if treated with immunomodulators. Several studies across different populations have shown a low adherence to the recommendation regarding cervical cancer screening. The uptake rates of the screening programme in Irish IBD patients are largely unknown.

Aims/Background
The aim of this study was to assess the uptake and adherence of IBD patients to the national cervical screening programme(CSP).

Method
This cross-sectional study was conducted from August to November 2018 in the outpatient department at University Hospital Galway. Female patients of cervical screening age (25-60 years) with a known diagnosis of IBD attending the clinics were recruited. Patients who agreed to participate were given a questionnaire to complete. The questionnaire asked about demographic data, name of drug therapy, cervical screening history, compliance to follow-up, and smear results if known. Ethical approval was granted.

Results
64 patients were studied with a mean age of 41years, SD= 9.7. 58 (91%) reported enrolment in the CSP. 21 (33%) of these patients had at one time had an irregular smear. The survey identified 48 (75%) women who reported regular follow-up with the CSP.

Conclusions
Although this study showed initial satisfactory enrolment to the cervical screening programme, there was a noticeable reduction of the adherence rates. Patients need ongoing education and encouragement to maintain participation in the screening programme.

ABSTRACT 46 (19S142)

Hepatitis A/B immunity in a Hepatitis C treatment cohort: Don't forget to vaccinate!

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Introduction
Direct anti-viral agents (DAA) have revolutionised the treatment of Hepatitis C (HCV). These are highly effective but expensive therapies. Co-infection with other hepatitis viruses can occur in up to 30%. In adults, clearance of Hepatitis B is common. Primary infection with Hepatitis A (HAV) and B (HBV) can have potentially life-threatening consequences. The updated EASL guidelines recommend vaccination against HAV and HBV for patients undergoing treatment for HCV.

Aims/Background
Assess background immunity to HAV/HBV in a cohort referred for treatment of HCV.

Method
Patients attending a dedicated tertiary referral Hepatitis C clinic over one month were recruited. Data collected included basic demographics (age, gender) and epidemiological data including ethnicity and mode

of transmission. Viral serology including Hepatitis A IgM/IgG, Hepatitis B sAg/anti-core Ab, HIV Ab, Hepatitis C genotype/viral load was recorded, and presence of cirrhosis documented.

Results
A total of 75 patients were recruited (female n=30, 40%) with mean age of 50.6 years (range 26-80). Irish (54.6%) and Eastern European (30.6%) ethnicities were most prevalent. Majority (n=45, 60%) had completed DAA treatment. Genotype 1 was common (59.4%) with G2 (9.4%) and G3 (31.2%). Contaminated blood products (25.4%), IVDU (25.4%), and post-tattoo (11.1%) were the common modes of transmission, with (31.7%) unknown. Cirrhosis was present in 17.3%. HAV IgG was positive in 68.25%. In terms of HBV serology: HBVsAg-/HBVcAb+ in 24%, HBVsAg-/HBVcAb-/HBVsAb+ in 29.6%. 46.4% were non immune and had no evidence of exposure or vaccination.

Conclusions
A significant number of patients attending for Hepatitis C treatments are non-immune to other common Hepatitides (HAV 31.75%, HBV 46.4%). Vaccination against HAV/HBV is simple and cost-effective and is recommended in this cohort. A vaccination pathway has been instituted and this will be re-audited.

ABSTRACT 47 (19S143)

The Precipitating Factors of Acute-on-Chronic Liver Failure in Hospitalized Cirrhotic Patients: a Single-Center, Retrospective Study in Belarus

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Introduction
Patients with cirrhosis may develop acute decompensation of cirrhosis as failure of one or more organs so-called acute-on-chronic liver failure (ACLF) syndrome which is usually associated with a precipitating event. Recognition of precipitating event may allow preventing occurrence of multiorgan failure

Aims/Background
Aim of the present study was to assess the most common precipitating factors of ACLF in hospitalized patients

Method
Consecutive 151 cirrhotic patients who admitted to the Department of Gastroenterology (City Hospital) between 2009 and 2011 were analyzed retrospectively. CLIF-C score was calculated for each patient according to the criteria from EASL-CLIF Consortium

Results
Of the 151 patients 44 were fulfilling to diagnostic criteria for ACLF (29.1%; 95%CI:22.0–37.1). Median age was 55 (IQR 43–61) years; male 57%. The underlying cause of cirrhosis was alcohol (61%). Among the patients with ACLF the in-hospital mortality rate was 16% and was higher compared to patients without ACLF (p=0.001). The most common of the organs failure were liver 70.5% (95%CI:57.0-83.9) and kidney 27.3% (95%CI:14.1-40.5). Stratification according to the CLIF Organ Failure Score was following: ACLF grade 1 – 68.2% patients, ACLF grade 2 – 15.9% and ACLF grade 3 – 15.9%. The occurrence of ACLF was associated with the upper gastrointestinal bleeding OR=4.1 (95%CI:1.5-11.2; p=0.01). Bacterial infections were not associated with ACLF OR=2.0 (95%CI:1.0-4.1; p=0.05). The white blood cell count was significantly higher in patients with ACLF 12.0 (8.4–19.2) vs. 7.1 (IQR 5.1–9.8), respectively (p=0.001)

Conclusions
In our study the most common precipitating event for ACLF was upper gastrointestinal bleeding. Bacterial infections were not significantly associated with ACLF, but the white blood cell count was significantly higher in patients with ACLF

ABSTRACT 48 (19S146)

Quality Improvement in Action: Development of a Stable Upper GI Bleeding Management Pathway in Mater Misericordiae University Hospital

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Introduction
Upper gastrointestinal bleeding (UGIB) is a common presentation in the Emergency Department (ED). It is a potential emergency but not all cases of UGIB require hospital admission.

Aims/Background
The Glasgow Blatchford Bleeding Score (GBS) is a well validated risk assessment score for UGIB. The aim of this project was to develop a pathway for the standardized management of UGIB based on the GBS by reviewing current practice.

Method
All UGIB presentations to the ED were identified over an 8-week period. GBS, admission status, appropriateness of admission in the context of GBS, time to endoscopy and endoscopy results were recorded. The data led to the creation of a Quality Improvement team. We conducted Plan-Do-Study-Act Cycles (based around staff education) to encourage GBS documentation and developed a UGIB management pathway.

Results
18% of cases (n=9) were inappropriately admitted to hospital with a GBS of 0-1. 33% of these cases had OGD performed and no findings requiring endoscopic intervention or follow-up were identified. Education resulted in 50% increase in GBS documentation. We developed a pathway to a) Support discharge of patients with GBS <1 and b) To organise OGD within 5 days for 'GBS>1 cases' suitable for discharge with early follow up via an electronic system.

Conclusions
A significant proportion of patients were admitted to hospital unnecessarily with stable UGIB resulting in inappropriate use of limited resources. With our pathway we expect to see a reduction in admissions, unnecessary investigations and length of hospital stay as a result.

ABSTRACT 49 (19S148)

What is normal? The challenge of finding normal controls for fatty liver disease studies

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Introduction
Fatty liver disease (FLD) is usually a consequence of excess alcohol consumption, the metabolic syndrome or both. Identification of metabolic risk factors early on can be useful for implementing therapeutic strategies to reducing future disease burden.

Aims/Background
We ran Liver Health Days for Mater Hospital Staff to screen for liver disease, metabolic syndrome features and behaviour patterns associated with FLD. Our secondary aim was to identify normal controls for future studies.

Method
Metabolic syndrome features were measured using standard tests. Fibroscan measured liver fibrosis (kPa) and liver fat (CAP). We used questionnaires on physical activity, diet and alcohol.

Results
139 staff attended (83F, 56M; mean age 45). 63 had a normal BMI (≤25kg/m2), 81 (58%) normal cholesterol (≤5.2mmol/L), 108 normal systolic BP (≤130mmHg), 120 normal diastolic BP (≤85mmHg), 126 normal fasting glucose (≤5.6mmol/L) and 120 normal triglycerides (≤1.7mmol/L). 114 had a normal Fibroscan (≤6.1kPa). Only 24/139 staff had no features of the metabolic syndrome and could be classified as "normal" for subsequent studies. Participation in sport (n=100/139) resulted in a significant improvement in features of the metabolic syndrome: BMI (25.96kg/m2 v 28.22kg/m2, p=0.007); Systolic BP (118.80mmHg v 125.97mmHg; p=0.039); Fibroscan Score (4.84kPa v 5.85kPa; p=0.016); total cholesterol (5.08mmol/L v 5.44mmol/L; p=0.031); LDL (3.01mmol/L v 3.34mmol/L; p=0.018); Triglycerides (1.03mmol/L v 1.40mmol/L; p<0.0001).

Conclusions
This study demonstrates the low prevalence of "normal" individuals with no features of the metabolic syndrome among staff attending Liver Health Days at our hospital. There needs to be more extensive screening, treatment and prevention (by promoting activity) in this population.

ABSTRACT 50 (19S149)

Assessing Quality Of Caecal Images On Colonoscopy Reports

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Introduction
Endoscopic image documentation has an important role in gastrointestinal endoscopic reporting. RCPI National Endoscopy QI Programme recommends, clear photographic evidence of terminal ilium, caecum or anastomosis must be obtained. ESGE recommends, caecum with visualization of the appendicular orifice confirms that the examination is complete. ASGE says still photography allows verification of ceacal intubation rates (CIR) of an individual endoscopist in the continuous quality improvement program.

Aims/Background
To establish whether caecal images are documented according to guidelines and endoscopist are able to recognize them

Method
Single blinded study, total 100 caecal images were selected randomly, blinded with secret codes and each endoscopists (2 consultants and 3 trainee) were given twenty images to identify, including eight of their own and twelve from others.

Results
Consultants could identify 80 % (19 out of 24) of other endoscopist's caecal images and 70% (11 out of 16) of their own. Trainee endoscopists could identify 48 % (17 out of 36) of other endoscopist's caecal images and 54 % (13 out of 24) of their own. Both consultant and trainee endoscopists could not identify 40% (40 out of 100) of the caecal pictures.

Conclusions
Proper documentation of caecal images is important in verification of caecal intubation and completion of colonoscopy. Ileocecal valve, triradiate fold and appendicular orifice help identifying caecal images. These anatomical land marks should be included in caecal images on endoscopy reports according to the guidelines. We recommended in our unit to have a uniform policy that these land marks should be included in caecal image reporting and re-audit in six months to assess any improvement in documentation.

ABSTRACT 51 (19S150)

Gastric Antral Vascular Ectasia (GAVE) – Its Prevalence And Association With Anti-coagulation At University Hospital

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Introduction
GAVE causes around 4% of non-variceal upper gastrointestinal bleed. It usually presents with anemia and often requires blood transfusion. Its prevalence has increased in last few years and more GAVE is being diagnosed lately. It's associated with liver cirrhosis, scleroderma and diabetes mellitus. However, not much work has been done so far to identify its association with anti-coagulation

Aims/Background
We aimed to find out the number of GAVE diagnosed at 2 points in 10 years at UHL and to determine their anti-coagulation status hence, 2008 and 2018

Method
We retrospectively reviewed oesophagogastroduodenoscopies

(OGD) performed in year 2008 and 2018 at UHL. We went through medical records of patients with GAVE to determine their anti-coagulation status

Results
A total of 2204 and 2234 OGDs were performed in 2008 and 2018 out of which 3 and 16 patients were diagnosed with GAVE respectively. Two out of three and nine out of sixteen were females in year 2008 and 2018 respectively. None of the GAVE patients were on anti-coagulation in 2008, whereas, 50% of GAVE patients were on anti-coagulation in 2018

Conclusions
GAVE is an uncommon but very important cause of upper gastrointestinal bleed. Its management becomes challenging when it is coupled with anti-coagulation. With our observation, we have concluded that the prevalence of GAVE in 2018 has increased by around five folds when compared to prevalence of GAVE in 2008. We also found that the 50% of GAVE patients in 2018 were on anti-coagulation. Further study and research is warranted to identify any association of GAVE with anti-coagulation

ABSTRACT 52 (19S152)

Title: Consult to Injury: The Burden of Referrals on the Gastroenterology Service in a Large Acute Hospital

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Introduction
In a large, acute hospital, the two-consultant gastroenterology department provides 20% of the general medical service, GI outpatient services, inpatient and outpatient diagnostic and interventional endoscopy across two sites, and an inpatient consult service. Numerous inpatient GI referrals can place strain on a diverse specialty service.

Aims/Background
To measure the source, number and nature of inpatient consultation requests and compare with other hospital specialties to determine appropriateness of consultations in relation to referral reason and source of referral.

Method
The e-referral system in OLOL, iPIMS, was used to retrospectively analyse the number of inpatient consultations requested over a one year period. We assessed the total number of consultations received, the topic of each consultation request, and used the Hounslow Clinical Commissioning Group Referral Guidance 2013 as a measure of appropriateness of referral. Sub-analyses were then carried out, focusing specifically on colitis referrals to investigate the status of investigations conducted at time of referral.

Results
Within the timeframe for the study, 1146 e-referrals were made to all hospital specialities. The gastroenterology department received 15% (n=176) of these, the second highest number of e-referrals of all specialities in OLOL. Surgeons accounted for 41% (n=70) of these consultation requests. Of these, 39% (n=27) queried a diagnosis of IBD or colitis, with 70% (n=19) of these queries from CT findings of indeterminate colitis. Of this 70%, a minority had further investigations completed at time of referral.

Conclusions
IBD referrals accounted for 29% of all gastroenterology consultation requests, with the majority originating from general surgery for query colitis and required further investigation by primary team. Appropriate intervention and re-analysis may reduce the referral burden on the gastroenterology service.

ABSTRACT 53 (19S153)

Hepatoma Surveillance in Hepatitis C Cirrhosis following Sustained Virological Response to Anti-viral Therapy

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Introduction
Hepatocellular carcinoma(HCC) is a well-known complication of chronic liver disease. Despite achieving sustained virological response(SVR) with direct acting anti-viral medications, patients with cirrhosis secondary to Hepatitis C remain at risk of developing HCC. They require lifelong hepatoma surveillance with six-monthly ultrasound scans and serum alpha-fetoprotein(AFP) levels as recommended by international guidelines.

Aims/Background
To audit our compliance with guidelines on the surveillance of HCC in patients with cirrhosis secondary to Hepatitis C and to determine the incidence of hepatoma in this cohort.

Method
Patients with compensated cirrhosis who were treated for Hepatitis C from July 2015 to July 2018 were included. Data was collected using electronic records. The standard used was the 'EASL Recommendations on Treatment of Hepatitis C 2018'.

Results
53 patients with compensated cirrhosis were treated; all achieving SVR. 73.6%(n=39) were male. The median age was 52years. Fibroscan results of 41.5%(n=22) patients improved to pre-cirrhotic range post treatment completion. Surveillance imaging was performed in these patients with a median interval of 11.5months (range 3-43months). 31 patients (58.5%) remained within the Fibroscan cirrhotic range. 90.3% (n=28) received surveillance imaging at a median 11-month interval (range 1-44 months). 3 patients have not been imaged. Serum AFP levels were performed at a median interval of 1month. HCC was detected in 2 patients(3.8%) during surveillance. Indeterminate lesions requiring ongoing surveillance were detected in 4 patients(7.5%).

Conclusions
Hepatomas were detected during follow up, highlighting the importance of surveillance despite SVR. A higher incidence was observed in patients with no improvement of Fibroscan result on achieving SVR. This audit showed variable compliance with guidelines. Improved resources are required to improve the standard of care delivered.

ABSTRACT 54 (19S157)

The successful use of endoscopic therapy to treat all grades of Barrett's oesophagus-related dysplasia and early neoplasia in St James's Hospital over a ten year period

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Introduction
Endoscopic therapy (ET), endoscopic mucosal resection (EMR) and radio-frequency ablation (RFA), is recommended for the treatment of any grade of Barrett's Oesophagus (BO) related dysplasia, or early neoplasia in specialist high-volume centres. However, outcome data are mainly limited to clinical trials with strict inclusion criteria. Outside of clinical trials it is often appropriate to tailor treatment on an individual patient basis, and more data on the use of ET in BO-related dysplasia and neoplasia in everyday clinical practice is required.

Aims/Background
To describe the real-life experience with ET for all levels of dysplasia, Intra-mucosal and certain cases of invasive cancer in a single tertiary-referral centre.

Method
A retrospective review of the BO database in SJH identified patients who underwent ET for dysplasia/neoplasia from 2008-2018. ET was performed by 2 senior endoscopists. Nodular mucosa was firstly removed by EMR, and RFA was performed at 3 month intervals until the absence of dysplasia/neoplasia/SIM was confirmed histologically. Follow-up biopsies were taken at 6 and 9months and annually thereafter.

Results
281 patients have undergone ET for BO-related dysplasia/neoplasia. Follow-up data was available in 218(77.58%), with eradication of dysplasia/neoplasia in 206(94.49%) and SIM in 180(82.57%). Of the 12 who failed to achieve eradication, 8 developed invasive cancer. 96(34.16%) had intramucosal(n=89) or early invasive cancer(n=7). Follow-up data was available in 81.25% (n=78), with eradication of dysplasia/neoplasia in 96.15%(n=75) and SIM in 83.33%(n=65). Durability beyond 6months was achieved in 98.27%, after a mean of 23months(6-75). Stenosis requiring dilatation occurred in 23 patients(8.16%), and intra-procedural bleeding in 3(1%).

Conclusions
Our data is directly comparable to the larger multi-centre reports in terms of eradication rates, durability of response and complication rates. Furthermore, we have demonstrated the successful eradication of invasive cancer in 7 patients using ET, which is currently recommended as a compassionate management approach by the guidelines.

ABSTRACT 55 (19S158)

Are 5-aminosalycilates an effective Treatment for Crohn's Disease?

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Introduction
5-aminosalycilates (5-ASA) are often used in combination with other medications in the treatment of Crohn's Disease (CD) and occasionally as monotherapy. However, their effectiveness in the treatment of CD has not been validated.

Aims/Background
Determine the effectiveness of 5-ASA in the treatment of CD.

Method
We performed a cross-sectional study over a 12-week period of patients presenting to our IBD clinic. Patients completed self-administered questionnaires collecting data on IBD phenotype, medications and surgical history. Patients with CD were subdivided into those only receiving 5-ASA (Group 1) and patients on no medical therapy were our control group (Group 2). Our primary end-point was time to first surgery after initial diagnosis of CD.

Results
166 patients completed the questionnaire. 90 had a diagnosis of CD. 24 were on a 5-ASA. Group 1: 14 patients were included. 5 (35.71%) were male. Mean age at diagnosis was 28.64 years. 6 (42.86%) proceeded to surgery (4 ileocolonic resection (ICR), 2 colectomies). Mean time to surgery was 14.47years. Group 2: 18 patients were included. 11 (61.11%) were male. Mean age at diagnosis was 28.00 years. 9 (50.00%) patients had surgery (4 ICR, 5 colectomies). Mean time to surgery was 11.50 years. There was no significant difference in mean time to surgery between those treated with a 5-ASA and those on no treatment (Mean time to surgery: Group 1; 14.47 years, Group 2; 11.50 years, $p = 0.297$).

Conclusions
Our study showed no difference in time to surgery between patients treated with 5-ASA and patients on no medications for CD. Our results indicate 5-ASA have no impact preventing or reducing time to surgery in CD. However, it must be noted our numbers are small and these results should be validated in a prospective study.

ABSTRACT 56 (19S159)

To do or not to do? An observational study of the management and outcomes of Anti-Drug Antibodies to Infliximab

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Introduction
Anti-drug Antibodies (ADAs) to Infliximab (IFX) are associated with loss of response to therapy and adverse outcomes in patients with Inflammatory Bowel Disease. At present, the evidence to clarify optimal management is lacking.

Aims/Background
The primary aim of this study is to identify best practice of management of ADAs to IFX and to identify predictors of development of ADAs. Secondary aims include review of adverse outcomes following development of ADAs.

Method
A retrospective observational study of adult patients receiving IFX who developed ADAs. Data in patients with ADAs >8mg/L was collected over 2 years.

Results
110 patients are included (55% male), 52% with Crohn's and mean age of 39.5 years. 24% were receiving combination therapy at initiation, 24% were started on an immunomodulator following development of ADAs, 23% had their dose of immunomodulator increased and 43% had their IFX escalated. There was a reduction overall in ADA levels from first detection to follow-up (p-value= 0.05). Pearson's coefficient demonstrated a significant correlation (p-value= 0.006) between the presence of ADAs and CRP but did not with albumin/fecal calprotectin. No strategy of treatment adjustment appeared superior in significantly reducing Ab levels but an increase in combination therapy resulted in a lower rate of IFX discontinuation (p-value = 0.001). 44% of patients failed IFX therapy, 67% were switched to another biologic. 15% required steroids, 13% were admitted and 10% required surgery.

Conclusions
There is a high rate of failure of IFX therapy with development of ADAs, optimising combination therapy is associated with a reduction in treatment failure. The overall reduction in ADAs is reflective of initiation of proactive monitoring.

ABSTRACT 57 (19S160)

The Importance of Introducing Colonoscopy Screening in the Adult Cystic Fibrosis Patients: A Single Tertiary Referral Centre Analysis

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Introduction
The risk of colorectal cancer (CRC) in patients with cystic fibrosis (PWCF) is 10times greater than the general population and 30times greater post-transplant. Due to this increased risk new screening guidelines were published in Gastroenterology by the CF Colorectal Cancer Screening Task Force in 2018.

Aims/Background
To benchmark current practise at our centre against current guidelines.

Method
Our endoscopy database was interrogated from 2012 to present to identify PWCF who received a previous colonoscopy.

Results
Group 1: PWCF non-transplant cohort; 161 patients were included. 26 were >40years. 4 patients had a previous colonoscopy (total number colonoscopies = 4). No colonoscopies were done for screening, all as patients were symptomatic. One patient had a polyp at colonoscopy. Adenoma detection rate (ADR) was 25%. 21 patients >40 have no previous colonoscopy. Surveillance for CRC in this cohort has yet to be implemented with 0% compliance to date. Group 2: PWCF post solid-organ transplant; 16 patients were included. 13 were >30 years. 11 patients had a previous colonoscopy (total number colonoscopies = 20). Reasons for index colonoscopy: 5 screening, 3 symptomatic, 3 no indication on report. 10 colonoscopies in total were done for screening. 3 patients had polyps found at index colonoscopy (2 adenomas high grade dysplasia, 4 adenomas low grade dysplasia) and surveillance colonoscopies were arranged subsequently. ADR was 27.27%. Current practise in the post transplant cohort is close to new recommendations with 84% compliance however only 45.45% of index colonoscopies were done initially for screening.

Conclusions
Current guidelines are only in existence over 12months. Our analysis suggests there is an awareness of the need for CRC screening in the post-transplant cohort but there is need for improvement. In PWCF with no previous transplant screening has not been a priority and needs to be implemented. Currently we are implementing a screening programme in keeping with current guidelines.

ABSTRACT 58 (19S162)

Evaluation of Implementation of Beaumont Hospital's Acute Severe Colitis Protocol

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Introduction
Beaumont Hospital Gastroenterology unit has developed an integrated care pathway for acute severe colitis to ensure appropriate, rapid and standardised care.

Aims/Background
This study audited the adherence to the acute severe colitis pathway.

Method
The study included acute severe inflammatory colitis patients admitted between October 2018 and January 2019. Patient's medical charts were retrospectively reviewed and the implementation and timing of each step of the pathway were examined.

Results
21 patients were included. Hydrocortisone, prophylactic enoxaparin and Calcichew D3F were appropriately prescribed on day 1 in 100% (n=21), 76% (n=16) and 85% (n=18) of cases respectively. Timely immunomodulatory screens, where indicated, were done in only 27% (n=1), stool sampling in 24% (n=5) and an Abdominal X-ray in 53% (n=10) within 24 hours of presentation. Of those requiring a TB screen, no formal documentation of Mantoux and quantiferon

results were done in 36% (n=4) and 55% (n=6) respectively. Within 48 hours, 67% (n=14) underwent endoscopic assessment. Overall, 81% (n=17) were seen by a dietician, with a mean waiting time of 6.5 days. In all, 86% (n=18) were not seen by a surgical team until > 24 hours into their admission. Appropriate Stoma nurse review was undertaken; however no formal documentation was recorded.

Conclusions
There were significant delays with multiple steps of the pathway and some issues in relation to appropriate documentation. The proposal is to introduce an acute colitis pathway checklist sticker which will be inserted into patient records at admission. In addition, formal stoma nurse review needs more definitive documentation.

ABSTRACT 59 (19S163)

Investigating the Indication for and Diagnostic Yield of Sigmoidoscopies in St. James's Hospital Over a 6 Month Period.

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Introduction
423 sigmoidoscopies were carried out in St. James's Hospital from January to June 2017 with a range of indications.

Aims/Background
1) Assess the yield of sigmoidoscopy in answering the clinical question across a range of indications/pathologies 2) Assess the percentage of sigmoidoscopies which proceeded to colonoscopy and the discrepancy between procedures

Method
A retrospective review of 423 procedures was carried out using the electronic patient record.

Results
Where a strong indication for sigmoidoscopy was present the diagnostic yield was high; i.e. in Inflammatory Bowel Disease assessments the clinical question was answered in 93% (n=62); where Graft vs Host disease in transplant patients was suspected, the clinical question was answered in 80% (n=4). However when the indication was derived from patient's symptoms, the diagnostic yield was lower; i.e. in PR bleeding the clinical question was answered in 42% (n=49) and in other symptoms (diarrhoea, constipation, abdominal pain) this was 13% (n=6). There was no yield from sigmoidoscopy for anaemia or for investigation for family history of colorectal cancer. For those patients with symptoms, 13% (n=22) proceeded to colonoscopy within 6 months, with a discrepancy found in 59%.

Conclusions
Where a strong indication for sigmoidoscopy was present i.e. known pathology, post colonic surgery or to carry out a procedure, the diagnostic yield was high with no requirement to proceed to colonoscopy. However, for sigmoidoscopies carried out to investigate subjective symptoms, the diagnostic yield was low with some discrepancies seen on follow up colonoscopy.

ABSTRACT 60 (19S164)

Comfort:In The Eye of the Beholder?

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Introduction
Patient comfort score is a recognized key performance indicator in the delivery of colonoscopy. Limited data exists regarding reported comfort concordance between nurses,doctors and patients following colonoscopy.

Aims/Background
To examine comfort score concordance reported between patients and endoscopy staff

Method
Endoscopist and nurse recorded comfort scores were prospectively recorded following colonoscopy and a patient comfort score was completed by the patient on discharge using the standard Gloucester comfort scoring system. Results were compared among groups using Pearson's correlation coefficient and a chi square test with a $p \leq 0.05$ considered significant.

Results
To date,104 patients have been included,61% female (n=63) with 72% (n=75) > 50yrs(mean 59 yrs range 23-89 yrs).86%(n=89) were diagnostic procedures and 80%(n=83) were performed by gastroenterologists. The median sedation used was 3mg of midazolam (0-5mg) and 50mcg of fentanyl (0-100mcg). Discordance was recorded across all groups. Concordance was greatest between nurses and doctors (r=0.85). Agreement between patients and doctors was moderate (r=0.51) and moderate levels of agreement were also noted between patients and nurses (r=0.55). 38% (n=40) of patients reported higher levels of discomfort (comfort score ≥3), compared with 25% (n=26) of doctors (p=0.05) and 30% of nurses(n=31) (p=0.1). Significantly higher levels of sedation(≥3mg midazolam) were required in these patients with a comfort score ≥3 compared with patients with less discomfort (63%vs 40%),p=0.03). Comparison of comfort scores according to procedure duration,age,or gender did not reveal significant differences. However,amongst younger patients, 31% (n=9) self-reported higher levels of discomfort,all of whom were female (p=0.002).

Conclusions
The perception of procedure related discomfort varies between these three groups, including endoscopists and nurses. This study highlights the challenge of accurate patient comfort score reporting as a quality performance indicator during colonoscopy

ABSTRACT 61 (19S165)

Audit on the management of alcoholic liver disease patients in South Tipperary General Hospital.

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Introduction
STGH opened a dedicated Liver ward in October 2017 to better manage patients with Liver Pathology. There are accepted guidelines on the treatment of decompensated ALD and the surveillance of varices and HCC in ALD patients and the purpose of the ward is to improve compliance with best practice.

Aims/Background
The aim of this study was to audit the management of patients with alcoholic liver disease who were admitted to South Tipperary General Hospital (STGH) between October 2017 to the end of 2018. In October of 2017 a dedicated liver ward was opened in STGH and the aim of this audit is to improve future management of patients with decompensated liver disease.

Method
HIPE was interrogated for patients who were discharged from STGH with a diagnosis of alcoholic liver disease. Charts were audited with the following data being collected. Length of stay Presence of Ascites - Time to Diagnostic Paracentesis and use of antibiotics Presence of Encephalopathy DF Score and Use of Steroids HCC Surveillance on Discharge for known cirrhotics Patients without evidence of ALD were excluded from the study as were patients who were admitted with non ALD related conditions.

Results
60 admissions comprising 41 patients with ALD were admitted to STGH in the 14 month period between October 2017 and December 2018 with an average length of stay of 10 days. 22 of these patients had known cirrhosis with 40% of them awaiting surveillance ultrasounds at the time of data collection. 56% of patients had surveillance endoscopy booked to monitor for evidence of oesophageal varices. In those patients who had diagnostic paracentesis only 33% was done within 24hrs of admission.

Conclusions
There is room for improvement in the management of ALD patients in STGH most notably in the time to diagnostic paracentesis and the surveillance of HCC in known cirrhotic patients.

ABSTRACT 62 (19S166)

NR4A1 Receptor Curtails Pro-tumourigenic And Invasive Signals In Colorectal Cancer

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Introduction
Inflammatory processes are pivotal pathogenic factors in colorectal cancer. NR4A1 receptors are emerging as regulators, concurrently repressing pro-inflammatory processes while activating resolution pathways. Whether the activation of NR4A1 could improve cancer-related immune dysregulation is unknown.

Aims/Background
Curtailing pathogenic inflammatory signals via an orphan nuclear receptor (NR4A1) in colorectal cancer.

Method
Ethical approval was acquired from St. Vincent's University Hospital. Tumour and normal control tissue (n=20) obtained from patients undergoing colorectal resection were exposed to a NR4A1 agonist (Cytosporone B (CsnB) 4-100μM) ex-vivo. The supernatant was collected, and RNA was extracted from tissues at 8 hrs. A cytokine/chemokine array was used to examine 104 secreted proteins associated with tumour inflammation, angiogenesis, fibrosis and growth factors. Quantitative enzyme-linked immunosorbent assay (ELISA) and qRT-PCR were used.

Results
Cytokine/chemokine array analysis revealed 50/104 were increased in tumours including inflammatory (IL-8, TNF-α), angiogenic factors (angiopoietin 1, vascular endothelial growth factor), and growth factors (fibroblast growth factor 7, leukemia inhibitory factor). Of those, 30/50 were repressed by ≥ 50% by the Nur77 agonist. Multiple targets identified from the array were confirmed using quantitative ELISA and/or qRT-PCR including cytokines (e.g. IL-8, TNF-α, IL-23, IL-6), and chemokines (e.g. CCL3, CCL4, CCL20).

Conclusions
Activation of an orphan nuclear receptor family member 4A1 (NR4A1) represses tumour derived pro-tumourigenic mediators such as cytokines, chemokines, growth factors, and angiogenic factors.

ABSTRACT 63 (19S167)

Audit of "Management of patients presenting with Decompensated Cirrhosis in the first 24 hours" in Cork University Hospital (CUH)

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Introduction
The "Decompensated cirrhosis care bundle- First 24 hours" (CCB) was developed to address the first 24 hours of hospital admission of patients with decompensated liver cirrhosis. It comprises of a simple checklist to ensure important initial investigations are conducted and it provides specific 'step by step' guidance on the management of ascites, infections, gastrointestinal bleeding (GI bleeding), acute kidney injury (AKI) and hepatic encephalopathy (HE). Implementing CCB has been shown to improve the patients' outcome.

Aims/Background
The aim of this audit was to review the treatment initiated within 24 hours of admission of patients with acute decompensated liver cirrhosis presenting to CUH. Our clinical practice was compared against CCB.

Method
The audit was undertaken in CUH during an 8-week period (November 2018- January 2019). 8 patients presenting with acute decompensated liver cirrhosis were included. Data was collected from patients notes, patients' medication and IPM system following the CCB checklist.

Results
The mean age was 52.6; 62.5% were male; 75% of liver cirrhosis were secondary to alcoholic liver disease. Mortality during admission was 12.5%. The commonest reason for admission was infection (62.5%). Our practice was in line with CCB recommendations when investigating/ treating patients presenting with ascites, GI bleeding but not fully meeting the CCB criteria in patients presenting with AKI, infection and HE.

Conclusions
These results were prior to implementation of CCB in CUH. Additional data gathered post implementation will provide a clearer overview on the CCB, its uptake and implications to treatment and outcome of patients presenting with decompensated liver cirrhosis in CUH.

ABSTRACT 64 (19S168)

Evaluation of Musculoskeletal Injuries Among Irish Nurse Endoscopists

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Introduction
Introduction Musculoskeletal injuries which include thumb, finger, hand, elbow, neck and back issues are common among endoscopists. Prevalence reported in the literature ranges from 37% to 89% (Ridtitid et al 2015). Causative factors are reported to include manipulation of angulation wheel, torqueing with right hand and prolonged standing.

Aims/Background
Aims The aims of this study are to measure incidence of injury among Irish nurse endoscopists, identify practice characteristics that may contribute to incidence and make recommendations as to prevention of musculoskeletal injury by preventative exercises.

Method
Method A questionnaire was sent to nineteen practising nurse endoscopists. A physiotherapist, with background in occupational health assessed a nurse endoscopist to identify range of motions and practises that may lead to injury.

Results
Questionnaire response rate was 78% (15/19). Mean endoscopic experience 5.57 years, range 2 to 13 years. Mean endoscopic procedures 633 (range 370 to 1300). 71% of respondents reported both lower back pain and thumb pain, 50 % reported both hand and neck pain and 42% reported elbow and shoulder pain. 70% of respondents had treatment for injuries ranging from physiotherapy to steroid injection.

Conclusions
Discussion Table height, monitor optimal viewing angle, elbow height and duration of static standing position have been identified as areas that are important for prevention of endoscopy related injury. With limited options to reduce hand and wrist load during procedure, proactive strengthening may be beneficial. Conclusion Modification of practice through preventative measures including specific exercises and optimising endoscopy room set up may help reduce risk of injury, thus enabling endoscopists to continue to perform endoscopy procedures into the future.

ABSTRACT 65 (19S169)

eHealth literacy in an outpatient Inflammatory Bowel Disease (IBD) population

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Introduction
Previous studies have shown that approximately half of the patients with IBD were using internet resources in relation with their disease. eHEALS is a validated 10 item questionnaire that assesses eHealth literacy (scores ≥ 26 being correlated with high eHealth literacy).

Aims/Background
New electronic resources are planned to be introduced in our IBD outpatient department (OPD) as eHealth has shown to increase medication compliance in IBD patients. The aim of this study is to assess the eHealth literacy using eHEALS questionnaire.
Method
Data was collected by asking the IBD patients presenting for review to fill the eHEALS questionnaire. In addition to the standard eHEALS questionnaire, several demographic questions were included in order to assess potential correlation between eHealth literacy and age group, diagnosis of Ulcerative Colitis versus Crohn's disease, years post diagnosis and severity of disease.

Results
The study was conducted on 70 IBD patients. The mean score was 25.57. 56% of the results were ≥ 26. Question (Q) 6 ("I know how to use the internet to answer my questions about health") had the highest score (mean 3.5, SD 0.92). Q 10 ("I feel confident in using information from the internet to make health decisions") had the lowest score (mean 2.69; SD 1.08). There were no correlations between eHealth literacy and age group, severity of disease and years post diagnosis.

Conclusions
Data shows good eHealth literacy, 39 of 70 patients scoring ≥ 26. The uptake of new electronic resources and its implications for adherence to treatment are expected to correlate with these results.

ABSTRACT 66 (19S170)

Is This Inflammatory Bowel disease ?

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Introduction
Inflammatory bowel disease is one of the main differential diagnosis whenever a patient is admitted to hospital with diarrhoea, cramps

abdominal pain and evidence of colitis on radiological investigations. These patients are sometimes un-necessarily subjected to invasive investigations like both upper and Lower GI endoscopies. By doing so not only puts the patients to un-necessary tests and wasteful use of resources but also increase the work load on Gastroenterology services.

Aims/Background
To conduct a study and see if patients admiited with symptoms of diarrhoea with or without blood , cramps actually have IBD. And what percentage of theses have infectious cause for their symptoms. Also how many of these did not require further invasive investigations.

Method
This was an observational prospective study. We included 48 patients in this study that were admitted to CUH, with diarrhoea with or without blood, abdominal pain(severity of pain 5 and above out of 10) and radiologically(CT) proven colitis from July 2018 to Feb 2019. This was their first presentation with above symptomatology and there was no chronicity from the history.. The subjects ranged from 16 years to 50 years old. All of these patients required more than 24 hours of hospital admission and required Intravenous fluids, analgesia +/- antibiotics. A gastroenterology consult was sought for all of them with a view to perform endoscopy to rule out IBD.

Results
Upon seeing and following up of these patients by a gastroenterology Registrar and a consultant. There were total 28(58%) cases of infectious colitis proven by stools cultures and they avoided endoscopy. In 12(25%) there was no cause found, they had negative stool cultures and endoscopy and histology showed non-specific changes. These cases on follow up were asymptomatic and did not require further testing/follow up. There were only 5(10%) confirmed IBD cases (histologically) and only 3(6%) cases where histology was consistent with ischemic ethology.

Conclusions
The vast majority of young age patients presented and being admitted to hospital with acute history of diarrhoea(less then a week), abdominal pain and or bleeding are infectious in origin and should not be investigated with CT scans or endoscopy. Also history of chronicity on presentation should be sought before a patient is subjected to invasive investigations.

ABSTRACT 67 (19S171)

Predicating response to Infiximab therapy in IBD. A Case-Control Study Comparing Primary non-responders and responders to Infliximab therapy in inflammatory bowel disease patients.

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Introduction
Biological therapy using antitumor necrosis factor alpha (anti-TNF) monoclonal antibody, namely Infliximab (IFX), has been used successfully for the treatment of inflammatory bowel diseases (IBDs) for many years. However, treatment failures are common. Primary non-response was reported to occur in 13–40% of patients in clinical trials [Ben-Horin et al. 2014; Ding et al. 2016]. Secondary loss of response (LOR) has been observed in another 23–46% of patients when defined by the need to dose adjust within the first 12 months of treatment [Gisbert and Panes, 2009; Ben-Horin et al. 2011; Ding et al. 2016

Aims/Background
In the literature on Anti-TNF Infliximab therapy in IBD, there is very little known about primary non-response. Multiple studies done so far are based on secondary loss of response to Infliximab due to the emergence of anti-Infliximab antibodies, or an underlying colorectal cancer or other complications like extensive gut surgery with less surface area for drug absorption. The main aim of this study is to see if the primary non-responders to IFX have characteristics that are different than those with a primary response. Secondly, no such similar study exists in the current literature.

Method
A Matched pair case-control study was designed after searching 1252 adult IBD patients' records who were either currently on or had completed Infliximab therapy in the year 1999 to 2018. Patient's age ranged from 19 years to 75 years. 104 were cases and 104 were controls in terms of age, sex and disease type (CD or UC). Out of the 104 cases, there were 38 Crohns' disease and 66 Ulcerative colitis patients. The total number of patients in this study was 208.

Results
The data for all 208 patients were analysed for five different variables to see an association between either of them and primary non-response to Infliximab therapy. Different characteristics of the included subjects were looked at and their association with primary-non-response to infiximab therapy. Smoking status, High BMI, low levels of CRP, low Haemoglobin and Low albumin levels were found to be predictors of poor response to Infliximab therapy. Separate tables and p-values were obtained for all of these parameters which will be included in the final presentation at ISG.

Conclusions
This study clearly showed that the risk of primary non-response to inflximab is high if the subject is a smoker, with high BMI, Low CRP,low Hb and low levels of Albumin, when matched at their baseline characteristics and disease types.

ABSTRACT 68 (19S172)

Consultant Triage alone and Combined Consultant and Endoscopy Nurse Triage Significantly Reduce Inappropriate Endoscopies Especially Urgent P1 Referrals.

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Introduction
The Irish public endoscopy service is facing unprecedented pressure in terms of a huge increase in endoscopy referrals over the past 10 years with currently over 20,000 patients on the Inpatient/Day case National GI Endoscopy waiting list. Despite established referral guidelines many patients are referred inappropriately from both

primary and secondary care for urgent and non-urgent endoscopies with high non-attendance and cancellation rates. There is a lack of data assessing the impact of consultant triage and endoscopy nurse triage on endoscopy referrals.

Aims/Background
To prospectively compare the effect of consultant triage alone (which is relatively less labour intensive) with combined consultant and endoscopy nurse triage (which is relatively more labour intensive) on endoscopy referrals to our endoscopy unit.

Method
All endoscopy referrals including GP letters, direct access and Surgical, Medical and ED referrals received over a 28 day period in February 2019 were included in this prospective study. Referrals were stratified pre-triage into urgent/priority 1 (P1) within 4 weeks, non-urgent/priority 2 (P2) within 3 months and surveillance groups before being triaged by 4 GI consultants based on established HIQA and BSG endoscopy referral guidelines. Any referrals with missing data, alarm symptoms, prior endoscopy/histology data were subsequently validated by telephone triage by our Endoscopy Triage Nurse. Outcomes were compared between pre-triage, consultant triage and combined consultant and endoscopy nurse triage. Statistical analysis was performed using student Chi Square test.

Results
Out of 312 endoscopy referrals during the study period, 12 patients were excluded as they had already undergone consultant triage. Of the 300 patients enrolled (median age 50, range 17-88, M:F 150:150). 142 (47%) were directly referred from their GP, 101 (34%) from the Surgical department, 31 (10.4%) from other Medical departments and 26 (8%) from the Emergency Department. Prior to triage 159 patients were referred for urgent P1 endoscopy, 125 for non-urgent P2 endoscopy and 16 for surveillance endoscopy. Consultant triage alone reduced P1 endoscopies by 16% from 159 to 133 ($p=0.02$) and combined consultant and endoscopy nurse triage reduced P1 endoscopies by a total of 30% to 112 ($p=0.0003$). Consultant triage increased overall P2 endoscopies marginally from 125 to 129 and subsequently to 124 after endoscopy nurse triage (P=N.S.). Consultant triage alone reduced all endoscopy referrals by 11% ($p<0.05$) redirecting referrals to HP testing/OPD/GP follow-up/CT colonography while combined consultant and endoscopy nurse triage reduced all endoscopy referrals by 21% ($p=0.01$).

Conclusions
Consultant triage alone significantly reduced 16% of urgent endoscopy referrals and 11% of all endoscopy referrals while combined consultant and endoscopy nurse triage significantly reduced 30% of urgent endoscopy referrals and 21% of all endoscopy referrals. Both consultant triage alone and combined consultant and endoscopy nurse triage can achieve significant reductions and cost savings in endoscopy referrals.

ABSTRACT 69 (19S173)

Alpha-Fetoprotein use as a standalone screening tool for hepatocellular carcinoma: single centre experience

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Introduction
The development of hepatocellular carcinoma (HCC) is a major complication of advanced liver disease. Current guidelines recommend screening with six monthly liver ultrasound and alpha-fetoprotein (AFP) in those at increased risk of HCC. Although AFP screening alone is not recommended due to poor sensitivity, it is performed in some centres due to the lack of availability of routine ultrasound. Weekly review of all AFP levels has been performed in our institution, in combination with ultrasound surveillance. AFP levels ≥10ng/ml are considered elevated, and trigger further case assessment.

Aims/Background
To determine the diagnostic yield of AFP screening for the diagnosis of HCC, and whether the identification of raised AFP levels impacted on clinical care.

Method
Retrospective analysis of all AFP levels reviewed in Beaumont Hepatology Unit over a 12 month period between 2017-2018. Patient data and demographics were collected from medical records.

Results
A total of 1,365 AFP levels were reviewed in 2018, reflecting 994 patients. Of these 71 (5.2%) were elevated, relating to 39 patients. Of these 39 patients, disease aetiologies included hepatitis C (n=21/39), hepatitis B (n=8/39), hepatitis C/alcohol (n=3/39), alcohol (n=8/39), autoimmune hepatitis (n=1/39) and alpha-1 antitrypsin deficiency (n=1/39). 21 of 39 (54%) of patients had documented liver cirrhosis, while the stage of liver disease in 2/39 was unclear. Of the remaining 16 non-cirrhotic patients, 4 had HBV infection, and 1 was pregnant. The detection of an elevated AFP level triggered further investigation in 18 patients (46%); liver ultrasound was requested in 14, and axial (CT/MRI) liver imaging in 4. 14 patients had investigations booked as part of surveillance program prior to AFP results. Only one HCC case was detected in the 39 patients (2.6%) with elevated AFP levels, and a raised AFP assisted the diagnosis of HCC in only 0.1% patients in whom it was measured.

Conclusions
AFP levels should not be used as a standalone screening tool for HCC detection.

ABSTRACT 70 (19S174)

Documenting alcohol intake on medical admission; How good are we at doing it?

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Introduction
Alcohol confers a significant health burden on the Irish healthcare system. Routine documentation of alcohol intake forms part of a standard medical admission. Often, documentation is scant and infrequent.

Aims/Background
Establish frequency of alcohol intake documentation as part of a patient's medical admission.

Method
Data was retrospectively collected from the medical admission proforma from patients admitted to Beaumont Hospital and

were under the care of the gastroenterology inpatient service. Demographics including patient gender, age and reason for admission was also collected.

Results
55 patients were included of which 51% were male. Median age was 72 years (range 17-95 years). Admission related to gastrointestinal conditions (50.9%), collapse (12.7%) respiratory (10.9%), cardiovascular (10.9%), renal (10.9%), haematological (1.8%), and dermatological conditions (3.6%). Among the 55 patients, alcohol intake was documented in 65.5% (n=36/55) while there was no record in 34.5% (n=19/55). Of the 36 patients with intake documented, 58% (n=21/36) was recorded as "units per week", 22% (n=8/36) recorded as "drinks per week", 8.5% (n=3/36) as "seldom"/"rarely"/"social", 5.5% (n=2/36) as "previous excess", 3% (n=1/36) recorded as "bottle per day" and 3% (n=1/36) was not quantified. Admitting doctors grade documenting alcohol intake was most frequently the Senior House officer 75% (n=27/36), followed by the registrar at 19% (n=7/36). Among those that had no alcohol status documented, most frequently the admitting doctor was a registrar 42% (n=8/19), followed by Senior House Officers 37% (n=7/52).

Conclusions
Documentation of alcohol intake during patients' medical admission is not done consistently. Increased awareness and education may help address this.

ABSTRACT 71 (19S176)

The Effect of Anti-coagulatiion and Anti-platelet Agents on FIT levels in Colorectal Cancer Screening.

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Introduction
Initial screening in BowelScreen is based on the Faecal Immunochemical Test (FIT). It is known that anti-coagulants and anti-platelets have no effect on guaiac-based FOB (e.g. causing false positives). The effect these medications have on FIT quantitative haemoglobin level has not been established.

Aims/Background
To investigate the relationship between FIT scores and concomitant anti-platelet or anti-coagulant use with adenoma and malignancy detection.

Method
Patients who underwent an index NCSS colonoscopy in our centre from January 2014 to December 2015 were included. FIT results were made available by BowelScreen. Data, including; demographics, medications and pathology, was collected.

Results
502 index colonoscopies were performed. 60.2% (n=302) were male. The median age was 66.45years. 22 malignancies and 32 adenomas with high grade dysplasia were detected. 327 patients were on no anti-coagulant or anti-platelet medication, with a median FIT 440ug/g. 14 adenocarcinomas (n=14 patients, 4.3%) and 21 high grade dysplastic adenomas (n=20 patients, 6.1%) were detected in this cohort. 6.8% of patients (n=34) were on therapeutic anti-coagulation; 6 in combination with an anti-platelet agent. The median FIT in anti-coagulated patients was 631.5ug/g. 1 adenocarcinoma and no high grade dysplastic lesions were detected in this group. This numeric difference was not statistically significant (p=0.72).

Conclusions
In this small cohort, yield of pathology was similar and anticoagulants did not appear to lead to differences in quantitative FIT Hb levels. A one size fits all level appears appropriate irrespective of anti-coagulant use. This finding correlates with findings in guaiac-based screening programmes but should be confirmed in larger cohorts.

ABSTRACT 72 (19S177)

Should Sessile Serrated Polyps Have Separate Surveillance

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Introduction
The serrated pathway accounts for up to 30% of CRC. Sessile serrated polyps (SSPs) have the highest malignant potential of serrated lesions. SSPs occur sporadically or part of the serrated polyposis syndrome (SPS). More recently, increased CRC risk has also been associated with an oligo-SPS phenotype and large, ≥10mm lesions.

Aims/Background
Our aim was to describe and evaluate SSP characteristics in an Irish cohort.

Method
Following ethical approval, patients with ≥1 SSP confirmed histologically between 2016-2018 were identified. Patients were stratified into four known risk groups: SPS defined by WHO criteria, ≥2 SSPs with 1≥10mm (Oligo-SPS), SSP ≥10mm (Large-SSP), and all other SSP's (Low-risk).

Results
195 SSPs in 145 patients were identified; 4/145(2.8%) SPS, 10/145(7%) Oligo-SPS, 25/145(17%), Large-SSP and 106/145(73%) Low-risk SSP. Mean lesion size was 6.5mm. SSP's were most commonly located in the ascending colon 54/195(28%), while a significant proportion were sigmoid lesions 45/195(23.1%). Overall, SSP subjects had a high synchronous polyp burden; ≥2 SSPs 47/145(37%), ≥1 advanced adenoma 17/145(12%), ≥1 non-serrated adenoma 59/145(41%). This did not differ significantly between groups; advanced adenomas; SPS 0%, Oligo-SPS 10%, Large-SSP 16%, Low-risk SSP 11% and ≥1 non-serrated adenoma; SPS 25%, Oligo-SPS 40%, large-SSP 44%, low-risk SSP 41%. SPS was recognised by endoscopists in 2/4(50%) cases.

Conclusions
SSP patients, irrespective of risk, have a high synchronous polyp burden, including advanced adenomas. The sigmoid, excluded by two WHO SPS categories was the location for 1/4 of SSPs. Further studies to evaluate the need for SSP targeted surveillance and to consider broadening the WHO criteria are warranted.

ABSTRACT 73 (19S178)

Maintenance phase of Haemochromatosis treatment: are we meeting targets?

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Introduction
Iron depletion by venesection is the gold standard therapy for Haemochromatosis, and is associated with several health benefits. Although international guidelines recommend maintaining serum ferritin levels between 50-100ug/L once a patient is de-ironed, practice varies widely from centre to centre.

Aims/Background
To review average ferritin levels during maintenance phase of Haemochromatosis treatment at our Institution.

Method
All patients undergoing maintenance venesection between 2009 to 2018 were included. The last ferritin level, HFE genotype and demographics were obtained.

Results
597 patients were identified, 407 men and 190 women, mean age 53 years. 388 (71%) were C282Y homozygotes, 145 (27%) compound heterozygotes and 12 (2%) H63D homozygotes; genetic testing was unavailable for 52 patients. The vast majoriy (>70%) of patients were having 2-4 venesections per year. The median serum ferritin level was 86ug/L, the mean ferritin was 103ug/L (+/- standard deviation 74). The serum ferritin of 105 (18%) patients lay between 0-50 , 253 (42%) between 50-100, 190 (32%) between 100-200, 43 (7%) between 200-400, and 5 (1%) patients >400; data was missing on one patient.

Conclusions
This study demonstrates broad compliance with international treatment targets for Haemochromatosis at our Institution.

ABSTRACT 74 (19S179)

Gastric Antral Vascular Ectasia, A descriptive study

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Introduction
The aetiology of Gastric Antral Vascular Ectasia (GAVE) remains unknown. In approximately 30% of cases of GAVE, liver cirrhosis is present. GAVE is found in 2-5% of patients awaiting liver transplant and is thought to be responsible for chronic blood loss anaemia in 3-26% of patients with cirrhosis. However, a paucity of data exists regarding the incidence of GAVE among patients with cirrhosis or those with oesophageal varices.

Aims/Background
1) Quantify the amount of patients with oesophageal varices with concomitant GAVE attending South Tipperary General Hospital. 2) Report the liver ultrasound (US) and liver biochemistry (LFT) of all identified patients with GAVE.

Method
The endoscopy database was searched for key terms including 'Oesophageal Varices',' Stomach GAVE',' Stomach Vascular lesions'. All reports retrieved were reviewed. In addition US reports and laboratory reports of all patients identified with GAVE were reviewed.

Results
140 patients identified. 7/76 (9.2%) patients with oesophageal varices were found to have GAVE. 48 patients underwent endoscopy for GAVE. 39.5% had a normal liver US. 35.4% (17/48)- no US. 25% of patients had an abnormal liver US. 52.6% of those with a normal liver US of LFT derangement.

Conclusions
Using oesophageal varices as a proxy indicator for liver cirrhosis our cohort of patients with concomitant varices and liver cirrhosis is less than the expected 30% reported elsewhere. A high proportion of patients with GAVE were found to have deranged liver function tests in the setting of a normal liver ultrasound. This may represent a high risk group in need of more detailed risk stratification given the apparent link with liver cirrhosis.

ABSTRACT 75 (19S181)

Discrepancies in Recording of Comfort Scores Between Nurses and Endoscopists in the Mercy University Hospital

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Introduction
The Modified Gloucester Comfort Scale is used internationally to assess discomfort experienced by patients undergoing colonoscopies. It has been found that the nursing comfort score and the endoscopist comfort score are often different.

Aims/Background
This was a retrospective audit to assess the accuracy of recording of comfort scores between the nurse and the endoscopist.

Method
The most recent 110 colonoscopies were chosen to be included. Comfort scores were recorded by the nurse for the procedure and recorded in the nursing records. The endoscopist was informed of the comfort score and then recorded it on the colonoscopy report. Data was collected retrospectively from the electronic report as well as from the subject's nursing records. 2 colonoscopies were excluded due to incomplete records.

Results
This audit found that only 55% of comfort scores for colonoscopies were recorded accurately between nurses and endoscopists in the Mercy University Hospital. 27% of colonoscopies had comfort scores under-reported by the endoscopist.

Conclusions
It is clear from these figures that there is a breakdown in communication between the nurse and the endoscopist leading to inaccurate recording of comfort scores on the final colonoscopy report It should be brought the attention of all endoscopists and nurses in the endoscopy department that documented final nursing comfort

scores should be relayed to the endoscopist prior to the patient being brought out to recovery. After this, a further audit should be performed to further assess accuracy of comfort score recording so that accurate quality indicators of endoscopy can be calculated.

ABSTRACT 76 (19S182)

FICE technology: A valuable tool in colon capsule endoscopy.
Author(s)

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Introduction
ESGE colon capsule (CCE) guidelines suggest referral for polypectomy based on polyp size (>6mm) and number (>3). Real time histological diagnosis with digital chromo-endoscopy is a recognised useful adjunct during standard colonoscopy. The use of this in CCE is unclear.

Aims/Background
Assess the impact of Flexible Spectral Imaging Colour Enhancement (FICE) on CCE polyp classification and its impact on referral for polypectomy.

Method
Paired CCE and colonoscopy polyps were identified from respective databases. Polyps were risk stratified by size >6mm and application of Kudo's pit pattern classification (1/2 – benign, 3/4/5 – adenoma) with White Light (WL) and FICE, by a single blinded experienced capsule endoscopist and compared to histology.

Results
33 paired polyps from 24 patients were examined, 22 adenomas and 11 benign lesions. Diagnostic accuracy for size >6mm, WL and FICE was as follows: PPV 94%, 100%, 84% and NPV 59%, 55%, 67%, respectively. In accordance with current practice 15 of 22 (68%) adenomas and 1 of 11 (9%) hyperplastic polyps were >6mm and would be referred for polypectomy. Applying Kudo's classification with White Light CCE imaging alone did not improve adenoma detection. FICE application improved adenoma detection to 17/22 (77%). FICE misclassified 3 hyperplastic polyps, but the original large hyperplastic polyp referred for polypectomy based on size was reclassified reducing the overall unnecessary referral rate to 6% (2/33).

Conclusions
Initial results indicate FICE in CCE has a good negative predictive value and enhances adenoma detection. Further investigation is warranted with a goal of incorporating FICE in future CCE recommendations.

ABSTRACT 77 (19S183)

High-Risk Factors For Gastric Retention In Small Bowel Capsule Endoscopy (SBCE): A Single Centre Retrospective Study

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Introduction
Certain conditions and medications have been identified as risk factors for gastric capsule retention (GCR). ESGE guidance recommends the use a real-time viewer to guide appropriate early preventative intervention.

Aims/Background
To examine the prevalence and associations of GCR in an Irish cohort.

Method
Patients with video confirmation of gastric retention for the duration of the study were identified from a SBCE database of 3048 cases. Clinical data was extracted from medical charts.

Results
A total of 70 cases were identified, giving a GCR rate of 2.3% (70/3048). Data was available for 61 SBCEs. In all, 36 (59.1%) were female and the mean age was 58 years. Eighteen patients (29.5%) were either current or ex-smokers. In keeping with standard SBCE practice, the commonest indications for SBCE were iron deficiency anaemia 32/62 (52.4%) and Crohn's disease 15/61 (24.6%). With regard to GCR risk factors; 10/61 (16.4%) had diabetes, 12 (19.7%) had hypothyroidism, 7 (11.5%) had had previous abdominal surgery and 14 (23%) were taking psychotropic medication. Twenty eight patients 28/61 (45.9%) had at least one associated risk factor and 14/61 (23%) had more than one.

Conclusions
GCR is a relatively frequent occurrence. Almost half of our GCR cohort (45.9%) had at least one and 23% had multiple risk factors, all of which could have been identified in advance of SBCE. Our data supports the prospective assessment of a targeted intervention, by way of real time video assessment and prokinetic administration when delayed gastric emptying occurs.

ABSTRACT 78 (19S184)

Genetic variation in a cohort of Lynch Syndrome patients

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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. 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.

Aims/Background
To assess genetic variations in the LS cohort from a High-Risk Family Colorectal Cancer Screening Clinic 1998-2019.

Method
A retrospective anonymised gene variant analysis of LS patients from the family clinic database. Identifying the specific variants in the MMR genes and analysing their risk classification using the CanVar UK classification tool.

Results
There were 96 LS patients identified, 46 male, 50 female. Gene distribution: MSH2 = 46%, MLH1 = 27%, MSH6 =13%, PMS2 =7%. There were 24 separate variants identified from 61 patients. Of these, 12 variants (52%) were identified only once each. In regard to risk classification, 9/24 variants were pathogenic, 2/24 likely pathogenic, 7/24 uncertain significance and 4/24 unclassified.

Conclusions
The presence of isolated single variants, ie only one variant existing in a dataset, is indicative of a lack of cascade testing within the same pedigree. Cascade testing of a pedigree should reveal multiples of the same variant. Further testing of family members may be needed to properly risk stratify the family and arrange appropriate and cost effective GI and non GI surveillance .

ABSTRACT 79 (19S185)

The use of EndoFaster©, a novel H.Pylori diagnostic tool, in an Irish hospital.

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Introduction
EndoFaster is a non-invasive, automatic gastric juice ammonia analyser interposed between the endoscope and the suction system. Early data suggests high accuracy for real-time H.Pylori and gastric atrophy testing.

Aims/Background
Assess diagnostic properties of EndoFaster in an unselected Irish population.

Method
PPI use, EndoFaster results, CLO and histology were recorded from consecutive patients undergoing routine gastroscopy. H.Pylori status was defined by antral and corpus histology. The sensitivity, specificity, PPV and NPV were calculated for each test. Pearson's r was used to correlate the two tests.

Results
A total of 84 patients underwent EndoFaster and histology testing, 43 (51%) were females, mean age was 57 (19-94) years. Additionally, dual CLO was available for 70 individuals. H.Pylori prevalence was 15% (13/84). Diagnostic accuracy for EndoFaster and CLO were both disappointing; sensitivities 62% and 58%, specificities 83% and 95%, positive predictive value 40% and 70%, negative predictive value 92% and 92%, respectively. Correlation was weak; r=0.34, p <0.004. In all 83% (70/84) were currently on a PPI at the time of testing. PPI use was associated with a reduced CLO sensitivity from 57% to 33% but a paradoxical improvement of EndoFaster sensitivity from 57% to 75%. Combining EndoFaster, in which the ammonia threshold can be adjusted for PPI use, with CLO improved overall sensitivity from 72% to 87%.

Conclusions
EndoFaster and CLO have similar diagnostic performances which differ depending on PPI use. The majority of patients are on a PPI which negatively affects rapid H.Pylori tests. A combination of EndoFaster and CLO could improve sensitivity.

ABSTRACT 80 (19S186)

Molecular screening of new colorectal cancers for Lynch Syndrome

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Introduction
Lynch Syndrome (LS) is the most common cause of inherited colorectal cancer (CRC). Traditionally screening of patients for LS was performed in patients at high risk based on personal/family history. Using clinical tools alone for screening, may miss patients who benefit from referral to clinical genetics.

Aims/Background
Critical review of all new CRC cases to evaluate improved screening/detection for LS.

Method
Data was gathered on IHC/MSI analysis of CRCs diagnosed from July 1st to December 31st 2017 and compared data from the same period in 2018.

Results
From July 1st to December 31th 2017; 81 CRCs diagnosed, 38 (48%) tested with IHC, 4 (5%) partially tested, 38 (47%) not tested. Of those tested 6 (14%) had a mutation, 4 (66%) were BRAF V600E +, 2 (33%) had no further testing despite mutation in MLH1. From July 1st to December 31th 2018; 91 CRCs diagnosed, 58 (64%) tested with IHC, 33 (36%) not tested. Of those tested 6 (10%) had mutations, all had BRAF V600E testing, 2 (33%) positive, 3 (33%) negative, 1 pending. Hypermethylation testing on 1 BRAF negative patient was positive, 2 (66%) had germline testing. Of the 42 (53%) CRCs tested for MSI in 2017, none had MMR mutations suspicious for LS. Of the 58 (64%) CRC 2018, 2 had mutations suspicious for LS.

Conclusions
Results indicate improved molecular screening for LS. Further adherence to international guidelines will improve surveillance and pharmacotherapeutic options. Sufficient evidence exists of cost effectiveness of these testing strategies to identify patient at risk of LS.

ABSTRACT 81 (19S188)

FIT and FC as a surrogate non-invasive marker for mucosal healing in Inflammatory Bowel Disease

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Introduction
Mucosal healing (MH) is one of the goals of IBD therapy. Currently the only way to assess MH is by colonoscopy. Faecal Calprotecnin (FC) and Faecal Immunochemical Test (FIT) which detect colonic inflammation and bleeding might be useful adjuncts.

Aims/Background
To assess FIT and FC as surrogate markers of MH.

Method
Following ethical approval, patients undergoing routine colonoscopy were prospectively recruited. Demographics, colonoscopy findings were documented. A FIT and FC were collected prior to colonoscopy. FIT and FC were processed in our laboratory and reported as µg/g of stool. MH was defined no visible activity on colonoscopy.

Results
Of 105 colonoscopies, FC and FIT results were available in 99 and 88 patients. Mean age 48.8, 52% (55) males, 34% (36) UC, 60% (63) Crohn's, 0.05% (6) IBDU. In all, MH occurred in 12%, (n=12). In MH the mean FIT and FC were 1142 and 353, while in active cases were 750 and 819. Only FC was significantly lower in MH cases (353 vs 819, p=0.05). Using standard cut-offs of >50; sensitivity, specificity, PPV and NPV for MH for FIT was poor; 59%, 33%, 89%, 9% and for FC was better at 74%, 73%, 91%, 44%. Overall correlation between the biomarkers was weak r=0.2, p<0.01. FC ROC analysis gave a specificity and sensitivity of 75% and 67% for a cut-off of <64µg/g, AUC=0.65.

Conclusions
MH was uncommon (12%) reflecting our clinical practice. FIT was a poor predictor of MH. FC might be a useful marker albeit ongoing research is needed to set an appropriate cut-off.

ABSTRACT 82 (19S189)

High incidence of H. pylori resistance in an Irish population which negatively impacts treatment.

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Introduction
Due to increasing antimicrobial resistance, eradication rates for H. pylori infection have significantly declined. Therefore, local antimicrobial monitoring is crucial.

Aims/Background
To evaluate the prevalence of H. pylori primary and multidrug resistance and their impact on treatment outcome.

Method
Antral and Corpus biopsies were prospectively obtained from patients undergoing routine endoscopy during 2018-2019. Culture was performed if CLO positive. Susceptibility to seven antibiotics was tested as standard. Patients were treated with standard eradication regimes and success was determined by C13UBT.

Results
66 patients were recruited, mean age 51 (31-81) years, 19 (56%) females. Culture was successful in 33 (50%). 61% (20/32) without (PR=primary resistance) and 39% (13/33) (SR=secondary resistance) with prior treatment. PR and SR groups were similar. Sensitivity to all antibiotics was similar between groups; 4/20 (20%) PR vs 1/13 (8%) SR. PR was high; Metronidazole 12/20 (60%), Clarithromycin 9/20 (45%), Amoxicillin 7/20 (35%), Levofloxacin 6/20 (30%), Rifampicin 9/20 (45%), Tetracycline 5/20 (25%), Moxifloxacin 2/20 (10%). Secondary resistance was higher; Metronidazole 11/13 (85%), Clarithromycin 9/13 (69%), Amoxicillin 6/13 (46%), Levofloxacin and Tetracycline 4/13 (31%), Rifampicin 2/13 (15%), Moxifloxacin 3/13 (23%). The dual resistance (Metronidazole and Clarithromycin) was 52% (17/33) and similar in the PR and SR groups. The multidrug (>3) resistance rate (MR) was 48% (16/33) and were similar in the PR and SR groups (9/20 vs 7/13) Disappointingly only 4/13 (31%) SR patients were eradicated and 9/20 (45%) PR patients (P=0.48).

Conclusions
Primary, secondary, dual and multidrug H. pylori resistance is high. Unsurprisingly, this is reflected in poor overall eradication.

ABSTRACT 83 (19S190)

The changing face of ERCPs in the South East

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Introduction
St Luke's Hospital provides an ERCP referral service for the south-east of Ireland. Recent years have seen an increase in emergency and elective presentations to the hospital. The demographics of those presenting is also evolving, with a rising median age of inpatient and outpatient presenting

Aims/Background
Our aims were to i) review the number and provenance of referrals for ERCP ii) identify any changes in indication for and findings at ERCP and iii) describe the evolution in types of intervention employed and rate of therapeutic success

Method
This single-centre retrospective analysis was conducted by reviewing the electronic database of ERCPs performed between January 2014 and December 2018. Data were extracted on patient demographics, year of procedure, referral source, radiological findings at ERCP, number and size of calculi, intervention(s) performed and prior bile duct or gallbladder interventions.

Results
A total of 1487 ERCPs were performed at St Luke's Hospital in the study period. Mean annual growth in number of procedures was 11.3% (range 5.9-22.5). The proportion of external to internal referrals grew from 1.79 to 2.52. Median age increased from 69 years to 72 years. Duct clearance improved from 64.0% to 75.6% over the study period.

Conclusions
Demand for ERCP is growing in the south-east of Ireland, with St Luke's Hospital providing a busy referral service for several other public hospitals. The demographic features of the cohort are changing in line with the increasing age and comorbidities seen in the broader inpatient population. Use of novel interventions has coincided with improved duct clearance in patients with CBD calculi.

ABSTRACT 84 (19S191)

Readability of patient oriented websites on role of diet in Inflammatory Bowel Disease

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Introduction
The internet is used by patients to access health information. The U.S. Department of Health and Human Services and American Medical Association recommend that patient-oriented literature be written at a fourth- to sixth-grade reading level to optimize comprehensibility.

Aims/Background
To asses readability of patient oriented websites on discussing the role of diet in Inflammatory Bowel Diseases (IBD).

Method
Google was searched to identify relevant websites using "diet in IBD", "Role of diet in inflammatory bowel disease" as the key search words. English language websites in the first three pages of results of Google search were included. Research articles and advertisements were excluded. Websites were divided into 3 main categories, government, non-profit organisation (NPO) and commercial. 2 validated readability assessment tools: Flesch Reading Ease (FRE) and Flesch-Kincaid grade level (FKGL) were utilised and scores were calculated using Microsoft Word.

Results
After exclusions 15 websites were included for analysis. Half of those (n=7) were government websites, 5 NPO and 3 were commercial. Mean FRE score 53.74, range 18.5 - 78.5. Mean FKGL score 9.48 and range was 5-15.9. Only 2/15 websites have recommended readability scores of up to 6th grade readability level; one was commercial and second one was NPO.

Conclusions
Most of the analysed websites were found to be above the sixth-grade readability level recommendations. Efforts need to be made to better customise online patient education materials to the general public.

ABSTRACT 85 (19S192)

Early Surgery versus Medical Therapy in Patients with Ileocolonic Crohn's Disease

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Introduction
Previous studies have demonstrated that early bowel resection (EBR) in ileocolonic Crohn's disease (CD) can result in an improved clinical course compared to standard medical treatment (SMT), including escalation to biologic therapy.

Aims/Background
We sought to compare the safety and efficacy of EBR versus SMT for the management of patients with ileocolonic CD.

Method
A systematic search was performed to identify studies that compared EBR (performed <1yr from initial diagnosis) or SMT for the management of ileocolonic CD. Log hazard ratios (InHR) for recurrence free survival (RFS) and their standard errors were calculated from Kaplan–Meier plots and pooled using the inverse variance method. Dichotomous variables were pooled as odds ratios (OR). Quality assessment of the included studies was performed using the Newcastle-Ottawa (NOS) and Jadad scales.

Results
7 studies of 1863 CD patients (EBR n= 581, 31.2%; SMT n= 1282, 68.8%) were eligible for inclusion. The median NOS was 8 (range 7-9). There was a reduced likelihood of overall (OR 0.53 95% Confidence interval [95% CI]: 0.34, 0.83, p=0.005, I^2=61%) and surgical (OR 0.47, 95% CI 0.24, 0.91, p=0.03, I2=83%) recurrence with EBR than with SMT. There was also a less requirement for maintenance biologic therapy (OR 0.24, 95% CI 0.14, 0.42, p<0.0001, I2=23%). Patients who underwent EBR had a significantly improved RFS than those who underwent SMT (HR, 0.62 95% CI 0.52, 0.73, p<0.001, I^2=0%). There was no difference in morbidity (OR 1.67, 95% CI 0.44, 6.36, p=0.45, I^2=61%) between the groups.

Conclusions
Surgery is associated with reduced recurrence and need for maintenance biologic therapy in ileocolonic CD. It is critical that both a surgeon and a gastroenterologist review patients early, at the time of diagnosis, to facilitate informed management decisions.

ABSTRACT 86 (19S193)

Hepatic CXCL9 and Poor T-cell Recruitment in Colorectal Liver Metastases

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Introduction
Many colorectal cancer patients develop hepatic metastases despite the liver's potent anti-tumour immune repertoire. The type and number of tumour infiltrating immune cells affects survival, and cellular trafficking is dictated by chemokines.

Aims/Background
We hypothesize that a dysregulation in the CXC family of chemokines and their receptor compromises immune infiltration and survival in colorectal metastases.

Method
To investigate this, archived paraffin embedded tumour and tumour adjacent tissue from colorectal liver metastases resections with 10 years of clinical data were recalled for immunohistochemical staining of CD45 (pan leukocyte marker), CD3 (T-cells), and CD8 (cytotoxic T-cells; n=50). Fresh donor liver, tumour, and tumour adjacent liver biopsies were collected from recent resections (n=18), and liver transplantations (n=25) for conditioned media development, and total protein homogenization.

Results
Average absolute cell counts for all three markers were found to be significantly higher in tumour liver tissue compared to donor liver (CD45 $p< 0.001$, CD3 $p=0.009$, CD8 $p<0.001$) with significant interpatient variation. High vs low immune recruiters were defined by the median cell counts within tumours, and were found to significantly correlate with overall survival (CD45 $p=0.001$, CD3 $p=0.3$, CD8 $p=0.04$). The cytokine microenvironment of liver tissue homogenates was tested with an 80 target protein array, which highlighted a prominent dysregulation in chemokines including CXCL9, CXCL10, and CCL8. Levels of T-cell chemoattractant, CXCL9, were measured by ELISA and found to be significantly higher in the tumour (282.3±84.2 pg/mg of protein) compared to donor liver (172.9±72.7 pg/mg of protein; $p=0.003$), and also demonstrating interpatient variation similar to that seen in immune infiltration. Blocking CXCL9 significantly reduced chemotaxis of leukocytes and CD8 cells in response to tumour conditioned media ($p=0.03$, 0.04 respectively).

Conclusions
In summary, we have confirmed the prognostic value of immune infiltration in our cohort of patients with colorectal liver metastases. Dysregulation of chemokines, in particular CXCL9, may explain the variation in patients' immune recruitment to the site of the tumour. CXCL9 may present a novel immunotherapeutic target for colorectal liver metastases.

ABSTRACT 87 (19S194)

Gastroenterology Going Green: A Qualitative Review of Attitudes Towards Recycling & Environmental Responsibility in the Mater Hospital Gastroenterology Department

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Introduction
Health care facilities generate significant waste and contribute negatively to environmental health. Irish hospitals produce an estimated combined 17,000 tonnes of landfill waste per annum. The World Health Assembly recently called for greater action on medical waste.

Aims/Background
Medical waste management is complex. Waste reduction strategies rely heavily on optimising staff attitudes and behaviour. Our study aimed to assess a) attitudes towards environmental protection among staff of the GI Unit, and b) willingness to adjust work practice for the benefit of the environment.

Method
A 9-point anonymous questionnaire with binary response options was designed to evaluate attitudes within the GI Unit. A free text suggestion box was included. Questionnaires were distributed to all GI Unit staff and were returned by internal post. Quantitative data was calculated using Excel and a thematic analysis of qualitative data was conducted.

Results
35 questionnaires were distributed. The response rate was 80%. 93% of respondents reported they had concerns about environmental health and climate change. 93% reported prioritising recycling in the home but 57% cited time constraints as a reason for not recycling at work. Only 29% reported receiving any formal training around waste management in work. Encouragingly 97% were open to change ideas within the unit and 64% agreed they would participate in an environmental team at work.

Conclusions
Results suggest that staff are open to playing a role in reducing the waste output of the hospital. We have used this as a springboard for the development of waste management strategies in the Mater Hospital.

ABSTRACT 88 (19S195)

Lack of evidence for increased rates of hepatocellular carcinoma following treatment with direct-acting antivirals: a meta-analysis and systematic review

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Introduction
Hepatitis C (HCV) is the leading cause of hepatocellular carcinoma (HCC) in the Western world. Achieving sustained viral response

(SVR) after treatment with interferon (IFN) reduces the risk from 3-5% to 0.5-1% annually. Several studies have reported unexpectedly high rates of HCC after treatment with direct-acting antivirals (DAA).

Aims/Background
The aim of our study was to compare HCC rates in DAA- and IFN-treated populations.

Method
A literature search was conducted using ScienceDirect, Ovid®, Web of Science and MEDLINE through January 2019. Studies were included if they measured rates of de novo or recurrent HCC (following curative treatment) HCV-infected persons. We included a total of 138 studies (n=177,512). Simple pooling of data and meta-analysis were performed, using the random effects method.

Results
Mean age was higher in the DAA-treated vs. IFN-treated group (58.4 vs. 52.6 yrs; p=0.0073), as was the prevalence of diabetes (34.5% vs. 11.7%; p =<0.001) and incident cirrhosis (47.8% vs. 34.2%, p=0.0017). The incidence rate of de novo HCC was calculated at 2.01/100py (95% CI:1.38, 2.67) in the DAA group and 1.45/100py (95% CI:0.98, 1.94) in the IFN-treated group. HCC recurred at 16.76/100py (95% CI:10.75, 22.91) in the DAA-treated group vs. 20.04/100py (95% CI:2.58, 45.21) after IFN. After adjusting for factors such as age and cirrhosis, the hazard ratio was 0.58 (95% CI:0.20, 1.07) for HCC occurrence and 0.59 (95% CI:0.24, 1.03) for HCC recurrence after DAA treatment compared to IFN-based treatment.

Conclusions
We did not find evidence for increased rates of HCC in DAA-treated compared with IFN-treated patients. Compared to those treated with IFN, older patients with additional pre-existing risk factors for HCC were treated with DAA. This imbalance appears to explain the higher numerical incidence of HCC among DAA-treated patients.

ABSTRACT 89 (19S196)

Effect of Gastroenterology Consultants going off general medical takes on endoscopy activity.

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Introduction
Longer patient waiting times for gastroenterology services, especially endoscopy, are a concern. Most Gastroenterologists in Ireland do general medical take as well as providing a specialty service.

Aims
To investigate whether eliminating the general medical take burden of a Gastroenterologist in a model 3 hospital will have a significant impact on the endoscopy activity.

Method
We compared the number and type of endoscopic procedures performed in our Hospital from October 2016 to April 2017 and a similar period in 2017/2018. The Gastroenterology Team was taken off the general medical Rota in 2017/2018. There was also no increase in auxiliary staff during the latter.

Results
We recorded a significant increase in the number of procedures performed in the Gastroenterology Unit while "off-take". There were 395 OGD's carried out in the 7 month "off-take" period compared to 225 in the "on-take" period, a 76% increase. 135 colonoscopies were performed while "off-take", a 32% increase. A 19% increase in sigmoidoscopies and a 100% increase in combined OGD's and colonoscopies were also recorded in the "off-take" period. This resulted in a total of 272 more procedures when "off-take".

Conclusions
Our findings show that substantially more endoscopic procedures were carried by the Gastroenterology Team when the Consultant was off the medical rota. This reduced general medicine burden on specialty Consultants had a significant impact on the growing endoscopy waiting list, providing safer and swifter care to patients. Reducing Gastroenterologists "on-take" commitment is one mechanism of increasing endoscopy activity.

ABSTRACT 90 (19S197)

Outcome of Infliximab Therapy in IBD Patients with Therapeutic Drug Levels and Concomitant Anti-Drug Antibodies

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Background:
Therapeutic drug monitoring (TDM) is increasingly utilised in IBD practice to guide dosing of anti-TNFs. Anti-drug antibodies (ADA) are postulated to be an indicator of secondary loss of response. We aimed to evaluate the outcome of patients with therapeutic Infliximab (IFX) levels and concomitant ADAs.

Methods:
IFX TDM has been available at SJH for a 1-year period. On a pilot basis, IBD patients receiving IFX had trough samples collected. IFX-levels and ADA were determined using a commercially available assay. IFX levels from 3 - 7 µg/L were considered therapeutic. ADA of 10AU/ml and greater were considered positive. Patients with a therapeutic IFX level and detectable ADA were included. IFX treatment decisions based on TDM were documented.

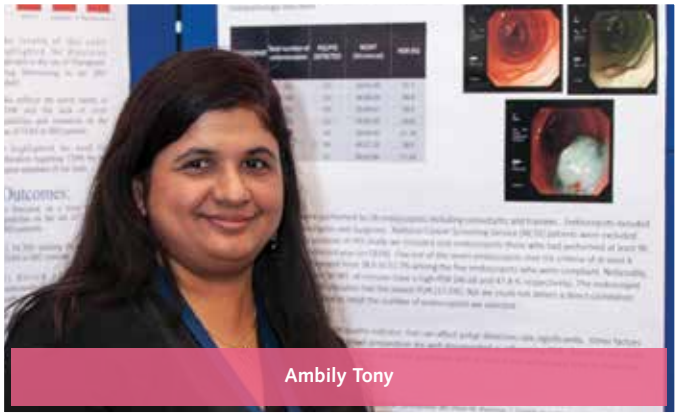
Results:
N=14 IBD patients were included, 43% male, with a median age of 30.1 years (17-72), 57% Crohn's disease. At baseline TDM assessment IFX level was 4.95µg/L (3-16.8 µg/L) and ADA median level was 48.5 AU/ml2 (11-347 AU/ml2). 64% (n=9) of initial study cohort remained on IFX therapy during follow up with therapeutic drug levels (>3 µg/L). In patients who underwent follow up TDM assessment, the median IFX level on follow up was 6.5µg/L (2-11µg/L) and ADA 17 AU/ml2 (<10-287). 21% of cohort had IFX dosing interval increased, 21% had IFX dosing interval decreased and 21% discontinued IFX therapy. 14% (n=2) of patients discontinued IFX therapy due to an infusion reaction.

Conclusion:
In the cohort of patients with therapeutic IFX levels and detectable ADAs ongoing therapy with IFX can be successful. A proportion of patients suppress anti-drug antibodies over time.

Winter Meeting 2018

Roisin Joyce-Moss, Hayley Collins, Tom Moloney & Gillian Dodd – Pfizer


Mr Chris Collins


Ambily Tony


Neil Power, Donal Murphy, Eoin Murphy, Mark Cullen & Loretta O'Brien – Abbvie


Shamindra Direkze, Deepa Jegadish Gandhi & Sandra McCabe


Mr John Burke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SIMPONI (golimumab) is indicated for adult patients with moderately to severely active UC who have had an inadequate response to conventional therapy including corticosteroids and 6-MP or AZA, or who are intolerant to or have medical contraindications for such therapies.[2]

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

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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 syringeSimponi 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 Simponi in patients with chronic infection or a history of recurrent infection including use of concomitant immunosuppressive therapy. Simponi should not be given to patients with clinically important active infection. Patients should be advised of the potential risk factors. Bacterial infections (including sepsis and pneumonia), mycobacterial (including TB), invasive fungal and opportunistic infections, including fatalities, have been reported. The invasive fungal infection should be suspected if they develop a serious systemic illness. There was a greater incidence of serious infections, including opportunistic infections and TB, in patients receiving golimumab 100 mg compared with patients receiving golimumab 50 mg. Serious infections have occurred in patients on concomitant immunosuppressive therapy that, in addition to their underlying disease, could predispose them to infection. There have been reports of active TB in patients receiving Simponi, including patients previously treated for latent TB. Patients should be evaluated for active or latent TB before Simponi treatment. All such tests should be recorded on the Patient Reminder Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be monitored closely for signs and symptoms of active TB and advised to seek medical advice if signs and/or symptoms of TB appear. Hepatitis B (HBV) reactivation: Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi Malignancies and lymphoproliferative disorders: Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy, additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded. Rare cases, usually fatal, of hepatosplenic T-cell lymphoma (HSTCL) have been reported, the majority of cases occurred in adolescent and young males nearly all on concomitant treatment with azathioprine (AZA) or 6 mercaptopurine (6–MP). The potential risk with the combination of AZA or 6 MP and Simponi should be carefully considered. A risk for the development for HSTCL in patients treated with TNF-blockers cannot be excluded. Colon dysplasia/carcinoma - Screen for dysplasia in all patients with UC who are at increased risk or had a prior history for dysplasia or colon carcinoma. In newly diagnosed dysplasia patients the risks and benefits of continued Simponi use should be carefully assessed. Melanoma and Merkel cell carcinoma (all TNF-blocking agents including Simponi) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. Heart Failure: Simponi should be used with caution in patients with mild heart failure (NYHA class I/II). Patients should be closely monitored and Simponi must be discontinued in patients who develop new or worsening symptoms of heart failure. Some cases had a fatal outcome. Neurological events: Use of anti-TNF therapy, including Simponi, has been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disorders, including multiple sclerosis and peripheral demyelinating disorders. Discontinuation of Simponi should be considered if these disorders develop. Carefully consider the benefits and risks before initiation of therapy in patients with a history of demyelinating disorders. Surgery: Patients requiring surgery whilst on Simponi therapy should be closely monitored for infections. Autoimmune processes: If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Simponi and is positive for antibodies against double-stranded DNA, treatment should be discontinued. Haematological reactions: There have been post-marketing reports of pancytopenia, leukopenia, neutropenia, agranulocytosis, aplastic anaemia, and thrombocytopaenia in patients receiving TNF-blockers, including Simponi. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant haematologic abnormalities. Vaccinations/therapeutic infectious agents: It is recommended that live vaccines or any therapeutic infectious agents should not be given concurrently. Allergic reactions: If an anaphylactic reaction or other serious allergic reaction occurs, administration of Simponi should be discontinued immediately, and suitable treatment initiated. The needle cover of the pre-filled pen contains latex and may cause allergic reactions in those sensitive to latex. Special populations: Older patients (≥ 65 years): Adverse events, serious adverse events and serious infections in patients aged ≥65 were comparable to those observed in younger patients. However, caution should be exercised when treating the elderly, particular attention should be paid to infections. There were no patients age 45 and over in the nr-Axial SpA study. Paediatric patients (<18 years): Vaccinations: it is recommended that prior to initiating Simponi therapy, paediatric patients be brought up to date with all immunisations in agreement with current immunisation guidelines. Excipients: Simponi contains sorbitol (E420). Patients with rare hereditary problems of fructose intolerance should not take Simponi. **INTERACTIONS** Combination of Simponi and other biological therapeutics used to treat the same conditions as Simponi, including anakinra and abatacept is not recommended. **PREGNANCY AND LACTATION** Administration of Simponi is not recommended during pregnancy or breast-feeding. Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Simponi treatment. **SIDE EFFECTS Refer to SmPC for complete information on side effects** Very Common (≥ 1/10): upper respiratory tract infection; Common (≥1/100): bacterial infections, lower respiratory tract infections, viral infections, bronchitis, sinusitis, superficial fungal infections, abscess, 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:** September 2018 *Simponi/PI-IRE/09-18*

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.** Simponi SPC, available at www.medicines.ie.

Date of preparation: February 2019.

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

IE-XBR-00007

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Winter Meeting 2018

Ciaran Judge - Oral Presentation 1

Tim Ryan - Oral Presentation 2

Rita Douglas - Oral Presentation 3

Fintan O'Hara - Oral Presentation 4

Stephanie Deniffe - Oral Presentation 5

Mairead McNally - Oral Presentation 6

Laksman Kumar - Oral Presentation 7

Erin Sullivan - Oral Presentation 8

Winter Meeting 2018

Abrar Ahmed Ansari, Ashraf Monger, Qasim Rasheed & Muhmmad Umair Tayyub

Dr Gavin Harewood & Prof. Paud O'Regan chairing session

Emer O'Driscoll, Anne Fennessy & Karl Hazel

Syafiq Ismail - Oral Presentation 9

Cathy Rowan - Oral Presentation 10

Annika Gallagher & Eabha Ring

Amy Ross & Joanna Ochogwu at Poster

Dr Colin Howden & Dr John Morris

Winter Meeting 2018

Neill Power, Julie Steen & Prof Glen Doherty - Poster 1st Place

David Kevans, Catherine Rowan & Prof Larry Egan
Oral Abstract 1st Place

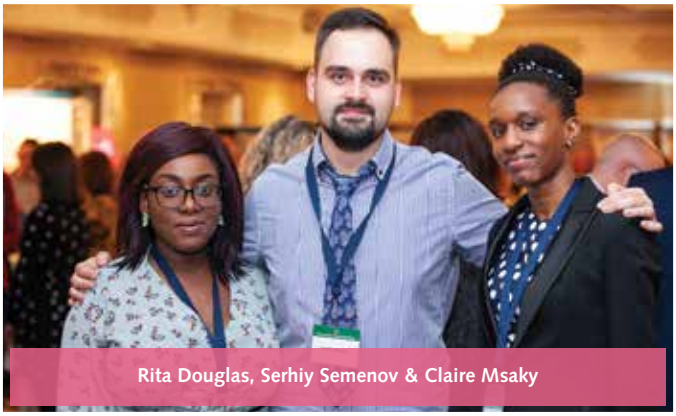
Winter Meeting 2018

David Kevans, Erin Sullivan & Prof Larry Egan - Oral Abstract 2nd Place

David Kevans, Syafiq Ismail & Prof Larry Egan - Best Video

David Kevans, Anne Fennessy, Prof Larry Egan & Elizabeth Grogan
Poster 3rd Place

David Kevans, Leanne Stratton Collecting on behalf of Geraldine Carroll, Prof Larry Egan & Elizabeth Grogan - Poster 2nd Place



Rita Douglas, Serhiy Semenov & Claire Msaky

John Ryan, Frank Murray & Ross McNicholas

Olga Fagan, Christopher Balfe & Roisin Corcoran

Geraldine Carroll, Leanne Stratton & Gemma Wasson

Winter Meeting 2018

Johnny Cash, Khalid Yousif & Brian Egan

Annmarie Anderson - HSL & Noemi De Dominias

Tony Tham, Luke O'Donnell & Garry Courtney

Casper Steenholdt, Prof Larry Egan & John Morris

Dr David Patch

Dr Michael Heneghan

Josephine Caragan, James O'Rourke & Mei Wang

Mark Gorman & Deyrick Deane – MSD

Winter Meeting 2018

Glen Barasona, Rima Grabauske & Liz Cosgrave

Vida Tan & Tanja Borsic

ISEN Meeting Speaking: Caroline Conneely, National Decontamination Quality Lead

Orla O'Brien, Sarah Jane Higgins & Barbara Hynes

Dr Anthony O'Connor

Winter Meeting 2018

St James's Nurses Group

Prof Padraic MacMathuna, Prof Paud O'Regan,
Leah O'Regan & Dr Maeve Skelly

Winter Meeting 2018

Syafiq Ismail, Claire Msaky, Prof Deirdre McNamara, Greg Murphy, Rita Douglas & Serhiy Semenov

Back: Sinead Nolan, Annie Coe, Angela Mullen, Annie O'Regan
Front: Amma Anderson & Aine Keogh.

Winter Meeting 2018

Crowd

Break Time

Winter Meeting 2018

Dr Casper Steenholdt

Takeda Stand

Amgen Stand

Dr Eoin Slattery & Dr Deirdre O'Donovan

Fleetwood Stand

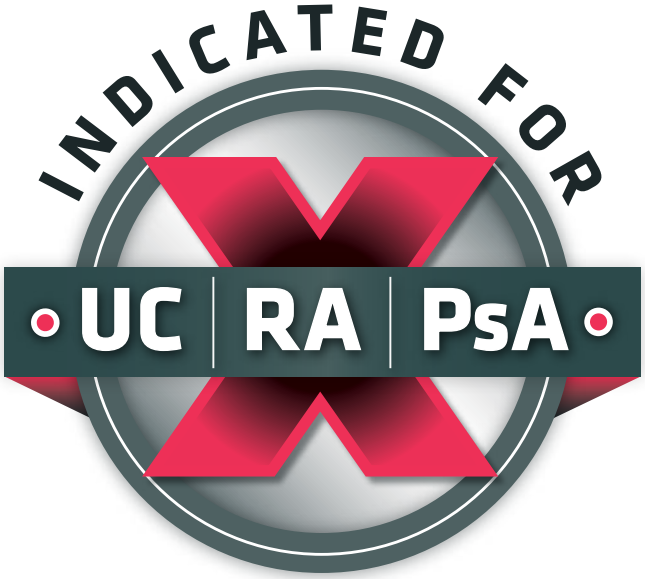
Winter Meeting 2018

Mark Devoy, Dr S. Sengupta & Mai Hanlon

Professor Larry Egan addressing the audience

XELJANZ®▼
(tofacitinib citrate)

MADE IN IRELAND



RAPID AND SUSTAINED EFFICACY[1-6]

A MARK OF XELJANZ

AN ORAL JAK INHIBITOR FOR THE TREATMENT OF RA, PsA AND UC[7]

XELJANZ®▼ (tofacitinib) Prescribing Information:

Please refer to the Summary of Product Characteristics (SmPC) before prescribing XELJANZ 5 mg or 10 mg film-coated tablets. **Presentation:** Film-coated tablet containing tofacitinib citrate, equivalent to 5 mg or 10 mg tofacitinib. **Indications:** In combination with methotrexate (MTX) for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying antirheumatic drugs. Can be given as monotherapy in case of intolerance to MTX or when treatment with MTX is inappropriate. In combination with MTX for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior disease modifying antirheumatic drug (DMARD) therapy. For the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic agent. **Dosage:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition for which tofacitinib is indicated. Tofacitinib is given with or without food. ***RA and PsA:*** The recommended dose is 5 mg administered orally twice daily. ***UC:*** The recommended dose is 10 mg given orally twice daily for induction for 8 weeks and 5 mg given twice daily for maintenance. For patients who do not achieve adequate therapeutic benefit by week 8, the induction dose of 10 mg twice daily can be extended for an additional 8 weeks (16 weeks total), followed by 5 mg twice daily for maintenance. Tofacitinib induction therapy should be discontinued in any patient who shows no evidence of therapeutic benefit by week 16. For some patients, such as those who have failed prior tumour necrosis factor (TNF) antagonist therapy, consideration should be given to continuation of the 10 mg twice daily dose for maintenance in order to maintain therapeutic benefit (see SmPC section 5.1). Patients who experience a decrease in response on tofacitinib 5 mg twice daily maintenance therapy may benefit from an increase to tofacitinib 10 mg administered twice daily. It is recommended not to initiate dosing in patients with an absolute lymphocyte count (ALC) less than 0.75 x 10^9/l, an absolute neutrophil count (ANC) less than 1x10^9 /l or in patients with haemoglobin less than 9 g/dL. ***Renal impairment:*** No dose adjustment is required in patients with mild or moderate renal impairment. Patients with severe renal impairment the dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal renal function is 5 mg twice daily. Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal renal function is 10 mg twice daily. Patients with severe renal impairment should remain on a reduced dose even after haemodialysis. ***Hepatic impairment:*** No dose adjustment is required in patients with mild hepatic impairment. Patients with moderate hepatic impairment dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal hepatic function is 5 mg twice daily.Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal hepatic function is 10 mg twice daily. Tofacitinib should not be used in patients with severe hepatic impairment. ***Elderly:*** No dose adjustment is required in patients aged 65 years and older. Use with caution as increase risk and severity of adverse events. ***Drug-drug Interactions:*** XELJANZ dose should be reduced to 5 mg once daily in patients receiving potent inhibitors of cytochrome (CYP) P450 3A4 (e.g., ketoconazole). XELJANZ dosage should be reduced to 5 mg once daily in patients receiving one or more concomitant medicinal products that result in both moderate inhibition of CYP3A4 as well as potent inhibition of CYP2C19 (e.g., fluconazole) Coadministration of XELJANZ with potent CYP inducers (e.g., rifampicin) may result in a loss of or reduced clinical response. Coadministration of potent inducers of CYP3A4 with XELJANZ is not recommended. **Contraindications:** Hypersensitivity to any of the ingredients, active tuberculosis (TB), serious infections such as sepsis, or opportunistic infections, severe hepatic impairment, pregnancy and lactation. **Warnings and Precautions:** Tofacitinib should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition for which tofacitinib is indicated. Patients treated with tofacitinib should be given a patient alert card. There was a higher incidence of adverse events for the combination of tofacitinib with MTX versus tofacitinib as monotherapy in RA clinical studies. Tofacitinib should be avoided in combination with biologics and potent immunosuppressants such as azathioprine, 6-mercaptopurine, ciclosporine and tacrolimus. ***Infections:*** Serious and sometimes fatal infections have been reported in patients administered tofacitinib. Rheumatoid arthritis patients taking corticosteroids may be predisposed to infection. Patients should be closely monitored for infections, with prompt diagnosis and treatment. Treatment should be interrupted if a serious infection develops. Use carefully in elderly or patients predisposed to, or with a history of infection (e.g. diabetes). ***Tuberculosis:*** Patients should be evaluated for both active and latent TB prior to being treated with tofacitinib, patients who test positive for latent TB should be treated with standard antimycobacterial therapy before administering tofacitinib. ***Viral Reactivation:*** In clinical studies viral reactivation and cases of herpes zoster have been observed. Screening for viral hepatitis should be performed in accordance with clinical guidelines prior to starting therapy with tofacitinib. The impact on chronic viral hepatitis is not known. ***Vaccinations:*** Prior to initiating tofacitinib, it is recommended that all patients be brought up to date with all immunisations in agreement with current immunisation guidelines. Live vaccines should not be given concurrently with tofacitinib. ***Malignancy:*** Lymphomas and other malignancies have been observed in patients treated with tofacitinib. Patients with highly active disease may be at higher risk than the general population. The effect of tofacitinib on the development and course of malignancies is not known. NMSCs have been reported, the risk of NMSC may be higher in patients treated with tofacitinib 10 mg twice daily than in patients treated with 5 mg twice daily. Periodic skin examination is recommended in patients at increased risk. ***Interstitial lung disease:*** Caution is recommended in patients with a history of chronic lung disease as they may be more prone to infection. Asian patients are known to be at higher risk of ILD caution should be exercised with these patients. ***Gastrointestinal perforations:*** Tofacitinib should be used with caution in patients who may be at increased risk e.g. diverticulitis or concomitant use of corticosteroids or NSAIDs. ***Cardiovascular risk:*** Risk factors should be managed as part of usual standard of care. ***Hypersensitivity:*** Cases of drug hypersensitivity associated with tofacitinib administration have been reported. Allergic reactions included angioedema and urticaria; serious reactions have occurred. If any serious allergic or anaphylactic reaction occurs, tofacitinib should be discontinued immediately . ***Laboratory Parameters:*** Increased incidence of lymphopenia and neutropenia have been reported and decreases in haemoglobin and should be monitored in accordance with the SmPC. Monitor ANC and haemoglobin at baseline, 4-8 weeks and 3 monthly, ALC at baseline and 3 monthly. Tofacitinib has been associated with increases in lipid parameters maximal effects are observed at 6 weeks. Monitoring should be performed 8 weeks after initiation and managed according to hyperlipidemia guidelines. Increases in liver enzymes greater than 3x ULN were uncommonly reported, use caution when initiating with potential hepatotoxic medicinal products. **Pregnancy & Lactation:** Use of tofacitinib during pregnancy and breast-feeding is contraindicated. **Side Effects:** The most common serious adverse reactions were serious infections; pneumonia, cellulitis, herpes zoster, UTIs, diverticulitis, appendicitis and opportunistic infections. The most commonly reported adverse reactions during the first 3 months in controlled clinical trials were headache, upper respiratory tract infections, nasopharyngitis, diarrhoea, nausea and hypertension. The most commonly reported adverse reactions in patients receiving tofacitinib 10 mg twice daily in the induction studies were headache, nasopharyngitis, nausea, and arthralgia. Commonly reported adverse reactions (≥1/100 to <1/10), were pneumonia, influenza, herpes zoster, urinary tract infection, sinusitis, bronchitis, nasopharyngitis, pharyngitis, anaemia, headache, hypertension, cough, abdominal pain, vomiting, diarrhoea, nausea, gastritis, dyspepsia, rash, arthralgia, pyrexia, oedema peripheral, fatigue, blood creatine phosphokinase increased. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** S1B. **Marketing Authorisation Number:** EU/1/16/1178/003 – 5 mg (56 film-coated tablets); EU/1/16/1178/007 – 10 mg (56 film-coated tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at EUMEDINFO@pfizer.com. ***For queries regarding product availability please contact:*** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

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

Last revised: 11/2018.

Ref: XJ 6_0.

RA = Rheumatoid Arthritis. **UC** = Ulcerative Colitis. **PsA** = Psoriatic Arthritis.

1. Mease P, et al. N Engl J Med 2017; 377: 1537–1550. **2.** Gladman D, et al. N Engl J Med 2017; 377: 1525–1536. **3.** Hanauer S et al. Poster presented at: World Congress of Gastroenterology at the American College of Gastroenterology Annual Scientific Meeting; October 13–18, 2017; Orlando, FL, USA. **4.** Sandborn WJ et al. N Engl J Med 2017; 376(18): 1723–1736. **5.** Fleischmann R et al. N Engl J Med 2012; 267: 495–507. **6.** Wollenhaupt J et al. Poster presented at: American College of Rheumatology/Association of Rheumatology Health Professionals Annual Meeting; November 4–9, 2017; San Diego, USA. **7.** XELJANZ Summary of Product Characteristics.

PP-XEL-IRL-0425
Date of preparation: February 2019

MAVIRET®

glecaprevir/pibrentasvir

DON'T LOOK BACK

ONE REGIMEN ALL GENOTYPES 8-WEEKS

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

8 WEEK TREATMENT[1]

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

12 WEEK TREATMENT[1]

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

16 WEEK TREATMENT[1]

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

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

STRAIGHTFORWARD ONCE-DAILY REGIMEN[1]

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

Maviret® ▼ 100mg/40mg film-coated tablets PRESCRIBING INFORMATION
PRESENTATION: Each film-coated tablet contains 100 mg glecaprevir and 40 mg pibrentasvir. Please refer to the Summary of Product Characteristics (SmPC) before prescribing. **INDICATION:** For treatment of Chronic Hepatitis C Virus (HCV) in adults 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 1-6): **No cirrhosis:** 8 weeks. **Cirrhosis:** 12 weeks. Patients who failed prior therapy with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin: GT 1, 2, 4-6: **No cirrhosis:** 8 weeks. **Cirrhosis:** 12 weeks. GT 3: **No cirrhosis:** 16 weeks. **Cirrhosis:** 16 weeks. **Special Populations:** HIV-1 Co-infection: Follow the dosing recommendations as above. For dosing recommendations with HIV antiviral agents, refer to SmPC for additional information. Elderly: No dose adjustment required. Renal impairment: No dose adjustment required. Hepatic impairment: No dose adjustment recommended in patients with mild hepatic impairment (Child-Pugh A). Maviret is not recommended in patients with moderate hepatic impairment (Child-Pugh B) and is contraindicated in patients with severe hepatic impairment (Child-Pugh C). Liver or kidney transplant patients: 12 weeks in liver or kidney transplant recipients with or without cirrhosis, with 16 week treatment duration to be considered for GT 3-infected patients who are treatment experienced with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin. Paediatric Population: No 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, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Suspected adverse events should also be reported to AbbVie Limited on 01-4287900. LEGAL CATEGORY:** POM(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:** April 2019. PI/1213/006.

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

IE-MAVI-190023 **Date of Preparation:** May 2019

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