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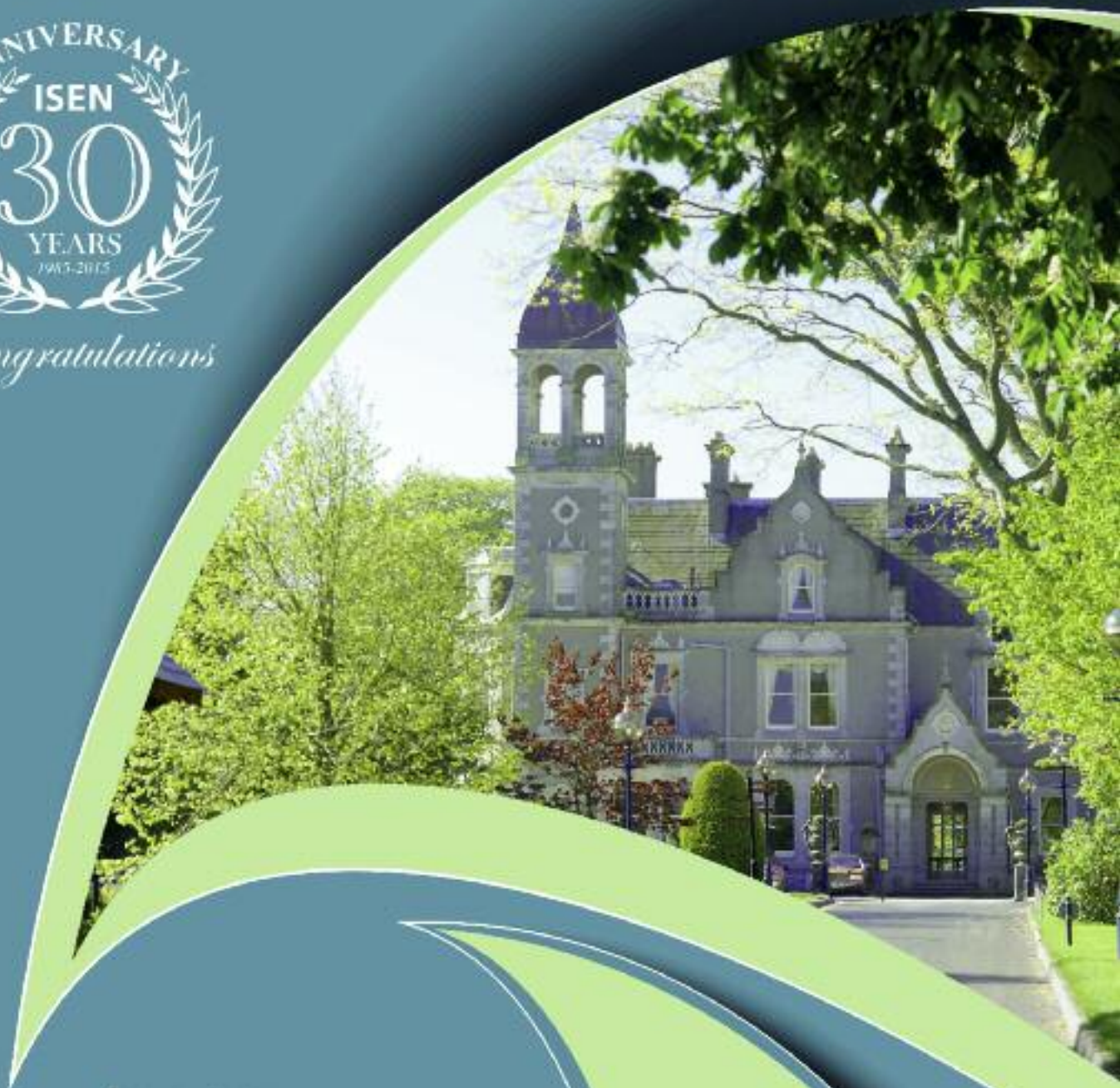
Irish Society of Gastroenterology

Summer Meeting

ANNIVERSARY ISEN 30 YEARS 1985-2015

Congratulations



4 - 5 June 2015
Killashee Hotel,
Naas, Co. Kildare

Welcome Message from the President Professor Humphrey O'Connor

Dear Colleagues and Friends,

It is a great pleasure as President of the Irish Society of Gastroenterology to welcome you to our Summer 2015 Meeting. We are returning to Kilashee House Hotel Naas where we had such a successful meeting last Summer. The key purpose of our meetings is to educate and update with the ultimate aim of improving patient care. With that in mind, we've put together a programme for this meeting with local and international experts which emphasises the multi-disciplinary team approach which delivers optimum care in gastroenterology. In previous meetings I have drawn on the expertise of Irish gastroenterologists abroad and that trend of calling on our internationally recognised diaspora continues here.

Our first session on Thursday morning starts with six of the best free papers followed by an expert session on Therapeutic Endoscopy. Endoscopy increasingly encroaches on surgery and this session should be of wide interest. A session on liver disease follows the coffee break with world experts including our own Professor Kevin Mullen and Professor Keith Lindor. It is then a great pleasure to welcome Professor Michael Goggins back to the ISG for a Keynote Lecture on his lifetime work on pancreatic cancer.

After the lunch break we are privileged to have Professor Geert D'Haens from Amsterdam, a true world authority on Inflammatory Bowel Disease. Six free papers follow and then what should be a terrific session on Oesophageal Disease. Professor Peter Kahrilas from Chicago teams up with our own Professor Paul Ridgway and it should be top class.

The AGM of the Society follows on after the academic sessions and later a Reception and Dinner, and Prize-Giving.

Friday starts with the very interesting launch of a new App for Liver Disease from the National Liver Unit at St. Vincent's University Hospital and this should see wide application. The first academic session is designed to give delegates some perspective on changes in Upper GI Disease over the past few decades. The line-up of speakers is intriguing including our own Professor Brendan Drumm; my valued mentor and friend, Professor Tony Axon from Leeds; and, a particular welcome to Professor KL Goh from Kuala Lumpur with some fascinating insights on the world map of gastroenterology.

After the coffee break we are hosting a Major Symposium on Inflammatory Bowel Disease, driven by recent and rapid changes in disease management. The session will cover the management of difficult disease; the place of Biosimilars; and provide an invaluable update on IBD in Pregnancy.

Hopefully you will find the programme interesting and there should be several key take-home messages. As always I would like to pay a sincere thanks to our friends from Industry for their whole-hearted support for our meeting and whose contribution allows us to host and bring together so many international speakers.

Once again a Céad Míle Fáilte to our nursing colleagues in endoscopy and hepatology. A very sincere congratulations to Mary Hackett-Brennan and her endoscopy colleagues on their 30th anniversary of ISEN. We wish them another 30 years of success and we welcome their founder members who are present here at this meeting.

This is my final meeting as your President and it has been a great honour to be President of the Irish Society of Gastroenterology. The role has been made easy by the terrific help and support provided by our CEO, Michael Dineen and Cora Gannon, our Secretary. Finally I would like to thank the Board of ISG for their unfailing guidance and support and to you, friends and colleagues, for your loyalty to ISG.

Have a great meeting.

Humphrey O'Connor
President ISG
Consultant Gastroenterologist

In adult patients with moderate to severe active Ulcerative Colitis 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.[1]

EFFICACY THAT LASTS[1-2,a]

The first and only subcutaneous anti-TNF with 4-week efficacy during maintenance treatment[1,2,b]

Please consult the Summary of Product Characteristics before prescribing.

[a]Based on results of PURSUIT Maintenance study.

[b]Patients with body weight less than 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks, thereafter. Patients with body weight greater than or equal to 80 kg: Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks, thereafter.[1]

Simponi®
golimumab

Simponi 50mg Solution for Injection in pre-filled pen Simponi 50mg Solution for Injection in pre-filled syringe (golimumab) *Prescribing Information. Refer to full SPC now before prescribing. Simponi (golimumab)* **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 antirheumatic 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 treatment of severe, active AS in adults who have responded inadequately to conventional therapy. *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. **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 or UC. After proper training in subcutaneous injection techniques, patients may self-inject, if the 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:* Simponi 50 mg given once a month, on the same date each month. Clinical response is usually achieved within 12-14 weeks of treatment (3 or 4 doses). Continued therapy should be reconsidered in patients who show no evidence of therapeutic benefit within this time period. In patients weighing more than 100 kg who do not achieve an adequate clinical response after 3 or 4 doses, increasing the dose of golimumab to 100 mg once a month may be considered, taking into account the increased risk of certain serious adverse reactions with the 100 mg dose compared with the 50 mg dose. *UC: Patients weighing < 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 50 mg every 4 weeks. *Patients weighing ≥ 80 kg:* Simponi given as an initial dose of 200 mg, followed by 100 mg at week 2, then 100 mg every 4 weeks. During maintenance treatment, corticosteroids may be tapered, following clinical practice guidelines. Clinical response is usually achieved within 12-14 weeks of treatment (after 4 doses). *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) and patients with renal and hepatic impairment:* Simponi is not recommended in these populations. **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 histoplasmosis, have been reported. 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. At each term should be recorded on the Patient Alert Card provided with the product. If active TB is diagnosed, treatment with Simponi should not be initiated. If latent TB is diagnosed, treatment with anti-TB therapy must be initiated before initiation of Simponi. Patients on Simponi should be monitored closely for signs and symptoms of active TB and advised to seek medical advice if signs and/or symptoms of TB appear. *Hepatitis B (HBV) reactivation:* Reactivation of HBV occurred in patients receiving Simponi who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Simponi. *Malignancies and lymphoproliferative disorders:* Caution is advised when considering Simponi treatment in patients with history of malignancy or continuing treatment in patients who develop a malignancy; additional caution should be exercised in patients with increased risk for malignancy due to heavy smoking. A risk for the development of malignancies in children and adolescents cannot be excluded. Rare cases, usually fatal, of hepatosplenic T-cell lymphoma (HSTCL) have been reported, the majority of cases occurred in adolescent and young males nearly all on concomitant treatment with azathioprine (AZA) or 6-mercaptopurine (6-MP). The potential risk with the combination of AZA or 6-MP and Simponi should be carefully considered. A risk for the development of HSTCL in patients treated with TNF-blockers cannot be excluded. *Colon dysplasia/cancer in colitis:* Screening 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. Malignancies: all TNF-blocking agents including Simponi and Merkel cell carcinoma (either TNF-blocking agents) have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancers. *Heart failure:* Simponi should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in the event of worsening symptoms of heart failure. *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 those disorders develop. Carefully consider the benefits and risks before initiation of therapy in patients with a history of demyelinating disorders. *Surgery:* Patients requiring surgery while 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, leucopenia, neutropenia, aplastic anaemia and thrombocytopenia in patients receiving TNF-blockers. Cytopenias including pancytopenia have been reported infrequently in clinical trials. Patients should be advised to seek medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Discontinuation should be considered in patients with significant haematologic abnormalities. *Vaccinations/Therapeutic infectious agents:* It is recommended that live vaccines or any therapeutic infectious agents should not be given concomitantly. *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:* 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. 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, viral infections, bronchitis, sinusitis, superficial fungal infections, anaemia, allergic reactions, seroconversion positive, dizziness, headache, hypertension, dyspepsia, gastrointestinal and abdominal pain, nausea, alanine aminotransferase increased, aspartate aminotransferase increased, pruritus, rash, pyrexia, cellulitis and injection site reaction, venous neoplasm. Serious, including fatal adverse events have been reported including septic shock, lymphoma, leukaemia, melanoma, Merkel cell carcinoma[1], hepatosplenic T-cell lymphoma[1], leucopenia, thrombocytopenia, pancytopenia, aplastic anaemia, serious systemic hypersensitivity reactions (including anaphylactic reaction), skin exfoliation, sarcoidosis, systemic, cutaneous, demyelinating disorders, congestive heart failure, arrhythmia, ischaemic coronary artery disease, thromboses, interstitial lung disease and lupus-like syndrome. [1]Observed with other TNF-blocking agents, but not observed in clinical studies with golimumab. **Package quantities:** 1.00 mg pre-filled pen containing 50 mg of golimumab in 0.5 ml solution for injection or 1.00 mg pre-filled syringe containing 50 mg of golimumab in 0.5 ml solution for injection or 1.000 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/1/09/560/001; 50 mg Pre-Filled Syringe EU/1/09/560/002; 100 mg Pre-Filled Pen EU/1/09/560/003. **Marketing Authorisation Holder:** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands. © Merck Sharp & Dohme Ireland (Human Health) Limited, 2013. All rights reserved. **Date of Revision of Text:** October 2013. Further information is available on request from MSD Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. **Date of preparation:** March 2014.

References: 1. EU Summary of Product Characteristics for SIMPONI 01/2014. 2. Sandborn WJ, Feagan BG, Marano C, et al. Subcutaneous Golimumab Maintains Clinical Response in Patients with Moderate-To-Severe Ulcerative Colitis. Gastroenterology 2014;146:85-95.

MSD Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland.

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ISG Summer Meeting
Killashee Hotel, Naas, Co.Kildare
Programme

Thursday 4th June

08.30 **Free papers (1 – 6)**

09.20 **Lecture 1 Therapeutic Endoscopy**
Prof Pradeep Bhandari,
Consultant Gastroenterologist Spire Portsmouth Hospital UK
"The role of ESD in upper GI Neoplasia"

Dr Bjorn Rembacken
Consultant Gastroenterologist and Endoscopist.
The General Infirmary, Leeds, UK
"Pitfalls in Polypectomy"

Prof Martin Lombard
Consultant Gastroenterologist & Hepatologist
Royal Liverpool University Hospital, U.K.
"ERCP – not just a numbers game"

10.45 **Coffee Poster viewing and meet the Industry**

11.15 **Lecture 2 Liver Disease**
Prof Kevin Mullen
Prof of Medicine, Director of Hepatology
Case Western Reserve Univ. School of Medicine
"Hepatic Encephalopathy"

Prof Keith Lindor, Prof of Medicine. Mayo Clinic Foundation Rochestor, MN
"An Update in managing Cholestatic Liver Disease"

12.15 **Lecture 3 Keynote Speaker Pancreatic Cancer**
Prof Michael Goggins,
Professor of Pathology, Medicine, and Oncology
The John Hopkins University School of Medicine
"Improving the early detection & treatment of Pancreatic cancer"

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

14.00 **Lecture 4 - Keynote Speaker**
Sponsored by Takeda Ltd
Prof Geert D'Haens, Professor of Gastroenterology, Academic Medical Centre, Amsterdam, The Netherlands
"Progress in IBD care – from immunosuppression to targeted therapy".

15.00 **Free papers (7- 12)**

16.00 **Coffee Poster viewing and meet the Industry**

16.15 to 17.30 **Lecture 5 - Oesophageal Disease**
Prof Peter Kahrilas, Prof. in Medicine. Nth Western University. Feinberg School of Medicine, USA
"The many faces of GERD:Who Responds to (GERD) Therapy"

Prof Paul Ridgway,
Consultant Surgeon Tallaght Hospital Dublin
"Laparascopic AntiReflux Surgery: when not to operate"

Prof Peter Kahrilas
"Achalasia; State of the Art in diagnosis & Therapy"

17.30 **ISG AGM**

19.30 **Reception, Dinner and Prize-giving**

Friday 5th June

09.00 **Launch of New Liver App**
Dr Diarmuid Houlihan
Consultant Hepatologist SVUH
"An App for Liver Disease"

09.30 **Lecture 6 - Upper GI**
The Changing Face of Upper GI Disease

Prof Brendan Drumm, Prof of Paediatrics, UCD
"The Epidemiology of an unplanned Triumph- Learning from our mistakes"

Prof Tony Axon, Consultant Gastroenterologist Univserity of Leeds. UK.
"Thirty years of Helicobacter"

Prof KL Goh, Consultant Gastroenterologist Senior Consultant at the University of Malaya
"Asia at the Crossroads - An east /west comparison of the Epidemiology of Gastrointestinal disease"

11.00 **Coffee & Meet the Industry**

11.30 **Lecture 7 - State of the Art**
IBD Symposium
Sponsored by Abbvie Ltd
Prof Edouard Louis, Prof of Gastroenterology Liege University Belgium.
"Best care in Chronic Refactory"

Dr Christian Selinger
Consultant Gastroenterologist
Nuffield Hospital Leeds, UK
"Quality improvement in IBD care - the role of a steroid assessment tool"

Prof Fernando Magro,
Consultant Gastroenterologist
Dept. of Gastroenterology,
Centro Hospitalar, Porto, Portugal
"Biosimilars in IBD enough evidence Or we need more"

Prof Arnold Vulto, Professor of Hospital Pharmacy and Practical Therapeutics
Erasmus University Medical Center, Netherlands
"Trust in Biosimilars needs full Understanding of the new Drug Paradigm"

Prof Axel Dignass,
Specialist in Internal Medicine
Markus Hospital, Frankfurt, Germany
"Management of IBD in Pregnancy and Lactation"

14.00 **Close of Meeting**

Introducing Entyvio: the first and only gut-selective biologic for patients with moderately to severely active ulcerative colitis (UC) or Crohn's disease (CD)

TREAT WITH PRECISION

The first and only gut-selective biologic[1]

- Achieved remission at Week 52 in:
  - 42% of UC patients vs 16% for placebo in patients responding at Week 6 ($P<0.001$)
  - 39% of CD patients vs 22% for placebo in patients responding at Week 6 ($P<0.001$)
- Targeted mechanism of action[1] different from anti-TNFα therapies
- One dose for all patients[1]: 300-mg IV infusion

References: 1. Entyvio Summary of Product Characteristics. Takeda Pharmaceuticals Ireland Ltd. www.medicines.ie accessed September 2014

ITEM CODE: IRE/VEDV14/0008e
DATE OF PREPARATION: APRIL 2015

Entyvio®
vedolizumab

Takeda

GUT-SELECTIVE BIOLOGIC

ABBREVIATED PRESCRIBING INFORMATION

INDICATIONS

Ulcerative Colitis

Entyvio is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis 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.

Crohn's Disease

Entyvio is indicated for the treatment of adult patients with moderately to severely active Crohn's disease 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.

IMPORTANT SAFETY INFORMATION

Contraindications

- Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, opportunistic infections, abscess and opportunistic infections such as Progressive Multifocal Leukoencephalopathy (PML).

Infusion-related Reactions and Hypersensitivity Reactions

- Hypersensitivity reactions have been reported, the majority were of mild to moderate severity.
- Discontinue treatment if anaphylactic or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IRR, slower infusion rate.
- 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.

Prior and Concomitant Drug Exposure

- 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 Not Vaccines

- Patients may continue to receive non-live vaccines.
- Patients recommended to be up-to-date with all appropriate immunizations prior to initiating therapy.
- Live vaccines may be administered concurrently only if benefit clearly outweighs risk.

Adverse Reactions

- 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 on 1800 927 370.

Irish Society of Endoscopy Nurses

Killashee Hotel, Naas, Co.Kildare

Time	Chair	Speaker	Topic
08.30-09:10		Registration	
09:15-09:30	Louise McCarville	Mary Hackett Brennan. ISEN Chairperson	Welcome to 30 Years of ISEN.
09:30-10:00	Mary Hackett Brennan	Sheila O'Connor Former Committee Member	Reeling Back Through the Years in Endoscopy.
10:00-10:25	Mary Hackett Brennan	Professor. Courtney Consultant Gastroenterologist Kilkenny	Why Endoscopy, 30 Years Later?
10:25-10:30	Louise McCarville	Mary Hackett Brennan ISEN Chairperson	Introduction of Former Committee Members.
10:20-11:10	**COFFEE**		
11:10-11:25	Mary Shea	Sara O'Neill IT Consultant	Launch of New ISEN Website.
11:25-12:50	Elaine Egan	Debbie Johnson Lead Advisor, JAG Ireland	Credit Where Accreditation is Due.
12:50-13:00	Mary Shea	Leah Palado	ESGENA in Vienna
13:00-14:00	**LUNCH**		
14:00-14:30	Margaret O'Donnell	Suzanne Phelan Pharmacist South Tipp General	New Oral Anti-Coagulant and Anti-Platelet Agents.
14:30-15:00	Leah Palado	Professor. Patchett. Consultant Gastroenterologist Beaumont Hospital	NQAIS.
15:10-15:40	Margaret O'Donnell	Dr. Brian Canavan Respiratory Consultant St. Luke's Kilkenny	Taking A Deep Breath Bronchoscopies.
15:40-16:00	Leah Palado	Deirdre Clune	Education Update, Questions & Answers & Raffle.

Irish Society of Endoscopy Nurses

30th Anniversary 1985 - 2015

Dear Friends and Colleagues

Back Row Left to right Fiona Kennedy , Grace Mc Evoy Peggy White
Front Row Left to right Ann Dixon Oonagh Ryan Mary Murnane.

It is a great honour to be Chairperson of the Irish Society of Endoscopy Nurses as it celebrates its 30 year anniversary. The ISEN was founded in 1985 by a small group of dedicated nurses working in endoscopy. The first meeting was held in University College Cork on Friday 6th June 1986. It was attended by 38 members. Today I am delighted to welcome back some members of that original committee as well as our colleague Professor Gary Courtney who addressed that first meeting 30 years ago and will do so again today.

The past 30 years have witnessed great changes in the world of endoscopy. There are ever changing techniques and developments in this field, requiring specialised and highly skilled nurses. There are National guidelines and European directives that form the basis of policies and standards that are applicable to endoscopy nursing. The summer and winter ISEN meetings provide the opportunity to highlight these new standards and guidelines, assisting our members in understanding how it will affect their practises,

We have seen the introduction of the Irish GRS and our members supported this web based assessment tool, working towards a standard for accreditation and a quality framework for service improvement. Later today we welcome Ms Debbie Johnson who will focus on the accreditation of endoscopy units.

Professor Steve Patchett will share with us an understanding of the National Quality Assurance Programme and its benefits for endoscopy. The roll out of the National Colorectal Cancer Screening Programme supported the training of Advanced Nurse Practitioners in Gastroenterology. The first twelve ANP's have recently completed their training. It is an exciting time to be working in this area of nursing with many career opportunities available

The ISEN continues to provide information supported by best available evidence to add to the existing knowledge already acquired by our members, enabling them to provide quality care to patients undergoing endoscopy procedures.

I would like to put on record the good relationship that exists with our colleagues in the ISG and acknowledge their continued support to the ISEN. Mr Michael Dineen CEO continues to generously assist and support us.

The ISEN meetings provide a relaxed forum for discussion of emerging and developing products and techniques with representatives and specialists. I wish to acknowledge the continual presence and support that is afforded to our members from all our friends and representatives from industry.

Finally I would like to thank you, our members for your continued support and attendance at our meetings. We now have a membership of approximately 120. During the years many friendships have been forged through the Irish Society of Endoscopy Nurses and we look forward to this continuing and to whatever the next 30 years hold.

Mary Hackett Brennan
Chairperson ISEN

Biographical Sketches

Prof. Humphrey O'Connor
President ISG
Consultant Gastroenterologist

A native of Cahersiveen, Co. Kerry, Prof. Humphrey O'Connor M.D., F.R.C.P.I., A.G.A.F., graduated with honours in 1977 from University College Dublin. The Gastroenterology "bug" was acquired during general medical training working for the late great Prof. Oliver Fitzgerald and the recently arrived Dr. Diarmuid O'Donoghue. Specialist training followed in the UK, firstly, in Leeds with Prof. Tony Axon and then Birmingham with Dr. Roy Cockel and Prof. Elwyn Elias. Prof. O'Connor was awarded the BSG Hopkins Endoscopy Prize in 1982. He returned to Ireland in 1989 as Consultant Physician at Tullamore General Hospital and was appointed in 2002 to Naas General Hospital, Tallaght Hospital and Clinical Professor of Gastroenterology, Trinity College Dublin. He has lectured and published widely on Helicobacter, GORD, ERCP, and pancreaticobiliary disease and retains a special interest in undergraduate clinical teaching. Away from medicine, he is a fanatical Kerry follower and plays very amateur golf.

Dr Subhasish Sengupta
Secretary ISG, Consultant Gastroenterologist
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 Barbara Ryan
MD,MSc,FRCPI Gastroenterologist,
Tallaght Hospital, Dublin

Barbara Ryan graduated from Trinity College Dublin in 1993. She completed her higher specialist training in Ireland during which time she completed a MSc in Molecular Medicine and also a MD in colorectal cancer biology. She did a fellowship in endoscopic ultrasound at the Klinikum Rechts der Isar, at the Techincal University of Munich and then moved to a gastroenterology fellowship the University Hospital of Maastricht in the Netherlands for two years in 2001. In 2003 she took up a consultant post in Manchester Royal Infirmary before returning to Ireland in 2004 to her current post. Her research interests include colorectal cancer, IBD and IBD-related bone disease. Her clinical interests include IBD, interventional endoscopy, pancreatobiliary endoscopy and endoscopic ultrasound.

Dr 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.

Dr Gavin Harewood
Consultant Gastroenterologist
Beaumont Hospital, Dublin

Dr Gavin Harewood is a medical graduate of National University of Ireland, Galway. Following completion of his general medical training, he moved to Rochester Minnesota where he completed a Fellowship in Gastroenterology and Hepatology along with a Masters Degree in Clinical Research in the Mayo Clinic.

He was subsequently appointed as a Consultant Gastroenterologist in the Mayo Clinic and developed a subspecialty interest in endoscopic ultrasound, health economics and clinical outcomes research. In 2006, he was appointed to his current Consultant post in Beaumont Hospital where he leads endoscopic ultrasound activities and serves as the lead Clinical Trainer in the Endoscopy Department. He also served as the Secretary for the Irish Society of Gastroenterology until 2014. In 2009, Dr Harewood completed a MBA Degree in Health Economics through the UCD Smurfit School of Business. He has authored more than 100 publications in the peer-reviewed medical literature, many dealing with the importance of resource utilisation and economics in healthcare.

Dr Johnny Cash
Consultant Hepatologist
Royal Victoria Hospital, Belfast

Dr Johnny Cash is a consultant Gastroenterologist and Hepatologist in the Royal Victoria Hospital, Belfast. His main clinical interests are liver transplantation and the complications of cirrhosis, particularly portal hypertension. He also has an interest in healthcare modernisation and has recently been appointed assistant medical director for continuous improvement in the Belfast Health and Social Care Trust. He has been the co-lead for medicine and clinical lead of the programmed treatment unit in the Royal Victoria hospital since 2011. He has been on the board of the Irish society of Gastroenterology since election in 2011 and is chair of the DHSSPS Drug Treatment & support advisory committee. In his spare time he is a keen fell runner.

Dr Karen Hartery
Gastroenterology SpR
Beaumont Hospital Dublin

Karen is a graduate of University College Cork. She is currently working as a Gastroenterology SpR in Beaumont Hospital Dublin and also currently represents the SpR grouping on the board of ISG.

Prof. Padraic MacMathuna
Consultant Gastroenterologist
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 Tony C.K. Tham
MB BCh BAO, MD, FRCP, FRCPI

Dr Tham qualified from the Queen's University of Belfast's medical school. He trained as a gastroenterologist and physician in the Northern Ireland training program. He completed his training as an Advanced Gastroenterology Fellow in the Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA.

He has been Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast since 1997. During this time, he has developed gastroenterology services in the Ulster Hospital, especially in therapeutic endoscopy and ERCP. His other interests include inflammatory bowel disease (IBD). He has more than 60 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies". He is currently co-writing the third edition.

He has contributed to several other book chapters. He is the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency. He sits on the Specialist Advisory Committee for general internal medicine at the Joint Royal College of Physicians Training Board. He is also on the British Society of Gastroenterology committee on clinical standards. He is an assessor for doctors applying for entry into the specialist register. He is an examiner for the Royal College of Physicians and also Queen's University. He has assisted in obtaining funding for IBD nurses and biological therapy in N. Ireland.

Speakers

Prof Geert D'Haens
Professor of Gastroenterology,
Academic Medical Centre, Amsterdam

Geert D'Haens was appointed as head of the AMC-IBD Unit in December, 2010 and Professor of Inflammatory Bowel Diseases at the University of Amsterdam. He is gastroenterologist trained at the university of Leuven and the University of Chicago, USA.

Geert D'Haens specialized in inflammatory bowel disease already early in his career and presented his doctoral thesis in 1996 on 'early postoperative recurrence of Crohn's disease'. From 1999 until to date Geert D'Haens created and led the Imelda GI Clinical Research Centre at the Imelda general hospital in Bonheiden, Belgium, where many new medications for inflammatory bowel disease and colorectal cancer have been investigated. D'Haens was the president of the Flemish Society of Gastroenterology from 2007 to 2011 and co-founder of the European Crohn's and Colitis Organization ECCO. Currently, he is scientific secretary of the International Organization for Inflammatory Bowel disease IOIBD and director of Robarts Europe, an academic clinical research organization with headquarters in Canada devoted to the study of IBD.

Prof Peter Kahrilas
Prof. in Medicine. Nth Western University. Feinberg School of Medicine, USA

Dr Peter J Kahrilas is the Gilbert H. Marquardt Professor in Medicine at the Feinberg School of Medicine at Northwestern University in Chicago. He joined the Northwestern faculty in 1986 and served as Division Chief for 7 years until 2006. Dr Kahrilas' research is on esophageal and oropharyngeal physiology and pathophysiology, topics on which he has published more than 300 original papers. Dr Kahrilas also does extensive peer-review service and is currently an associate editor of the American Journal of Gastroenterology. He was elected to the American Society for Clinical Investigation (ASCI) in 1998 and the Association of American Physicians (AAP) in 2015.

Prof Martin Lombard
Consultant Gastroenterologist & Hepatologist
Royal Liverpool University Hospital, U.K.

Medicine and Gastroenterology in Dublin and studied Hepatology at Kings College Hospital & the Institute of Liver Studies in London. He is currently a Consultant Hepatologist and Gastroenterologist at the Royal Liverpool University Hospital holding an Honorary Chair at the University of Liverpool. He has an extensive publication record in Liver and HPB disorders and has been a Clinical Director at both of the acute Trusts in Liverpool and Chaired the National Training Board for Gastroenterology previously. He conducted a national audit of ERCP in England during the last decade, the results of which have been used to benchmark standards of service and training.

As the first National Clinical Director for Liver Disease at the Department of Health (2010-13), he co-produced the Atlas of Variation of Liver Disease with NHS Rightcare, the NCEPOD report on alcohol related deaths, the Nurse Competency Framework for Specialist Nurses with RCN, and contributed to

numerous annual reports with the HPA and the CMO and was a contributor to the Lancet Commission on Liver Disease.

As at 2014 in addition to his clinical practice, he is Chair of the Cheshire & Merseyside Clinical Senate, a member of the National Clinical Reference Group (HPB) for NHS England and as President-elect of the British Society of Gastroenterology he Chairs the Joint Specialty Committee the Royal College of Physicians.

Prof Keith Lindor,
Prof of Medicine
Mayo Clinic

Dr. Keith Lindor is executive vice provost and dean of the College of Health Solutions at Arizona State University (ASU). He is working collaboratively with university and industry partners to create and deliver academic offerings that will better prepare the next generation of health professionals to lead change in the context of a quickly evolving health care system.

Dr. Lindor joined ASU in January 2012. Before coming to ASU, he served as dean of the Mayo Medical School and was a professor of medicine and chair in the Division of Gastroenterology and Hepatology. He also served as editor-in-chief of Hepatology and will be the president of the American Association for the Study of Liver Diseases organization in 2016.

Dr. Lindor's clinical interests include: cholestatic liver diseases in adults, particularly primary biliary cirrhosis and primary sclerosing cholangitis as well as nonalcoholic steatohepatitis.

He received a bachelor's of chemistry degree from the University of Minnesota and medical degree from Mayo Medical School. He completed his residency in internal medicine at Bowman Grey School of Medicine at Wake Forest University and his gastroenterology fellowship at the Mayo Clinic.

Prof Kevin Mullen
Prof. of Medicine, Director of Hepatology
Case Western Reserve Univ. School of Medicine

After a mixed Internships In the Mater Hospital in Dublin and a straight Internal Medicine Residency year in Dalhousie University in Halifax, Nova Scotia he completed his Internal Medicine Residency in McMaster University In Hamilton, Ontario in Canada. After moving to the USA he completed Gastroenterology and Liver fellowships in Case Western Reserve University (CWRU)and the National Institutes of Health respectively. . After returning to CWRU Dr Mullen joined the staff of Metrohealth Medical Center in Cleveland and rose through the ranks to become a full professor of Medicine. A very active teacher and clinician Dr Mullen has also continued his research on Hepatic Encephalopathy . His interest in Hepatology largely came from his working alongside Anthony Tavill and Arthur McCullough both of whom became Presidents of the AASLD. The late E Anthony Jones in the NIH led him into the field of hepatic Encephalopathy and Jay Hoofnagle also from the NIH introduced him to the treatment of viral hepatitis.

Prof KL Goh
Consultant Gastroenterologist
Senior Consultant at the University of Malaya

KL Goh is Professor of Medicine at the University of Malaya, Kuala Lumpur where he is Head of Gastroenterology and Hepatology and Chief of the Combined GI Endoscopy Unit at the University of Malaya Medical Center. He has published widely in international journals particularly in the areas of Helicobacter pylori, gastroesophageal reflux and GI and Liver cancers and with a focus on epidemiology of these diseases in the Asian Pacific region. He is editor emeritus of the Journal of Gastroenterology and Hepatology and Chairman of the Journal of Gastroenterology and Hepatology Trust Foundation. He is an associate editor of the Journal of Digestive Diseases and sits in the editorial boards of 7 journals.

He has been an invited speaker in numerous international meetings as well as a faculty in live therapeutic endoscopy workshops in the Asian Pacific region as well as in North America and Europe. He organizes an annual international therapeutic endoscopy workshop at his unit dating back from 1993, which has attracted worldwide recognition and his unit has been recognized by the World Endoscopy Organization as a "Center of Excellence" from 2008-2014 and now renewed from 2015-2020. He was the President and Organizing Chairman of the highly successful APDW 2010 held in Kuala Lumpur in September 2010.

Currently he is President of the Asian Pacific Digestive Week Federation and was President of the Asian Pacific Association of Gastroenterology (from 2010-2014) and Vice-President of the World Gastroenterology Organization from 2011. He was a governing council member of the World Digestive Endoscopy Organization (OMED) from 2002-2005. Professor Goh is a Past-President of the Malaysian Society of Gastroenterology and Hepatology in 1996/7. He was awarded the highly prestigious national "Merdeka Award" for Outstanding Scholastic Achievement for "Elevating the Study and Practice of Gastroenterology and Hepatology in Malaysia to Global Standards" from the Prime Minister of Malaysia in 2011. At the DDW, in 2014, Professor received the American Society of Gastrointestinal Endoscopy (ASGE) Crystal Award for International Service.

Prof Fernando Magro
Cons Gastroenterologist
Dept. of Gastroenterology,
Centro Hospitalar, Portugal

Associate Professor in Pharmacology and Therapeutics, Faculty of medicine, Porto Department of Pharmacology and Therapeutics. Consultant in Gastroenterology, Hospital de São João, Porto, Portugal.

Graduation and Post-Graduation:
Doctor of Medicine: Graduation Date (MD): 1989; University of Porto, Portugal. PhD in translation Pharmacology (2007): "Monoaminergic System in IBD and in a transmural model of colitis" Assistant professor of Pharmacology and Therapeutics (2007-2012)

Interest focus on inflammatory bowel disease and epithelial inflammation since 1995. He has been studying the cross-talk between epithelial transporters and inflammation and developed various clinical studies in ulcerative colitis and

Crohn's disease. Was founder of Portuguese IBD group. Member of GuiCom in ECCO 2010-13 and ClinCom since 2014. He was organizer of three European ECCO Consensus: European Consensus on the histopathology of inflammatory bowel disease, Oportunistic infections in IBD and Reproduction and Pregnancy Consensus.

Author or co-author of various peer-reviewed articles in basic and clinical science, books, and book chapters. He is member of JCC Board and serves as a reviewer for several specialist journals, including JCC, Gut, IBD, Alimentary Pharmacology and Therapeutics and American Journal of Gastroenterology.

Prof Michael Goggins
Professor of Pathology,
Medicine, and Oncology
The John Hopkins University
School of Medicine

Dr. Goggins is a Professor of Pathology, Medicine and Oncology at The Johns Hopkins University School of Medicine. He was born in New York City and moved to the West of Ireland as a teenager. He received his Bachelor's degree and medical degree from Trinity College Dublin in 1988 and completed his internship and internal medicine training (1988-91) and gastroenterology and internal medicine fellowship training (1991-5) in St. James Hospital, Dublin. He was a lecturer in Clinical Medicine at Trinity from 1992-5. He then completed a research fellowship in Pathology and a clinical fellowship in gastroenterology at Johns Hopkins University and joined the faculty in 1999. He was promoted to Professor of Pathology, Medicine and Oncology in 2008. He has directed the Pancreatic Cancer Early Detection Research Laboratory since 1999. He is also an Attending Physician at Johns Hopkins Hospital in the Department of Medicine, the Division of Gastroenterology/Hepatology and member of the Division of Gastrointestinal Pathology and the Oncology Cancer.

Dr. Goggins has written or co-authored more than 250 peer-reviewed publications. He was recognized a few years ago by Essential Science Indicators as the 6th-most highly cited pancreatic cancer scientist over the previous decade. He is a member of the Scientific Advisory Board of the Sol Goldman Pancreatic Cancer Research Center at Johns Hopkins University. He has served on numerous national advisory committees on pancreatic cancer. He has been a National Institute of Health grant reviewer for over 10 years and serves on the NCI Cancer Oncology Trials and Specialized Programs in Research Excellence (SPORE) study sections.

He is a member of the Hopkins GISPORE team, and the PACGENE and Panc4 consortia. As a member of the pancreatic cancer research team at Johns Hopkins University, he was awarded the 2012 AACR Team Science award. He is PI of PanCan/AACR Research Acceleration Award to fund a multicenter study (Cancer of the Pancreas Screening (CAPS).
His early detection research focuses on evaluating the potential clinical utility of measuring markers of early pancreatic cancer in pancreatic fluids and blood. The ongoing CAPS5 study is measuring mutations in the pancreatic fluid of patients undergoing pancreatic screening using next-generation sequencing. He is also evaluating novel markers including microRNAs and proteins identified using sequencing-based approaches.

Prof Pradeep Bhandari
Consultant Gastroenterologist Spire
Portsmouth Hospital UK

Pradeep Bhandari is a Gastroenterologist who leads the early gastrointestinal cancer services at Portsmouth. In 2004, he went to National cancer center in Tokyo on a visiting fellowship and trained in the principles of early cancer diagnosis and endoscopic resection of superficial neoplasia.
He was appointed as a Consultant Gastroenterologist in Portsmouth in 2005. He developed an early cancer service providing advanced endoscopic diagnosis and resection for upper and lower gastrointestinal neoplasia. This service provides the basis of various research projects and advanced training program apart from providing a tertiary referral service for UK.

Dr Bhandari was appointed as a Professor of Gastrointestinal Endoscopy in 2012 and heads the Gastroenterology research at Solent centre for digestive diseases in Portsmouth. His research focus has been around the use of acetic acid in diagnosis of Barrett's neoplasia, cost-effectiveness of endoscopic interventions, advanced endoscopic resections and endoscopic outcome predictors.
He was awarded the Hopkins Endoscopy prize by the British Society of Gastroenterology in 2013 and has twice received the ASGE crystal award for his endoscopic work. He sits on to the BSG Endoscopy and research Committee and is a specialist advisor to NICE. He is a member of BSG, ESGE and ASGE.

Dr Bhandari has authored and Co-authored several peer reviewed publications, Guidelines, Cochrane reviews and Book chapters. He has lectured at various National and International meetings. He enjoys watching football and playing Cricket and racquet sports.

Dr Bjorn Rembacken
Consultant Gastroenterologist
and Endoscopist.
The General Infirmary, Leeds, UK

Bjorn Rembacken was born in Sweden and qualified from Leicester University in 1987. He undertook his postgraduate education in Leicester and in Leeds. His MD was dedicated to inflammatory bowel disease. Dr Rembacken was appointed Consultant Gastroenterologist, Honorary Lecturer at Leeds University and Training Lead for Endoscopy in Leeds in 2005. Although his MD was entitled "The role of Escherichia coli in inflammatory bowel disease", his heart was always in endoscopy!

Dr Rembacken has a particular interest in therapeutic endoscopy including EMR and ESD techniques.

Positions
BSG Endoscopy committee
BSG Research committee
BSG Information committee
European Society of Gastrointestinal Endoscopy board
World Association of Digestive Endoscopy (OMED) - MST working group lead
UEG eLearning editor

Prof Tony Axon
Consultant Gastroenterologist
Univserity of Leeds. UK.

Tony was born in Tintagel, Cornwall, educated in Yorkshire and graduated in medicine from Barts in London 1965. After time spent in Pathology he moved to St Thomas's and in 1975 took up a consultant post as General physician and Gastroenterologist at the General Infirmary at Leeds.

Expected to teach and undertake research in addition to clinical responsibilities, he focussed on intestinal permeability, safety and quality in Endoscopy, Inflammatory bowel disease, Helicobacter and gastric cancer authoring over four hundred and seventy papers. He was elected to the RCP Council in 1992 but decided to focus on Gastroenterology having been Chairman of the BSG Endoscopy Committee in 1989. He became BSG President in 2000, President of the European Society of Gastrointestinal Endoscopy 2000, President of the United European Gastroenterology Federation 2005, and President of the World Endoscopy Organisation in 2005. He was awarded an honorary chair in Gastroenterology by the University of Leeds in 1995 He has travelled extensively delivering over three hundred invited lectures in sixty countries.

He is married to Jill and has three children and ten grandchildren, ages ranging from four to eighteen. He lives in Nidd, North Yorkshire, near Harrogate. Since retirement from the NHS he, together with his family, invented and marketed the Endocuff™, an attachment that fits on the tip of the colonoscope. It retracts colonic folds, stabilises the colonoscope tip, speeds up intubation and increases adenoma detection.

Prof Paul Ridgway
Consultant Surgeon
Tallaght Hospital Dublin

Consultant UGI/HPB Surgeon Tallaght Hospital, Associate Professor of Surgery Trinity College Dublin, Vice Chairman NASCE, a MJC of the UEMS, Past Council Member Society of Academic and Research Surgery (SARS), Past council member ASiT.

Dr Christian Selinger
Consultant Gastroenterologist
Nuffield Hospital Leeds. UK

Dr Christian Selinger works as a Consultant Gastroenterologist with a special interest in inflammatory bowel disease in Leeds. He completed gastroenterology training in Manchester and advanced training in inflammatory bowel disease in Sydney, Australia. He was awarded an MD from the University of Manchester for his research on IBD in 2013 and an MSc with distinction in Gastroenterology from the University of Salford in 2011. His research expertise lies within gastroenterology, especially inflammatory bowel disease and endoscopy.

Prof Brendan Drumm
Prof of Paediatrics, UCD

Brendan Drumm undertook his undergraduate medical studies at The National University of Ireland Galway. His postgraduate training in Paediatrics took place at the Hospital for Sick Children in Toronto where he was subsequently a Paediatric Gastroenterologist and Assistant Professor at the University of Toronto. In 1990 he was appointed Head of the Department of Paediatrics at University College Dublin. He is a Fellow of the Royal Colleges of Physicians in Canada, Ireland and the UK, and of the American Gastroenterology Association. His research was supported over a 20 year period by grants from the Wellcome Trust in the UK, the European Union, the American Gastroenterology Association and has been published on many occasions in journals such as the New England Journal of Medicine, The Lancet, Gastroenterology and the Proceedings of the National Academy of Sciences.

In 2005 he was appointed as the first Chief Executive Officer of the Health Service Executive, a company established by the Irish Government to manage the delivery of all health and personal social services in Ireland. As CEO, he initiated the largest public service transformation programme ever undertaken in Ireland. Appointing clinicians as leaders of change was a central component of the programme. Between 2005 and 2009 Ireland progressed from being ranked second from last by The European Health Consumer Index to 13th of the 33 countries included in the index.

In 2010 having completed his term of office at the HSE Brendan Drumm returned to his academic position at University College Dublin where his work focuses on two related areas, promoting caring as the most important component of clinical practice and the need for clinicians to be the leaders of transformational change in healthcare delivery. He also works on developing innovative approaches to delivering health care in developing countries.

Prof Axel Dignass
Specialist in Internal Medicine
Frankfurt, Germany

Training: Since 12/2005 Head, Department of Medicine I and Professor of Medicine and Gastroenterology, Agaplesion Markus Hospital, Academic Teaching Hospital Goethe-University, Frankfurt/ Main
Special Scientific Interests: Inflammatory bowel diseases, Immunosuppressive and biologic therapy, Colonic Cancer, Small bowel transplantation, Molecular mechanisms of intestinal wound healing and cell migration, Anemia and iron deficiency, Guidelines and Medical Education
Membership in scientific organizations (selection)
International Organization for the Study of Inflammatory Bowel Diseases (IOIBD), German Society for Digestive Diseases and Metabolism, American Gastroenterological Association, German Society for Internal Medicine, German Society for inflammatory Bowel Diseases, German Cancer Society, European Crohn's and Colitis Organization, Kompetenznetz CED e.V., German IBD Study Group (GISG), United European Gastroenterology (UEG)
Reviewer for scientific journals and scientific societies (selection): Editorial Board Member Journal of Crohn's and Colitis und APT

Prof Edouard Louis
Prof of Gastroenterology
Liege University Belgium

Edouard Louis was born in Belgium, on April 1st 1965. He obtained the title of Medical Doctor with Magna cum laude in June 1990, at the state university of Liège, Belgium. Part of his training in Gastroenterology, was done at the Oxford University, UK (1994-1995). He graduated in June 1996 as a specialist in Gastroenterology. Edouard LOUIS obtained his Ph.D. in 1996, as a fellow of the National Funds for Scientific Research of Belgium (FNRS), with a work on gastrointestinal immunization with soluble antigens. He obtained his "aggregation" for University teaching in 1999 with a work on the characterisation and genetics of immuno-inflammatory reaction in Crohn's disease. Edouard LOUIS was promoted associate Professor of Gastroenterology at Liège University in October 2002 and Senior Research Associate at the National Funds for Scientific Research of Belgium (FNRS) in October 2005. He has been Professor of Gastroenterology and Head of the Gastroenterology department at Liège University hospital since October 2010. His Scientific work contributed to more than 220 papers in international journals, with an H-index of 48. He has been General Secretary of the Belgian Society of Gastroenterology 2005-2009, President of the Belgian IBD Research group (2008-2011), member of the Scientific Committee of the ECCO (European Crohn and Colitis Organisation) (2010-2013) and Chair of this Scientific Committee (2013-2015). He has bee member of the board of the GETAID (groupe d'étude thérapeutique des affections inflammatoires digestives) (2004-20012). He is presently president of the GETAID (2013-2016).

Prof Arnold Vulto
Professor of Hospital
Pharmacy and Practical Therapeutics
Erasmus University Medical Center,
Netherlands

Arnold G. Vulto (1952) obtained his pharmacy-degree from Groningen University (The Netherlands) in 1981, with undergraduate studies in Cambridge (UK). He was trained as a pharmacologist at the Rudolf Magnus Institute at the University of Utrecht and at the Karolinska Institute (Stockholm, Sweden). He specialised in hospital pharmacy at the University Hospital Maastricht and obtained his PhD from Utrecht University.

In 1988 he was appointed Head of the Hospital Pharmacy of the Veterinary Faculty, University of Utrecht and in 1995 as Deputy Head / Research director of the Hospital Pharmacy of the ErasumusMC in Rotterdam, where he became in 2004 professor of of Hospital Pharmacy / Practical Therapeutics.

Professor Vulto is the (co)author of more than 120 international peer reviewed papers and has been supervising 15 PhD-projects. He was member of the Board of Directors of the EAHP and was Chairman of its Scientific Committee. He was a member of the Steering Committee and chair of the Program Committee of the First Global Conference on the Future of Hospital Pharmacy (Basel). He received different awards: "Visionary guidance and leadership" in hospital pharmacy (EAHP) and the Jan Glerum Lifetime Achievement Award for his contribution to the training of hospital pharmacists. Professor Vulto was almost 10 years Editor in Chief of the European Journal of Hospital Pharmacy Practice.

Winter Meeting 2014

Dr Deirdre O'Donovan, Dr Mary Shuhaibar, Dr Anna Kelly

Winter Meeting 2014

Humphrey O'Connor presenting 2nd Oral prize to Aman Yadav (Drogheda)

Humphrey O'Connor presenting 3rd Oral prize to Grainne Holleran (AMNCH)

Humphrey O'Connor presenting 1st Oral prize to David Gibson (SVUH)

Mr Colm O'Boyle, Bariatric Surgeon, Bonsecours Hospital. Cork

Colm O'Boyle & Diarmuid Duggan

Alimentary Health Representatives

Prof Ted Dinan in Jovial mood

Prof Peter Whorwell Manchester

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President ISG
Consultant Gastroenterologist

Dr Subhasish Sengupta, Hon Secretary ISG
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Consultant Gastroenterologist

Dr Karen Hartery,
Specialist Registrar

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Consultant Gastroenterologist

Dr Johnny Cash,
Consultant Hepatologist

Dr Barbara Ryan,
Consultant Gastroenterologist

Dr Paul Lynch,
Consultant Gastroenterologist

Mr Fiachra Cooke,
General Surgeon

Dr Tony Tham,
Consultant Gastroenterologist

Professor Padraic MacMathuna
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Mespil House, Sussex Road. Dublin 4
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Professor Colm O'Morain

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2002-2005	Professor Colm O'Moráin
1999-2002	Dr John Collins
1997-1998	Dr Paud O'Regan
1995-1996	Dr Diarmuid O'Donoghue
1993-1994	Mr Gerry O'Sullivan (R.I.P.)
1991-1992	Dr Tom O'Gorman
1989-1990	Professor Tom PJ Hennessy
1987-1988	Dr Michael J Whelton
1985-1986	Professor TG Parks
1983-1984	Mr Joseph McMullin (R.I.P.)
1981-1982	Dr John Fielding (R.I.P.)
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1975-1976	Professor Donald Weir
1973-1974	Professor Ciaran McCarthy
1971-1972	Professor Patrick Collins (R.I.P.)
1969-1970	Professor Peter Gatenby
1967-1968	Dr Byran G Alton (R.I.P.)
1964-1966	Professor Patrick Fitzgerald (R.I.P.)
1962-1964	Professor Oliver Fitzgerald (R.I.P.)

Oral Presentations – Summer Meeting 2015

Ref	Author	Paper	Day & Time	Title of Paper
15S 152	Dr Susanne O'Reilly	1	8.30	Is Screening Really Screening? Colorectal Symptoms in Clients Attending for Colonoscopy in the National Colorectal Cancer Screening Prog
15S 137	Ms Sarah Whelan	2	8.38	Key components of the human hepatic tumour surveillance system (soluble CD1d and iNKT cells) are inversely related in colorectal metastases
15S 119	Dr. Brian Callaghan	3	8.46	Efficacy of hepatic transient elastography in screening for presence of oesophageal varices in patients with liver disease.
15S 130	Dr Elgaily Elrayah	4	8.52	Fibroscan can predict recurrence of the primary liver disease in the post liver transplant patients
15S 136	Mr. Cathal Harmon	5	9.00	Eomes-Natural Killer cells: Evidence of in situ development in the adult human liver.
15S 140	Dr Audrey Dillon	6	9.08	Liver stiffness predicts decompensation in a mixed aetiology cirrhotic population
15S 103	Dr Vikrant Parihar	7	15.00	A significant change towards top-down prescribing of iInfliximab in clinical practice
15S 106	Mrs Lucy Lafferty	8	15.08	A comparison of exclusive enteral nutrition (een) and corticosteroids (cs) in the induction of remission in paed. crohn's (cd)
15S 122	Ms Denise Brennan	9	15.16	A comparison of prevalence of Helicobacter pylori infection and rates of antibiotic resistance in patients undergoing gastroscopy versus urea breath test at Tallaght Hospital.
15S 123	Dr Edel McDermott	10	15.24	Methylomic profiling in Inflammatory Bowel Disease; New Insights into Disease Pathogenesis and Activity
15S 135	Dr Mary Hussey	11	15.32	Altered tissue glucocrticoid metabolism is associated with Inflammatory Bowel Disease
15S 107	Dr Zaid Heetun	12	15.40	Crohn's disease (CD) is associated with increased Foxp3+CD39+CD161+ cells and high levels of TNFα and IFNγ dual producing cells in lamina propria.

ABSTRACT 1 (15S152) ORAL PRESENTATION

Title of Paper: Is Screening Really Screening? Colorectal Symptoms in Clients Attending for Colonoscopy in the National Colorectal Cancer Screening Programme

Author(s): S O'Reilly, B Nolan, J Rea, M Buckley, H Mulcahy, G Doherty, G Cullen

Department(s)/Institution(s): Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin 4 School of Medicine and Medical Science, University College Dublin

Introduction: BowelScreen aims to screen individuals aged 60-69 in the general population for colorectal cancer (CRC). A number of clients attending for colonoscopy have reported colorectal symptoms suggesting that some may use the screening programme as a mechanism to seek medical attention.

Aims/Background: We aimed to identify symptomatic BowelScreen clients presenting for colonoscopy and compare the outcomes of their procedure to asymptomatic clients.

Method: A prospective, questionnaire-based study targeted at individuals attending for BowelScreen colonoscopy. The questionnaire included colorectal symptoms, previous colonoscopy, demographic information and knowledge of symptoms of CRC. Data were correlated with colonoscopy reports and histologic findings.

Results: 143 patients completed questionnaires. 61.5% of the cohort had adenomas at colonoscopy (29% with an adenoma >1cm). 4.9% had cancer. 38% reported colorectal symptoms in the preceding year. 64% of symptomatic patients had a previous colonoscopy compared to 49% of asymptomatic (p=0.55). Asymptomatic patients were more likely to have adenomas than symptomatic (69% vs. 49%, p=0.03), but there was a trend towards an increased CRC in symptomatic patients (9% vs. 2%, p=0.06). Symptomatic patients with no previous colonoscopy had a higher incidence of adenomas, large adenomas and cancer. Patients with symptoms and a previous colonoscopy were significantly more likely to have cancer (p=0.043)

Conclusions: Almost 40% of BowelScreen clients attending for colonoscopy are symptomatic and 64% of these clients have had a previous colonoscopy. Symptomatic patients without a history of previous colonoscopy are more likely to have pathology identified, but those who had symptoms and a previous scope were more likely to have a cancer.

ABSTRACT 2 (15S137) ORAL PRESENTATION

Title of Paper: Key components of the human hepatic tumour surveillance system (soluble CD1d and iNKT cells) are inversely related in colorectal metastases

Author(s): Whelan S[1], Fahey R[1], Lloyd A[1], Geoghegan J[2] O'Farrelly C[1]

Department(s)/Institution(s): 1. School of Biochemistry and Immunology, Trinity College Dublin, Ireland. 2. National Liver Transplant Unit, St Vincent's University Hospital, Dublin 4

Introduction: Invariant natural killer T (iNKT) lymphocytes are important anti-tumour cells characterised by an invariant T-cell receptor and found in relatively large proportions in healthy human liver. INKT cell numbers and activity are decreased in patients with hepatic malignancy. They are restricted by an MHC-like molecule CD1D but little is known about CD1D and iNKT cell numbers in liver metastasis.

Aims/Background: To examine CD1D and iNKT cells in donor and resected metastatic liver.

Method: We developed a qRT-PCR method for detecting the iNKT TCR gene rearrangement and correlated it with flow cytometry. Bioinformatic analysis identified CD1D splice variants; a soluble variant (sCD1D) was predicted. Western blotting was optimised to measure sCD1d protein in lysates and serum.

Results: INKT cells were found to be significantly depleted from metastatic liver compared to donor (n=30). Geometric mean (GM) in donor = 0.0003 and metastatic liver =0.001725 p<0.0001). SCD1d protein was only detectable in liver (n=29) and sera from patients with liver metastasis (n=15).

Conclusions: We show high levels of sCD1D and low iNKT cell numbers in metastases. We hypothesise that sCD1d directly causes iNKT cell depletion, inhibiting their anti-tumour activity. High levels of sCD1d in serum may reflect compromised anti-tumour activity; we propose that measurement of sCD1d levels will provide a novel prognostic tool for patients with liver metastases.

ABSTRACT 3 (15S119) ORAL PRESENTATION

Title of Paper: Efficacy of hepatic transient elastography in screening for presence of oesophageal varices in patients with liver disease.

Author(s): R. O'Kane, B. Callaghan, N.I. McDougall, W.J.Cash

Department(s)/Institution(s): Hepatology Unit, Royal Victoria Hospital Belfast

Introduction: Current guidelines recommend that all cirrhotic patients should undergo screening endoscopy to identify those who would be high risk of bleeding from oesophageal varices.
Portal hypertension is associated with development of hyperdynamic circulation with complications such as ascites, hepatic encephalopathy and oesophageal-gastric varices.
Oesophageal varices are present in 50% of patients at time of diagnosis of cirrhosis with increased frequency in Child-Pugh C classification in comparison to Child-Pugh A (85% vs 40%).1,2

Aims/Background: To evaluate if liver stiffness measurement (LSM) using transient elastography (TE) is a useful tool in predicting the risk of oesophageal varices in patients with liver disease.

Method: A retrospective analysis of all patients who underwent fibroscan from Jan 1st 2008 until Dec 31st 2011 was undertaken. A LSM score of 14.1KPa or above was used as a cut-off to identify those with cirrhosis. Endoscopy records were then analysed to determine whether patients underwent endoscopy to exclude oesophageal varices.

Results: Of the total 551 fibroscans performed from 2008-2011, 118 patients had a LSM > 14.1KPA in keeping with possible cirrhosis. A total of 71 patients (60.1%) with a LSM greater than 14KPA proceeded to endoscopy of which 29 patients (24.6%) had oesophageal varices confirmed on endoscopy. Patients with higher range LSM had increased incidence of varices with 14/23 (60%) of patients with LSM >30 confirming varices.

ABSTRACT 4 (15S130) ORAL PRESENTATION

Title of Paper: Fibroscan can predict recurrence of the primary liver disease in the post liver transplant patients

Author(s): Elgaily Elrayah, Prof. Aiden McCormick

Department(s)/Institution(s): Liver Unit, St Vincent's University Hospital, Dublin, Ireland

Introduction: Fibroscan is used for assessing the degree of liver fibrosis in patients with chronic liver disease especially chronic Hepatitis C infection, which is a major indication for liver transplantation . However recurrence of the primary liver disease has significant impact on the patient's and graft survival .Early recognition of the primary disease recurrence is vital for prompt and meticulous management.

Aims/Background: For assessing the validity of the Fibroscan in the prediction of the recurrence of the primary liver disease in the post liver transplant patients.

Method: Prospective study involved 123 consecutive liver transplant patients. For each patient we took ten valid measurements by the Fibroscan, Fibroscan scores were correlated with the underlying liver disease, and the results of liver biopsy in patients who had it.

Results: Chronic hepatitis C infection is the most common underlying liver disease and indication for liver transplantation in this cohort. The Fibroscan scores are higher in patients with chronic hepatitis C infection compared to those transplanted for non viral Fulminant hepatic failure (mean 19.805, versus 6.750, p value 0.024)

Liver biopsy was done in 21 patients to establish the diagnosis of abnormal LFTs in the post-transplant period The fibroscan score are higher in patients with histological evidence of established cirrhosis than those with chronic rejection, steatosis, and recurrence of the disease without fibrosis (p value 0.0001).

Conclusions: Fibroscan can predict the recurrence of the primary liver disease in post liver transplant patients . especially those with chronic hepatitis C infection.

ABSTRACT 5 (15S136) ORAL PRESENTATION

Title of Paper: Eomes- Natural Killer cells: Evidence of in situ development in the adult human liver.

Author(s): Harmon C[1], Fahey R[1], Whelan S[1], Geoghegan J[2], Houlihan D[2], O'Farrelly C[1]

Department(s)/Institution(s): 1. School of Biochemistry and Immunology, Trinity College Dublin, Dublin 2. 2. National Liver Transplant Unit, St Vincent's University Hospital, Dublin 4

Introduction: Natural Killer (NK) cells are innate lymphocytes with pivotal roles in anti-viral and tumour immunity. NK cells are enriched in healthy human liver, accounting for 30-50% of lymphocytes compared to 5% in blood. NK cell development is a complex process; however the transcription factors EOMES and T-BET have been identified as key regulators of this process.

Aims/Background: Novel populations of immature EOMES- NK cells have been identified in murine livers and are believed to differentiate within the liver. We aimed to investigate these in human liver perfusate.

Method: During transplantation, Wisconsin preservative-perfused donor livers (n=11) were flushed with saline and mononuclear cells from the perfusate were isolated and assessed by flow cytometry. NK cells were analysed for expression of activatory and inhibitory receptors; NKG2C, NKG2D, NKp44, NKp46, NKG2A and transcription factors EOMES and T-BET.

Results: Over 40% of hepatic lymphocytes were CD56+CD3- (43.1±9.18%). Hepatic NK cells appear phenotypically immature, with lower expression of the activatory receptor NKG2C (9.86±3.76% vs 14.92±5.53%) and increased expression of inhibitory receptor NKG2A (12.82±7.1% vs 3.37±1.58%). EOMES- NK cells are present in substantial numbers in the human liver (9.77±7.3%) and are enriched in the CD56dim population compared to CD56bright (17.85% vs 3.24%).

Conclusions: Here we provide evidence of EOMES- NK cells in the human liver. Fetal liver is a recognised site of haematopoiesis and haematopoietic progenitors persist in the adult liver. We believe growth factors in the liver encourage the differentiation of immature EOMES- NK cells. These resident liver NK cells may be pivotal in maintaining the livers natural tolerogenicity.

ABSTRACT 6 (15S140) ORAL PRESENTATION

Title of Paper: Liver Stiffness Predicts Decompensation In A Mixed Aetiology Cirrhotic Population

Author(s): Audrey Dillon, Zita Galvin, Stephen Stewart

Department(s)/Institution(s): Centre for Liver Disease, Mater Misericordiae University Hospital, Dublin 7

Introduction: Liver stiffness (LSM) measured by transient elastography is increasingly used to predict portal hypertension in patients with liver cirrhosis.

Aims/Background: The aim of this prospective cohort study was to determine the utility of LSM in predicting outcomes in a mixed aetiology cohort with compensated cirrhosis.

Method: Patients received a Fibroscan™ examination at baseline and were followed up. Decompensation was defined as the development of ascites, encephalopathy, jaundice or variceal bleed.

Results: 140 patients were followed up for a median of 33 months. Primary aetiologies were ALD (40%) and HCV infection (31%).

ABSTRACT 7 (15S103) ORAL PRESENTATION

Title of Paper: A Significant Change Towards Top-Down Prescribing of Infliximab in Clinical Practice

Author(s): V. Parihar [1,*], S. Maguire [1], A. Shahin [1], M. O'Sullivan 1, M. Kennedy [1], Z. Ahmed [1], C. Smyth [1] , R. Farrell [1,2]

Department(s)/Institution(s): 1.Gastroenterology Connolly Hospital, 2. Medicine, RCSI, Dublin.

Introduction: The past decade has seen evidence from controlled IBD studies (1) supporting a top-down strategy using early intervention with anti-TNF therapies in a subset of patients.

However, there is a paucity of data on whether this top down strategy has been adopted in clinical practice

Aims/Background: We evaluated our clinical experience with infliximab in a single Centre cohort of IBD patients over the past 6 years to see if there had been any significant changes in how early anti-TNF therapies are introduced.

Method: We retrospectively reviewed the records of 54 IBD patients who received infliximab infusions between Jan 2008 and Dec 2014 in our infusion unit. Patient demographics, diagnosis, smoking history, concurrent immunosuppressant, time between diagnosis and infliximab/surgery, and adverse events were recorded.

Results: A total of 54 IBD patients [33 Crohn's disease, 21 Ulcerative colitis; 29 females, 24 males, mean age 36 (range 16-81)] received a total of 1000 infliximab infusions [mean 17, range 1-59] with a median follow-up of 30 months. The median time from diagnosis to infliximab for the first 27 patients was 13 years compared to only 2 years for the subsequent 27 patients; p<0.0001. 32 patients (60%) were on oral ASA, 31 (57%) on thiopurines. 13 patients (24%) received prior Adalimumab therapy 20 (37.5%) were switched to Adalimumab due to loss of efficacy or adverse events, and 8 (15%) required either an increase in infliximab dose or infusion interval shortening (Figure 1).

Figure 1

Characteristics of IFX Patients	
No. of Patients	54
Type of Disease (%)	
UC	21
CD	33
Unclassified Colitis	0
UC phenotype (E1/E2/E3), (n)	2/9/10
CD phenotype, (n)	
A1/A2/A3	5/25/3
L1/L2/L3/L4	5/5/23/0
B1/B2/B3	12/14/7
P	5
Smoking Status n, (%)	
Non smoker	35(65%)
Former or Current smoker	19(35%)
Concomitant medications	
Thiopurines	31(57)
Oral 5-ASA	32(60)
Biological treatment, n (%)	
Previously received ADA	13(24%)
Switched to ADA	20(37.5%)
On IFX(at 12months)	34(62.5%)
Serious adverse Effects	9(17%)
IFX dose/frequency alteration	8(15%)

IFX: Infliximab; ADA:Adalamumab; ASA:Aminosalicyclic acid

9 patients (17%) stopped infliximab due to significant adverse events. At 1 year follow-up of patients on Infliximab for more than 12 months
34 patients remained on infliximab (62.5%). There were no reported deaths. A subset of 22 IBD patients were prospectively enrolled in 2014 and received a total of 103 short (30-60) minute maintenance infliximab infusions over 12months, with zero infusion reactions or significant adverse events.

Conclusions: Infliximab is beneficial in almost two-thirds of IBD patients while over one-third of patients had to stop Infliximab or switch to Adalimumab due to poor efficacy or adverse events. IBD patients diagnosed since 2010 were started on Infliximab within 2 years of their disease onset compared to 13 years for those IBD patients diagnosed before 2010. This reflects a change towards early prescribing of anti-TNF therapy in clinical practice over the past 5 years.

References: 1. Hommes D, Baert F, Van Assche G, et al. Early combined immunosuppression or conventional management in patients with newly diagnosed Crohn's disease: an open randomised trial. Lancet. 2008;371(9613):660-7

ABSTRACT 8 (15S106) ORAL PRESENTATION

Title of Paper: A Comparison Of Exclusive Enteral Nutrition (Een) And Corticosteroids (Cs) In The Induction Of Remission In Paediatric Crohn's Disease (Cd)

Author(s): L Lafferty[1,2], A Carey[1,3], M Tuohy[1,2], S Sugrue[2], B Bourke[1], A Broderick[1], S Quinn[1], S Hussey[1]

Department(s)/Institution(s): 1 Department of Gastroenterology, Hepatology and Nutrition, Our Lady's Children's Hospital, Crumlin, Dublin 12, Ireland. 2 Dublin Institute of Technology, Kevin Street, Dublin 8, Ireland. 3 National Children's Research Centre, Our Lady's Children's Hospital, Crumlin, Dublin 12, Ireland

Introduction: Exclusive enteral nutrition (EEN) is recommended as an appropriate initial treatment of paediatric Crohn's Disease (CD), with documented benefits including improved mucosal healing and enhanced bone health 1. EEN has been shown to be as effective as corticosteroids (CS) without the recognised detrimental side-effects 2.

Aims/Background: The aim of this study was to compare the effectiveness of EEN and CS in inducing remission in paediatric patients.

Method: A retrospective case review examining hospital databases, medical and dietetic records of all patients who completed a full course of EEN, as a primary treatment, between 2004 and 2013 was undertaken. This group was matched by age, gender and phenotype to a cohort who received CS as an initial treatment. Each patient's phenotype was classified based on the Paris classification. Remission was defined as a Paediatric Crohn's Disease Activity Index of ≤10 and the absence of clinical symptoms, as defined by Physician Global Assessment (PGA). Changes in weight and height z-scores from pre-treatment to maximum follow-up were examined.

Results: Remission was achieved in a significantly greater number of patients who received EEN (86%) as an initial treatment versus CS (54%) (P=0.02). Urban dwellers had significantly higher remission rates when treated with EEN compared with CS (P=0.002), this was not observed in those living in rural locations (P=0.558). The median number of dietetic contacts received was 5

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Selective serotonin (5-HT4) receptor agonist, antiserotonergic agent, available as 1 mg and 2 mg film-coated tablets for oral administration, once daily, with or without food, at any time of the day. **Indication:** Resolor is indicated for symptomatic treatment of chronic constipation in women in whom laxatives fail to provide adequate relief. **Dose:** Women: 2 mg once daily. Older people (> 65 years): Start with 1 mg once daily and increase to 2 mg once daily if necessary. Patients with severe renal impairment (GFR < 30 ml/min/1.73m2): 1 mg once daily. Patients with severe hepatic impairment (Child Pugh class C) start with 1 mg once daily which may be increased to 2 mg if required to improve efficacy and if the 1 mg dose is well tolerated. No dose adjustment required in patients with mild to moderate renal or hepatic impairment. Men: not recommended until further data become available. 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This effect is too small to be clinically relevant. Therapeutic doses of probenecid, cimetidine, erythromycin and paroxetine did not affect the pharmacokinetics of prucalopride. **Pregnancy:** Animal studies did not indicate harm. Experience of Resolor during human pregnancy is limited. Cases of spontaneous abortion have been observed in human clinical studies although, in the presence of other risk factors, the relationship to Resolor is unknown. Resolor is not recommended during pregnancy. Women of childbearing potential should use effective contraception during treatment with Resolor. **Lactation:** Prucalopride is excreted in breast milk, however at therapeutic doses no effects are anticipated on the breastfed newborn/infant. In the absence of human data Resolor is not recommended during breastfeeding. **Effects on ability to drive and use machines:** No studies have been performed. Resolor has been associated with dizziness and fatigue, particularly on the first day of treatment, which may affect driving or using machines. **Side effects:** The most commonly reported side effects in Resolor clinical trials were headache and gastrointestinal symptoms (abdominal pain, nausea, diarrhoea) occurring in about 20% of patients each. These events occur mostly at the start of therapy and usually disappear within a few days whilst continuing Resolor. Other common adverse events in controlled trials included dizziness, vomiting, dyspepsia, rectal haemorrhage, flatulence, abnormal bowel sounds, pollakiuria and fatigue. Uncommon adverse events included anorexia, tremor, palpitations, fever and malaise. After the first day of treatment the most common adverse events were reported with similar frequency for Resolor and placebo except nausea and diarrhoea: these remained higher but the difference between Resolor and placebo was smaller (1 to 3%). Palpitations were reported in 0.3% of placebo patients, 1.0% of 1 mg Resolor patients and 0.7% of 2 mg Resolor patients. As with any new symptom, patients are advised to discuss new onset palpitations with their physician. **Legal category:** POM. **Marketing Authorisation Holder:** Shire Pharmaceuticals Ireland Limited, 5 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. **Date of preparation:** November 2014. **Marketing Authorisation Number:** EU/1/09/581/001 (1 mg), EU/1/09/581/002 (2 mg). **Further information is available from:** Shire Pharmaceuticals Ireland Ltd, 5 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. Tel: 01 4297700.

Adverse events should be reported to HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517; Website: www.hpra.ie ; E-mail: medsafety@hpra.ie. Adverse events should also be reported to Shire on 1800 818016.

Ref 1: Resolor Summary of Product Characteristics. www.medicines.ie

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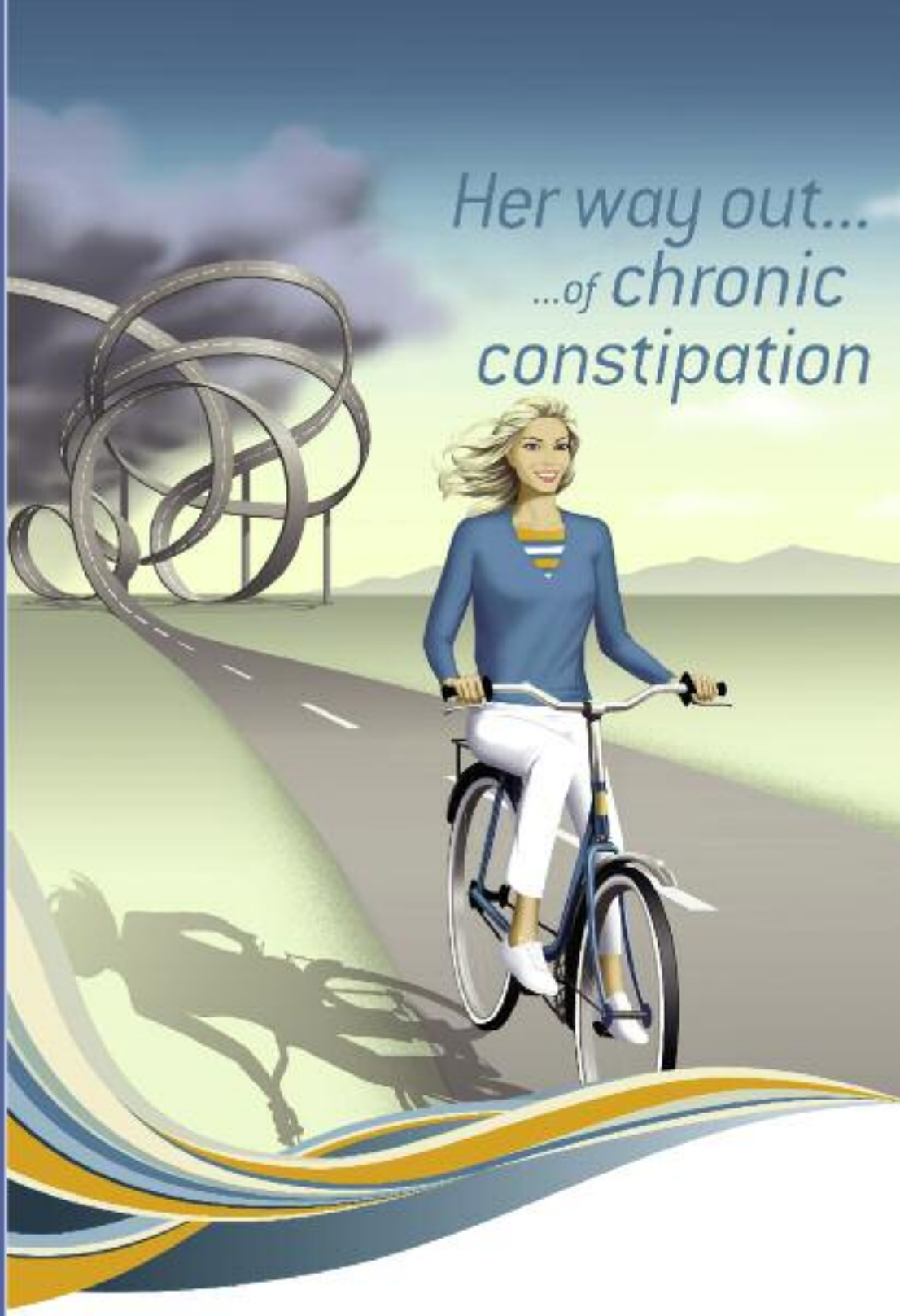

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in urban locations and 2.5 in rural locations. Improvements in weight z- scores were observed in both cohorts; however patients treated with CS had significant deterioration in height z-scores post-treatment (P=0.000), which was not evident in the EEN cohort (P=0.232).

Conclusions: EEN is more effective than CS in inducing remission in paediatric patients with CD. Increased dietetic contacts associated with urban dwellers significantly improves EEN remission rates. The use of EEN avoids the negative impact on height z-scores as observed in those treated with CS.

References: 1. Ruemelle F, Veres G, Kolho K, Griffiths A, Levine A, Escher J. Consensus guidelines of ECCO/ESPGHAN on the medical management of pediatric Crohn's disease. J Crohns Colitis 2014; 8: 1179–1207. 2. Soo J, Malik B A, Turner JM, Persad R, Wine E, Siminoski K et al. Use of exclusive enteral nutrition is just as effective as corticosteroids in newly diagnosed pediatric Crohn's disease. Dig Dis Sci 2013; 58: 3584–3591.

ABSTRACT 9 (15S122) ORAL PRESENTATION

Title of Paper: A comparison of prevalence of Helicobacter pylori infection and rates of antibiotic resistance in patients undergoing gastroscopy v urea breath test at Tallaght Hosp.

Author(s): Denise Brennan, Joseph Omorogbe, Mary Hussey, Grainne Holleran, Clifford Kiat, Colm O'Morain, Sinead Smith*, Deirdre McNamara*

Department(s)/Institution(s): Trinity Academic Gastroenterology Group (TAGG), Department of Clinical Medicine, Trinity College Dublin. *Joint senior authors

Introduction: Due to emergence of antibiotic resistant H. pylori infection, the European Helicobacter study group has recommended local surveillance of antibiotic resistance. Currently, this surveillance is done primarily on patients undergoing invasive testing by means of gastroscopy. However, most patients are tested for H. pylori by non-invasive methods, such as the urea breath test (UBT), using a "Test and Treat" approach. As such, data obtained solely from gastroscopy patients may not truly reflect the prevalence of H. pylori infection and the rates of antibiotic resistance.

Aims/Background: To compare prevalence of H. pylori infection and the rates of antibiotic resistance in Tallaght hospital patients referred for a gastroscopy with those referred for UBT.

Method: Between August 2014 and March 2015, adult patients were prospectively recruited to the study from our endoscopy department and UBT clinic. Following ethical approval and informed consent, a stool sample was obtained from patients undergoing a UBT and an additional gastric biopsy sample was obtained from patients undergoing endoscopy for H. pylori testing. Patients were considered to be H. pylori-positive based on a positive UBT result or a positive Campylobacter-like organism (CLO) test respectively. DNA was harvested from the stool or biopsy samples of H. pylori-positive patients and analysed for mutations conferring clarithromycin or levofloxacin resistance using the GenoType HelicoDR assay (Hain Lifesciences).

Results: In total, 144 patients (38% male, mean age 53 years) underwent gastroscopy and 123 patients (30% male, mean age 41 years) a UBT. A higher percentage of women than men underwent testing by both methods. The prevalence of H. pylori infection in the gastroscopy cohort was low, 18% (26 patients, 46% male, mean age 47 years). While the prevalence of infection in the UBT group at 37% (46 patients, 35% male, mean age 40 years) was significantly greater, odds ratio 2.7 (p=0.014, 95% CI -33.5355, -4.46452). To date, 21/26 CLO positive gastric samples have been analysed for resistant genotypes. H. pylori DNA was detected in 100% (21/21). A clarithromycin and levofloxacin-resistant genotype was observed in 62% (13/21) and 5% (1/21) respectively. In addition, 19/46 stool samples have been analysed for resistant genotypes. H. pylori DNA was detected in 95% (18/19). A clarithromycin and levofloxacin-resistant genotype was observed in 89% (16/18) and 17% (3/18) respectively. Overall the rate of both clarithromycin and levofloxacin resistance was significantly higher in the UBT cohort (P = 0.034, 95% CI -51.0844, -2.91556 and P= 0.017, 95% CI -21.1930, -2.80695 respectively). Among H. pylori-infected patients, there were a greater number of males in the gastroscopy cohort (46% vs 35%), while also being significantly older (47 vs 40 years; p=0.039, 95% CI -14.00, -0.39). Neither demographic is likely to account for our observed difference in resistance rates.

Conclusions: The prevalence of antibiotic resistance of H. pylori is lower in those diagnosed by gastroscopy than UBT, which has a major implication for future surveillance testing and suggests non-invasive methods should be employed in a national program. The causes of the significant difference in both prevalence of H. pylori infection and antibiotic resistance rates in those diagnosed by gastroscopy versus UBT warrants further investigation.

ABSTRACT 10 (15S123) ORAL PRESENTATION

Title of Paper: Methylomic profiling in Inflammatory Bowel Disease; New Insights into Disease Pathogenesis and Activity

Author(s): Edel McDermott[1,2], Elizabeth J. Ryan[1,2], Miriam Tosetto[1], David Gibson[1,2], Joe Burrage[3], Denise Keegan[1], Kathryn Byrne[1], Eimear Crowe[2,4], Gillian Sexton[1], Kevin Malone[2,4], Ronald A. Harris[5], Richard Kellermayer[6], Jonathan Mill[3,7], Garret Cullen[1,2], Glen A. Doherty[1,2], *Hugh Mulcahy[1,2], *Therese M. Murphy[2,3]

Department(s)/Institution(s): 1Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin, Ireland 2School of Medicine and Medical Sciences, University College Dublin, Ireland 3University of Exeter Medical School, University of Exeter, Devon, UK 4Department of Psychiatry, Psychotherapy & Mental Health Research, St. Vincent's University Hospital, Dublin, Ireland. 5Department of Molecular and Human Genetics; Baylor College of Medicine; Houston, TX, USA. 6Department of Pediatrics; Baylor College of Medicine; USDA/ARS Children's Nutrition Research Center; Texas Children's Hospital; Houston, TX, USA 7MRC Social, Genetic & Developmental Psychiatry Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK.

Introduction: Inflammatory Bowel Disease (IBD) is a heterogeneous disorder with a complex aetiology. Quantitative genetic studies suggest only a small proportion of the variance observed in IBD is accounted for by IBD-associated genetic variants, indicating a potential role for epigenetic mechanisms in disease aetiology.

Aims/Background: To assess genome-wide DNA methylation changes specifically associated with IBD and disease activity.

Method: DNA methylomic profiling was performed on bisulfite modified DNA obtained from peripheral blood mononuclear cells of 150 IBD cases and 40 controls using the Infinium

HumanMethylation450 BeadChip. Linear regression was used to examine differences in DNA methylation levels between i) UC and CD cases compared to controls and ii) active IBD versus inactive disease, whilst controlling for potential confounders. Technical and functional validation was performed using pyrosequencing and real-time PCR.

Results: We identified numerous significant changes in DNA methylation in genes associated with pathways integral to the pathogenesis of IBD. Gene ontology enrichment analysis highlighted significant enrichment for pathways associated with immune responses and cellular responses to molecules of bacterial origin, implicating a potential role for host defence against infection in IBD. We found considerable overlap between UC and CD DMPs, with 45% of CD-associated differentially methylated positions (DMPs) also differentially methylated in UC. Traf 6 gene expression was decreased in IBD, in keeping with Illumina findings of hypermethylation.

Conclusions: This is the first epigenome-wide association study in IBD. Our data provide new insights into potential pathways and molecules which are targets of aberrant DNA methylation and may contribute to the pathogenesis and activity of IBD.

ABSTRACT 11 (15S135) ORAL PRESENTATION

Title of Paper: Altered tissue glucocrticoid metabolism is associated with IBD

Author(s): M Hussey, A Cannon, J O'Sullivan, G Holleran, B Hall, C Kiat, M Sherlock, D McNamara

Department(s)/Institution(s): Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin

Introduction: Glucocorticoids (GCS) are known to modulate a number of immunological responses. Within tissues expressing glucocorticoid and mineralocorticoid receptors including the colon, GCS metabolism is regulated by the isozymes of 11 beta hydroxysteroid dehydrogenase (11βHSD). 11βHSD 1 acts as an oxoreductase, converting inactive cortisone into active cortisol while 11βHSD 2 acts as a dehydrogenase producing cortisone. Variations in expression may have a role in IBD.

Aims/Background: To examine the expression of 11βHSD 1 & 2 in IBD

Method: Following informed consent, patients with known IBD aged 18-80yrs were recruited; exclusion criteria (1)Steroid ≤6 weeks(2)Coagulopathy,(3)Pregnancy,(4)Cushing/Conns Syndrome. Disease activity was assessed using biochemical (CRP), clinical (Harvey-Bradshaw Index/Mayo Score) & histological parameters. Controls with a normal colonoscopy without a history of IBD were also recruited. Two additional biopsies were obtained including inflamed & non-inflamed samples from IBD patients where possible, whereas a single additional colonic biopsy was obtained from controls. Biopsies were stored in RNA later & analyzed in batch, using Quantitative real time RT-PCR(TaqMan) & commercially available Probes & Primers. Relative transcript levels were determined using 18S as a reference gene.

Results: To date 27 individuals (17IBD, 14 Crohn's Disease & 3 Ulcerative Colitis) have been recruited. IBD and control cohorts were demographically similar with 53% vs. 70% being female, with a mean age of 46 yrs (19-54yrs) and 57 yrs (19-83yrs) respectively. Overall based on histology 59% (n=10) had mild disease & 41% (n=7) had moderate/severe disease. The mean HBI/Mayo score was 5.5 (0-21) & the mean CRP was 12.5 mg/l. Overall levels of 11βHSD1 were; controls (514+/-156 au), inflamed (422+/-236au) & non-inflamed (102+/-37au), with a significantly higher level in controls vs. non-inflamed samples (p=0.03, 95% CI -790 to -33.9). Mean levels of 11βHSD2 were as follows; controls (497+/-158 au), inflamed (50+/-23 au), non-inflamed (74+/-39au). There was a significant downregulation of 11βHSD2 in inflamed (p=0.002, 95% CI -709.6 to -184.7) & non-inflamed tissue (p=0.03,95%CI -808 to -38.9) compared with controls. The mean ratio of 11βHSD1 to 11βHSD2 was; controls 1.7:1, inflamed 45:1, non-inflamed 3.7:1. There was a significant difference in 11βHSD 1 & 2 ratios between the inflamed tissue & controls (p=0.01) and inflamed & non-inflamed tissue (p=0.04). Disease severity did not effect11βHSD1 or 11βHSD2 expression.

Conclusions: Background 11βHSD1 levels in IBD non inflamed tissue are low compared to controls rising in response to inflammation, accompanied by a down regulation of 11βHSD2. This suggests a potential baseline deficiency of 11βHSD1 and 2. Our findings suggest relative 11βHSD expression may impact IBD natural history & treatment responses.

ABSTRACT 12 (15S107) ORAL PRESENTATION

Title of Paper: Crohn's disease (CD) is associated with increased Foxp3+CD39+CD161+ cells and high levels of TNFα and IFNγ dual producing cells in lamina propria.

Author(s): Zaid Heetun, Louise Elliot, Elizabeth Ryan, Sean Martin, Glen Doherty

Department(s)/Institution(s): Department of Gastroenterology, Department of Colorectal Surgery, St Vincent's University Hospital, Elm Park School of Medicine and Medical Science, University College Dublin, Belfield

Introduction: Dysfunction of+ Tregulatory (Treg) cells and increased inflammatory cytokine production is associated with CD.

Aims/Background: To compare Treg cell frequency and phenotype and T cell cytokine secretion in lamina propria mononuclear cells (LPMCs) of CD patients with matched peripheral blood mononuclear cells (PBMCs).

Method: Patients' blood and tissue samples were collected at surgical resection (n=9). Healthy controls (HCs) (n=4) were obtained at time of endoscopy. Tissue samples were digested into a single cell suspension. For assessment of cytokine production, PBMCs and LPMCs were stimulated with PMA/Ionomycin for 6 hours prior to staining. Samples were then analysed with a nine-color flow cytometer (Cyan).

Results: We demonstrate a similar proportion of Treg cells in blood and tissue with no difference between HCs and patients. However CD39+CD4+ T cells and CD39+ Treg cells were significantly expanded in the LP compared to PB. Higher levels of CD39+ Treg cells were also observed in inflamed tissue compared to samples from healthy controls. LPMCs were enriched for multi-functional T cells that secreted two or more cytokines (IL-17, IL-22, TNF-α and IFN-γ). In contrast the majority of CD4+ T cells in peripheral blood secreted a single cytokine. LPMCs isolated from inflamed tissue secreted higher levels of IL-17 and IL-22.

Conclusions: CD4+ LPMCs from CD patients are multifunctional and secrete high levels of TNF-α, IFN-γ, IL-22 and IL-17, with

significant numbers of cells secreting more than one of these mediators The Treg cells present in diseased tissue were CD161+ suggesting that they may in fact be pro-inflammatory.

ABSTRACT 13 15S 100 POSTER PRESENTATION

Title of Paper: Coeliac Disease DEXA scanning - are the guidelines being followed?

Author(s): Reed O, Murphy S

Department(s)/Institution(s): Department of Medicine, Daisy Hill Hospital, Southern Health & Social Care Trust

Introduction: Coeliac Disease is an immune-mediated small intestinal enteropathy that results in malabsorption. Osteoporosis and bone fracture risk is increased with coeliac disease as with the fracture risk being 600/100 000 person-years vs 444/100 000 person years in non-Coeliac patients1.

Aims/Background: To assess the adherence to guidelines for Osteoporosis in Coeliac Disease2,3. Are the appropriate initial biochemical investigations being performed after a diagnosis? If patients are referred for Dual-energy X-ray absorptiometry (DEXA) scanning was this as per guidelines and what were the results?

Method: A random sample of Coeliac patients were collected from Patient Administration System (PAS). Clinical records were reviewed using patient notes & Northern Ireland Electronic Care Record (NIECR). DEXA scan results were analysed using Northern Ireland Picture Archiving and Communications System (NIPACS).

Results: A random sample of 49 patients was generated. The majority of patients appropriately had a Bone profile checked (91.3%), however only 38.8% of patients had Vitamin D levels checked and 8.1% had Parathyroid (PTH) levels checked.
79.6% of patients had DEXA scans (39/49). All the patients that met the guideline criteria were appropriately scanned and 75% of these had reduced bone mineral density (BMD). However 25.6% (10/39) did not meet criteria and had DEXA Scans. 70% of these were normal and 30% had reduced BMD.

Conclusions: More patients should have Vitamin D and PTH checked on diagnosis. Criteria for DEXA scans should be reviewed prior to booking in order to avoid inappropriate investigations being performed. Currently a Trust wide check list is in development.

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2. Diagnosis and management of adult coeliac disease: guidelines from the British Society of Gastroenterology. BSG; 2014 June 10
3. Guidelines for osteoporosis in inflammatory bowel disease and coeliac disease. BSG; 2007 June

ABSTRACT 14 15S 101 POSTER PRESENTATION

Title of Paper: Chronic Pancreatitis in Ireland - The Management of an Orphan Disease

Institution/Hospital: Trinity College Dublin / Professorial Surgical Unit, Tallaght Hospital Job Description: PhD Candidate

Author(s): Hazel Ní Chonchubhair, Sinead Duggan, Dara Kavanagh, Kevin Conlon

Department(s)/Institution(s): Professorial Surgical Unit, Trinity Centre for Health Sciences, Trinity College Dublin & Tallaght Hospital, Dublin 24

Introduction: No epidemiological data exist for chronic pancreatitis (CP) in Ireland, nor is there a central patient registry for this progressive disease

Aims/Background: We developed a survey of surgeons/ gastroenterologists with the following objectives: to determine national and regional trends in CP management, and to attain expert opinion on the proposed development of a National CP Disease Registry

Method: Study design was a cross-sectional descriptive survey. A 25-question survey was emailed to gastroenterologists/general surgeons throughout Ireland facilitated by the Royal College of Surgeons Ireland and the Irish Society of Gastroenterology. Questions included demographics, institution-type, patient numbers, CP management (caseload, dedicated team, diagnosis, guidelines) and CP disease registry (perceived need/benefit/ barriers). Data analysis utilised SPSS and qualitative content analysis

Results: Most of the group were surgeons (57%). Over half had >8 years consultant level experience. Sixty-one percent worked in university hospitals. Most (70%) were not aware of national/international consensus guidelines for CP management. Whilst 81% reported seeing CP patients regularly, 72% have no dedicated multidisciplinary team for CP. Regarding CP diagnosis, the majority used CT (92%), FE-1 (74%), MRCP (72%) and EUS (60%). The majority (81%) identified that 'pain-control' could be improved, followed by 'treatment' (62%), 'follow-up' (51%) and 'nutrition' (51%). Most (76%) stated that an Irish CP disease registry would be a useful undertaking

Conclusions: Deficits exist in guideline awareness and in multidisciplinary management of CP patients in Ireland. Most respondents were positive about the benefits of a CP registry which would aid disease surveillance, health service delivery and facilitate research on CP management in Ireland

ABSTRACT 15 15S 102 POSTER PRESENTATION

Title of Paper: The first report of chronic pancreatitis prevalence and hospital activity in Ireland

Author(s): Hazel Ní Chonchubhair, Sinead Duggan, Kevin Conlon

Department(s)/Institution(s): Professorial Surgical Unit, Trinity Centre for Health Sciences, Trinity College Dublin & Tallaght Hospital, Dublin 24

Introduction: The European prevalence of chronic pancreatitis (CP) is reportedly 13-49.3 per 100,000 population. The CP prevalence in Ireland and the UK is unknown

Aims/Background: For the first time we sought to establish the prevalence of CP in Ireland. We also aimed to examine age/gender/geographical trends in patient activity over 5yrs

Method: Using the Hospital In-Patient Enquiry database, we examined activity (codes K86.0/K86.1) ('chronic pancreatitis'/'chronic alcoholic pancreatitis') between 2009-2013.

Population census data for 2011 was used to estimate prevalence. 'Total patients' and 'total discharges' (accounts for multiple admissions) were recorded

Results: The prevalence of CP in Ireland ranged from 11.7 to 13.4 per 100,000 population between 2009 and 2013, and appeared to stay level during this period. The majority were male (55-71.2% between 2009-13), and most were 40-69yrs. There was geographical variation; the Northwest had the highest patient activity (patient discharges) per capita (17.6-22.7 per 100,000) over 5yr. Total bed days ranged from 6,613 to 7,224 annually, corresponding to 18.8-20.9 full-time CP-occupied beds in Ireland from 2009-13

Conclusions: Notwithstanding the limitations of the administrative database, this represents the first epidemiological data for CP prevalence in Ireland. Prevalence appears to be significant, with regional variations requiring further investigation. Furthermore, prevalence rate are undoubtedly underestimated as data only accounts for patients who were hospitalised in any given year. The resource burden of CP is emphasised by the constant use of 19-21 in-patient beds throughout the study period

ABSTRACT 16 (15S 104) POSTER PRESENTATION

Title of Paper: Single centre expereince in surveillance for Hepatocellular carcinoma in patient with liver cirrhosis

Author(s): Ammar Shahin, Vikrant Parihar, Zuhair Ahmed, Claire Smyth, Richard farrell

Department(s)/Institution(s): Gastroenterology, Connolly Hospital and RCSI, Blanchardstown Dublin 15

Introduction: Hepatocellular carcinoma accounts for about 85-90 % of primary liver malignancies. It is the third most common cause of cancer death. Liver cirrhosis is the leading risk factor. The only large randomized controlled trial of HCC surveillance versus no surveillance was performed in China. Surveillance was performed with alpha-fetoprotein (AFP), and Ultrasound (US). There was higher cancer detection in the surveillance group and a 37% reduction in the mortality. Other radiological tests including MRI and Triphasic CT scan are useful when US views are limited.

Aims/Background: 1. Check our compliance with surveillance to the international guidelines.
2. Whether US scan is an adequate imaging tool or other cross sectional images were recommended.
3. Due to increase demands and waiting time of US, to establish when the best time to order the surveillance US.
4. The role of AFP in HCC surveillance.

Method: The charts of the patients who were confirmed to have cirrhosis (n=43), were reviewed and the dates of their surveillance scans and AFP check dates were reviewed and compared to the international standards.

Results: Only 19 patients out of 43(44%), had their surveillance US every 6 months.12% of the patients, had US within 6-12 months, 7 patients were diagnosed within the last 6 months. Regarding AFP, 25 patients were getting it checked every 6 months

Conclusions: US scan was effective in 72 % of the patients as the sole radiological surveillance tool. AFP may expedite the radiological imaging if it is abnormally high, though normal result does not exclude HCC

ABSTRACT 17 (15S 108) POSTER PRESENTATION

Title of Paper: A Cross-sectional Study of the Clinical Phenotype in Coeliac Disease in a Large Cohort of Irish Patients.

Author(s): By P. Dominguez Castro1, C. Kiat3, J. Liong Chin1, G. Harkin3, V. Trimble1, T. Martin2, D. Kevans1 P. MacMathuna2, V. Byrnes3, N. Mahmud1, R. McManus1, NP. Kennedy1.

Department(s)/Institution(s): 1 Institute of Molecular Medicine & Department of Clinical Medicine, Trinity Centre for Health Science, St James's Hospital, Dublin 8, Republic of Ireland, 2Gastrointestinal Unit, Mater Misericordiae University Hospital, Eccles St., Dublin 7, Republic of Ireland, 3Department of Clinical Medicine, University College Hospital Galway, Galway, Republic of Ireland.

Introduction: Coeliac disease (CD) occurs both in adults and children at a rate of approximately 1% in most populations (1). There has been a considerable increase in CD positive serology over time. CD has a wide spectrum in its clinical presentation (1-5). The co-existence of CD with other disorders has been well reported (6, 7). Few studies have addressed the clinical phenotype of coeliac disease in the Republic of Ireland (ROI), and those available consist of small samples with little information on associated disorders (8, 9).

Aims/Background: The aim of this study is to explore the clinical phenotype of a large cohort (n=340) of coeliac patients attending referral centres in the ROI.

Method: Retrospective analysis of medical charts from a cohort of coeliac patients (median age 59 years, range 18-87 years) attending referral centres.

Results: The median age of diagnosis was 45 years (range 0.5-86 years). Onset of CD was symptomatic in 276 patients (81.5%), while 19 presented with a subclinical phenotype (5.6%). 263 patients reported having ever suffered from common disorders associated with CD (i.e. osteoporosis, iron deficiency, depression), these patients were diagnosed later in life (Mean=44.2 years) than those who did not report having had any of these conditions (Mean=36.1 years) (p=0.002). 118 patients (34.8%) had a coexistent autoimmune disorder, the most prevalent being thyroid disease (20.4%).

Conclusions: CD seems to be associated with other autoimmune and non-autoimmune conditions. Diagnosis later in life appears to predispose to the development of associated non-autoimmune disorders

Coeliac Patients	Characteristics	Median/%
Females/Males n=340 (%)		60.7/39.3
Age of diagnosis gender (years), n=339	Males	48.5
	Females	45.0
Diagnosis by age range (years), n=304 (%)	<15	13.6
	16-35	19.0
	36-55	37.5
	>55	31
Clinical presentation at diagnosis*, n=340 (%)	Classical CD	47.1
	Non-classical CD	41.1
	Subclinical CD	5.6
	Not available	12.9
Presence of autoimmune disease gender, n=340 (%)	Males Yes/No	26.2/73.8
	Females Yes/No	38.4/61.6
Type of autoimmune disease, n=340 (%)	Thyroid Disorders	20.4
	Type 1 Diabetes	5.2
	Psoriasis	4.4
	Inflammatory Bowel Disease	2.4
	Rheumatoid Arthritis	1.8
	Pernicious Anaemia	1.8
	Vitiligo	0.5
	Systemic Lupus Erythematosus	0.3
	Other	6.8

* Clinical presentation at diagnosis was classified according to the Oslo definition of CD as: Classical, non-classical and subclinical

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ABSTRACT 18 (15S 109) POSTER PRESENTATION

Title of Paper: Inadequate use of VTE prophylaxis and overuse of Proton Pump Inhibitors in hospitalised Inflammatory Bowel Disease patients.

Author(s): Mohamed H Alhinai, Padraic MacMathuna, Jan leyden, T. Barry Kelleher.

Department(s)/Institution(s): Mater Misericordiae University Hospital.

Introduction: Inflammatory Bowel Disease (IBD) patients are at an increased risk of thrombosis, particularly when hospitalized. Thromboembolic complications are serious extraintestinal manifestations complicating the course of IBD. Several guidelines now recommend pharmacologic prophylaxis with low-molecular-weight heparin (LMWH) for hospitalized IBD patients.

Aims/Background: To assess the use of PPI and the adherence of administering pharmacologic venous thromboembolism (VTE) prophylaxis to hospitalized patients with inflammatory bowel Disease.

Method: A retrospective review of patients admitted with IBD to a single tertiary referral center between January 2013 and September 2014. For each patient, demographic data, diagnosis and laboratory investigation were recorded. PPI use and time to administration of VTE prophylaxis and dose used were assessed.

Results: 135 eligible patient admissions were reviewed. 5 (3%) were excluded because of anticoagulation use at admission. Of the remaining 130 patients, 85(65.4%) received VTE prophylaxis and 45 (34.5%) did not receive any form of VTE prophylaxis during hospitalization. Of the 85 patients who did receive VTE prophylaxis 40 (47%) did not receive it in the first 48 hours of admission time and in 18 (21%) were administered a suboptimal dose (20 mg Enoxaparin). PPI was administered to 47 (36%). In 40 (31%) no indication for administration was identified.

Conclusions: VTE prophylaxis was not administered to 34.5 % of IBD inpatients and in those who did receive it, it was delayed (47%) and regularly at a suboptimal dose (21%). PPI use was excessive and not indicated in almost one third. Further efforts are required to improve VTE prophylaxis in IBD.

ABSTRACT 19 (15S 110) POSTER PRESENTATION

Title of Paper: No Great Expectations; Patient Perception of Endoscopy Waiting Times in an Irish Setting

Author(s): C. Murphy, G. Mohamed, N. Walsh, M. Buckley, J. McCarthy

Department(s)/Institution(s): Centre for Gastroenterology, Mercy University Hospital, University College Cork, Cork, Ireland

Introduction: As the demand for endoscopy services in Ireland increases, it is necessary to enhance efficiency at each step of the endoscopy process. A recent departmental study demonstrated that delays at each stage of the process were a major factor in the optimal use of endoscopy resources and highlighted areas of targeted improvement. Patient perception of these delays has not previously been investigated.

Aims/Background: To examine patient's perception of Endoscopy Day Ward waiting times.

Method: Patient satisfaction questionnaires in accordance with JAG guidelines were distributed to 217 patients between June-August 2014. These questionnaires examined patient satisfaction at each stage of the endoscopy process. The scores from this study were compared with data from a retrospective efficiency study of 238 endoscopy procedures examining length of delays at each endoscopy stage.

Results: Overall, there was a 99% satisfaction rate with the entire endoscopy process. There is an average delay of 1.35 hours between a patient's arrival time at the department and the patient being "procedure ready". However, 98% of patients were satisfied with this wait time. The transition from "procedure ready" to "commencement of procedure" has an average wait time of 2.63 hours; 94% of patients being satisfied with this delay.

Conclusions: Patients attending the department for endoscopy appear to expect long delays between each step of the endoscopy process and are in general satisfied with the average waiting times. Additional patient questionnaires should be undertaken following targeted service improvements to ensure that these actions lead to further improvements in satisfaction scores.

ABSTRACT 20 (15S 111) POSTER PRESENTATION

Title of Paper: Experience with protease-inhibitor based triple therapy for the treatment of chronic hepatitis C genotype 1.

Author(s): Iqbal N, Bolger E, Anwar A, Kale V, Cannon M, Murray F E.

Department(s)/Institution(s): Dept of gastroenterology & hepatology, Beaumont hospital.

Introduction: The advent of direct acting antiviral agents have revolutionized the hepatitis C treatment. Boceprevir and telaprevir were the first HCV NS3/4A protease inhibitors which showed significant improvement in sustained virological response (SVR), when added to Peginterferon (IFN) and Ribavirin (RBV), in both treatment naïve & treatment experienced patients. These direct acting antiviral agents were approved by FDA in May 2011 and became the standard of care for chronic hepatitis C genotype 1.
Treatment with both of these agents is no longer recommended due to the development of newer regimens with higher efficacy and

improved safety profile.

Aims/Background: This study aimed to identify all the patients with HCV genotype 1 treated with boceprevir- or telaprevir-based triple therapy at our institution and to characterize demographic details, degree of hepatic fibrosis, prior treatment experience, side-effects, SVR and outcome of treatment.

Method: This was a retrospective study. Data were obtained by reviewing patient's charts, laboratory and radiology database to establish patients demographic details, psychiatric history, degree of hepatic fibrosis, prior treatment experience, baseline laboratory parameters, treatment duration, side-effects and SVR etc. Data was analysed by using SPSS version 19.

Results: A total of 19 (13 male) patients received protease-inhibitor based triple therapy with mean age 51 ± 10.4. The majority of patients contracted virus secondary to IVDU (14), while 2 patients were infected through contaminated blood products and remainder 3 had no known source. Most of patients were treatment naïve (17) while only two had prior treatment (1 null responder and 1 partial responder). 13/19 patients (68%) were non-cirrhotic while 6/19 patients were cirrhotic. In cirrhotic median baseline Hb & platelets were 14.2 (IQR 2.5) and 144 (IQR 64) respectively. In non-cirrhotic, these values were15 (IQR 1.4) and 225 (IQR 103) respectively. 8/19 (42%) had history of depression and were assessed by psychiatrist before commencing treatment. 15/19 (78%) were treated with telaprevir- while 4/19 received boceprevir- based triple therapy. Two patients were excluded from SVR analysis (one has just completed treatment hence no SVR available while the other patient only took one dose of treatment and became intolerant). Overall, SVR was achieved in 71% of cases. Subgroup analysis revealed an SVR of 60% in cirrhotic and 75% in non-cirrhotic. Anaemia was noted in 47% which was mostly treated with RBV dose reduction and blood transfusion. Moderate thrombocytopenia and neutropenia developed in 11% and 15 % respectively which was treated with IFN dose modification. Mild rash was noted in 6/19 patient. One cirrhotic patient on telaprevir developed severe rash which required cessation of telaprevir at week 9, & worsening anaemia with premature cessation of treatment at week 24. Despite that she achieved SVR. One patient experienced severe depression during lead in phase with prompt cessation of treatment at week 2.

Conclusions: Overall protease-inhibitor based triple therapy was reasonably well tolerated with an SVR of 71% which is consistent with international standards. Higher SVR was noted in non-cirrhotic compared to cirrhotic patients (75% vs 60%). Although AASLD guidelines no longer recommend these first generation protease inhibitors. However, in Ireland this is an option we can offer at present to non-cirrhotic chronic hepatitis C genotype 1a who have mutation in Q80K.

ABSTRACT 21 (15S 113) POSTER PRESENTATION

Title of Paper: Does an Alcohol Liaison Nurse outpatient clinic for alcohol related liver disease patients lead to improved outcomes?

Author(s): Richard Howard, Brian Callaghan, Neil McDougall, Roger McCorry

Department(s)/Institution(s): Hepatology unit, Royal Victoria Hospital, Belfast

Introduction: Alcohol related harm is estimated to cost society £900 million annually in Northern Ireland. Despite this huge economic impact it is estimated that only 9% of the in need population are treated for alcohol problems.1 Given the high costs, morbidity and mortality of alcohol dependence it is vital to increase the proportion receiving effective interventions. From 2012-2014 the alcohol liaison nurse (ALN) service in the Royal Victoria Hospital offered a clinic for hepatology outpatients who were identified as being hazardous/dependent drinkers. Attendees were given extended brief interventions from an ALN.

Aims/Background: We investigated the efficacy of this clinic in patients with alcohol related liver disease.

Method: With the aid of the Electronic Care Record, outcomes of referrals to the clinic were assessed retrospectively.

Results: 69 appointments were offered to a total of 50 patients, with 31 (62%) patients attending for an extended brief intervention. 5 (16%) attenders and 3 (16%) non-attenders reported abstinence at time of review at their most recent hepatology clinic attendance (p =NS).There were 29 alcohol related readmissions (10 patients) amongst attenders compared with 14 (5 patients) in non-attenders (p =NS).At the time of review of the records there had been 1 mortality in each group (p =NS).

Conclusions: Due to the high rate of non-attendance (54%) and negligible impact on outcomes this clinic was ultimately withdrawn. The ALN service has now been revised to focus on screening of A+E attenders and inpatients, with ALNs offering brief interventions to those identified as being hazardous/dependent drinkers.

ABSTRACT 22 (15S 114) POSTER PRESENTATION

Title of Paper: Exclusive Enteral Nutrition in the Treatment Of Crohn's Disease in an Irish Paediatric Hospital Over a Ten-Year Period

Author(s): M Tuohy[1, 2], A Carey[1, 3], L Lafferty[1, 2], S Sugrue[1, 2], B Bourke[1,3], AM Broderick[1], S Quinn[1], S Hussey[1,3]

Department(s)/Institution(s): Department of Gastroenterology, Hepatology and Nutrition, OLCHC; School of Biological Sciences, Dublin Institute of Technology, Kevin St, Dublin 8; National Children's Research Centre, OLCHC

Introduction: Exclusive enteral nutrition (EEN) is a safe and effective treatment modality for inducing remission in paediatric Crohn's disease (CD). Current consensus guidelines recommend EEN as first-line therapy in active disease.

Aims/Background: This study aimed to examine the use of EEN in the treatment of CD in an Irish paediatric hospital from 2004 to 2013.

Method: Medical, dietetic, laboratory and radiological records of paediatric CD patients initiated on EEN between 2004 and 2013 were retrospectively reviewed. Data regarding patient demographics, EEN administration and anthropometric and laboratory parameters were recorded. Changes in disease activity were assessed using the Physician Global Assessment (PGA) and Paediatric Crohn's Disease Activity Index (PCDAI)1. Patients were phenotyped using the Paris Classification2. Statistical analysis was carried out using SPSS. A P value of <0.05 was considered to be statistically significant.

Results: 80 CD patients (median age 13.5 years, 63% male) were

commenced on EEN; 59 completed the full treatment course. Seventy percent entered clinical remission (PCDAI ≤10). EEN was found to be most effective when used as an initial treatment (P=0.004) and when administered to older patients (P=0.04). A positive association was observed between number of dietetic contacts and treatment outcomes (P=0.03). Significant improvements were observed in weight z-scores at all time points and height z-scores at maximum follow-up.

Conclusions: EEN is effective in inducing clinical remission in paediatric CD, particularly when administered to older patients and as a primary treatment. Increased dietetic contact during treatment appears to have a significant influence on outcomes and completion rates.

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ABSTRACT 23 (15S 115) POSTER PRESENTATION

Title of Paper: Room turnover time in endoscopy

Author(s): G.Mohamed, C.Murphy, M.Lucy, J.Mc Carthy, M.Buckley

Department(s)/Institution(s): Department of gastroenterology, Mercy University Hospital

Introduction: The demand for diagnostic and therapeutic procedures continues to grow and this driving an increasing need and interest in making the endoscopic process more efficient.

Aims/Background: Objective: To assess endoscopy room turnover time.

Design: Prospective study from February 9 to April 1/ 2015

Patients: Outpatient and inpatient procedures in endoscopy room 1 MUH.

Method: We examined the endoscopy room turnover time concentrating on the time elapsed between the end of one procedure and the start of the next .The procedure was considered delayed if the interval between it and the previous procedure was more than 15 minutes or if the first procedure of the day or the first procedure after a break started more than 15 minutes after its scheduled start time. One hundred and thirty three procedures were examined and the reasons for the delay were divided into groups.

Results: Overall ,the procedures were delayed (>15 minutes between procedures) for 46 patients of 133 patients. The major cause of the delay was patient related for 18 of these 46 procedures (39.13)(see table below).

Among the 46 patients whose procedures were delayed, 12 (26.66)were delayed longer than 15 minutes ,resulting in a longer than 30 minutes interval between procedures.

Table 1. Reasons for delayed endoscopic procedures.

Reason	Procedures,no. (%)
(Total no.= 46)	
Patient related	18 (39.1%)
Physician related	8 (17.4%)
Cannulation in the room	8 (17.4%)
Equipment related	4 (8.6%)
Cancellation	1 (2.2%)
Nurse related	1 (2.2%)
>2 reasons	1 (2.2%)
Other	5 (10.7%)

Conclusions: The room turnover time is major factor for efficiency in endoscopy (1).In the majority of the cases in this study ,the cause of the room turnover delay was patient related. Improving the patient scheduling and admission time appears to be an important potential mechanism to improve room turnover time and meet the rising demand for endoscopic services.

1/Efficiency of an endoscopy suite in teaching hospital, Gastrointestinal endoscopy –volume 64 ,No5:200 ,760-764

ABSTRACT 24 (15S 116) POSTER PRESENTATION

Title of Paper: Feasibility of same-day colon capsule endoscopy for incomplete colonoscopy

Author(s): Grainne Holleran, Mary Hussey, Barry Hall, Deirdre McNamara

Department(s)/Institution(s): Departments of Gastroenterology, Tallaght Hospital and Department of Clinical Medicine, Trinity College Dublin

Introduction: Rates of incomplete colonoscopy (IC) range from 2-19%, resulting in subsequent radiological imaging or repeat endoscopic procedures. Colon capsule endoscopy (CCE) is a non-invasive method of visualising the colon with a comparable diagnostic yield (DY) to optical colonoscopy (OC). CCE has been shown to have a superior DY than CT colonography following IC. The feasibility of a same-day CCE after IC has not been reported but may avoid the need for repeat bowel preparation, and reduce diagnostic delay and demands for radiological or repeat endoscopic procedures.

Aims/Background: To determine the feasibility of same-day CCE for IC

Method: A prospective pilot study was performed. Any patient without a contraindication was offered CCE immediately following IC. The protocol for the procedure is outlined in the table. This initial protocol was revised due to high rates of incompletion, with an additional 1L of PEG being given 1 hour prior to swallowing the CCE.

Results: To date 9 patients [44%, n=4 female, mean age 64 years (33-81)] have undergone same-day CCE for IC. The indication for OC in the group was: anaemia-22% (n=2), overt bleeding-22% (n=2), weight loss-22% (n=2), and altered bowel habit-34% (n=3). OCs were incomplete due to excessive looping-78% (n=7), patient intolerance-11% (n=1) and diverticulosis-11% (n=1), with none for poor bowel preparation. In total, 56% (n=5) underwent the initial protocol, and 44% (n=4) were given the modified preparation. In all, 67% (n=6) of CCEs were complete, confirmed by visualisation of the dentate line, and 33% (n=3) were incomplete. Incompletion

rates were 40% (n=2) using the initial protocol and 25% (n=1) with the revised protocol. The DY for colonic findings was 44% (n=4) (diverticulae n=2, colitis n=1, haemorrhoids n=1), with an additional DY over OC of 22%. In addition there were significant findings in the small bowel in 22% (small bowel polyp n=1 and ileitis n=1).

Initial protocol	
Day 0	Standard 4L of PEG
Day 1	Incomplete colonoscopy
1 hour post OC	10mg of domperidone Digital recorder attached / CCE swallowed
Small bowel reached	1st booster of 45mls sodium picosulfate Patient can then eat and drink and leave the endoscopy department
3 hours later	2nd booster of sodium picosulfate
Day 2	Return recorder to endoscopy department
Initial protocol	
Day 0	Standard 4L of PEG
Day 1	Incomplete colonoscopy
1 hour post OC	10mg of domperidone Digital recorder attached / CCE swallowed
Small bowel reached	1st booster of 45mls sodium picosulfate Patient can then eat and drink and leave the endoscopy department
3 hours later	2nd booster of sodium picosulfate
Day 2	Return recorder to endoscopy department

Conclusions: Same-day CCE following IC is safe and feasible. Our pilot study shows that additional preparation beyond standard boosters may be required to improve capsule propulsion and CCE completion rates following IC. Larger studies using our modified protocol are warranted to optimise the protocol and to determine the cost-benefit analysis.

ABSTRACT 25 (15S 109) POSTER PRESENTATION

Title of Paper: Refractory Coeliac Disease induced by ipilimumab/nivolumab combination therapy.

Author(s): Grace Harkin, Gregory Leonard*, Valerie Byrnes.

Department(s)/Institution(s): Dept of Gastroenterology, *Dept of Oncology, University College Hospital, Galway, Ireland.

Introduction: Ipilimumab has been reported to cause immune mediated disorders of the GI tract,with reported cases of colitis and a recent case report of new onset coeliac disease following treatment.

Aims/Background: We report the case of a 53y/o male with Stage III metastatic colorectal adenocarnicoma,who at the time of diagnosis had been on a gluten free diet for 2 years with improvements in serum anti-TTG to 400U/ml) and histology.

Method: He underwent surgery and received adjuvant chemotherapy (FOLFOX,and FOLFIRI plus Bevacizumab),which was uneventful.Subsequently he entered a phase 2 clinical trial of Nivolumab 1mg/kg and Ipilimumab 3mg/kg for metastatic disease.After his second dose of chemotherapy he was hospitalised with severe diarrhoea. He settled with oral steroids 1mg/kg.Following further chemotherapy diarrhoea reccurred.He was withdrawn from the study.Stool cultures were negative,anti-TTG titre was 7U/ml,there was no evidence of colitis on colonoscopy,and duodenal biopsy revealed a significant deterioration in the degree of villous atrophy and increase in IELs with preservation of CD8+ cells.Diarrhoea improved with IV steroids but relapsed again when switched to oral prednisone.Despite cessation of chemotherapy,small bowel malabsorption persisted causing weight loss of 14kg over four months.He was commenced on an oral budesonide formulation which allows release in the small bowel with resolution of diarrhoea and weight gain of 7.5kg to date.

Results: To our knowledge,this is the first case of refractory coeliac disease induced by either ipilimumab or novilimumab or their combination.

Conclusions: Given the increasing indications of Ipilimumab as a chemotherapeutic agent,clinicians should be aware of this potential adverse effect in patients with known coeliac disease.

ABSTRACT 26 (15S 118) POSTER PRESENTATION

Title of Paper: Audit of delayed endoscopy access for children in a tertiary centre

Author(s): Fitzgerald M, Mulligan S, Lonsdale U, Hussey S

Department(s)/Institution(s): National Centre for Paediatric Gastroenterology, Hepatology and Nutrition, Our Lady's Hospital for Sick Children, Crumlin, Dublin

Introduction: International best practice advocates that children undergo endoscopy by specialist paediatric endoscopists in a dedicated paediatric facility. Endoscopy waiting times based on clinical rather than national targets are more meaningful.

Aims/Background: To compare actual endoscopy waiting times against hospital benchmark times according to clinical indication over a 2 year period, and to determine whether specific patient groups are at higher risk of delayed diagnosis.

Method: Data was retrospectively collected from booking forms and theatre records in Our Lady's Children's Hospital Crumlin from 01/01/13 to 31/12/14. Data collected included indications for endoscopy, time from booking to procedure, responsible consultant and hospital preference. Data was entered and analysed using Microsoft™ Exel .

Results: Overall, 1114 endoscopies were performed across the study period. 107 cases were excluded due to incomplete data. The principal endoscopy indications were Suspected/Clinically Active IBD (20%), Positive Coeliac Test (15%), Chronic GORD/Eosinophilic Oesophagitis (15%) and Non-Progressive Dysphagia (13%). In total 464 (48%) of endoscopies were performed within the acceptable clinical timeframe. A significant proportion of endoscopies were performed outside of the clinical timeframe in both 2013 (56%) and 2014 (43%). The mean time for those delayed beyond their clinical window was 6weeks 2days. Diagnostic categories affected most by delays included Non-Progressive Dysphagia (81%), Epigastric Pain/PUD (74%), Poorly Controlled GORD (71%), and Positive Coeliac Screen (66%).

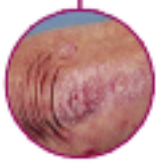
Conclusions: Children with a high pre-test probability of significant GI disease experience excessive delays in diagnostic endoscopy. This constitutes an unsustainable clinical risk. Timely endoscopy access for children must become a clinical priority within tertiary paediatric hospitals.

Trust in HUMIRA

HUMIRA has 11 approved indications[1]

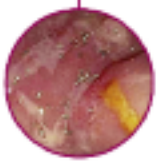
2003
Approved for use in **RA**

2005
Approved for use in **PsA**



2006
Approved for use in **AS**

2007
Approved for use in **CD**



Rheumatoid Arthritis (RA)

HUMIRA in combination with methotrexate, is indicated for:

- the treatment of moderate to severe, active rheumatoid arthritis in adult patients when the response to disease-modifying anti-rheumatic drugs including methotrexate has been inadequate.
- the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with methotrexate.

HUMIRA can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate.

HUMIRA has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function, when given in combination with methotrexate.

Psoriatic Arthritis (PsA)

HUMIRA is indicated for the treatment of active and progressive psoriatic arthritis in adults when the response to previous disease-modifying anti-rheumatic drug therapy has been inadequate. HUMIRA 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)

HUMIRA is indicated for the treatment of adults with severe active ankylosing spondylitis who have had an inadequate response to conventional therapy.

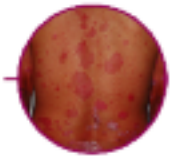
Crohn's Disease (CD)

HUMIRA is indicated for treatment of moderately to severely active Crohn's disease, in adult patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; or who are intolerant to or have medical contraindications for such therapies.

Date of Preparation: April 2015 IREHUM140419a(1)

2008

Approved for use in **Ps**

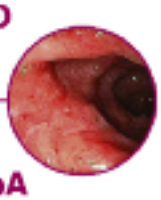


Approved for use in **Polyarticular JIA**

2012

Approved for use in **Paed CD**

Approved for use in **UC**



Approved for use in **nr-axSpA**

2014

Approved for use in **ERA**

2015

Approved for **Paed Ps**

Psoriasis (Ps)

HUMIRA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA.

Polyarticular juvenile idiopathic arthritis

HUMIRA in combination with methotrexate is indicated for the treatment of active polyarticular juvenile idiopathic arthritis, in patients from the age of 2 years who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). HUMIRA can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. HUMIRA has not been studied in patients aged less than 2 years.

Paediatric Crohn's Disease (Paed CD)

HUMIRA is indicated for the treatment of severe active Crohn's disease in paediatric patients (from 6 years of age) who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies.

Paediatric plaque psoriasis (Paed Ps)

Treatment of severe chronic plaque psoriasis in children and adolescents from 4 years of age with an inadequate response to or who are inappropriate candidates for topical therapy and phototherapies.

Ulcerative Colitis (UC)

HUMIRA is indicated for treatment of moderately to severely active ulcerative colitis 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.

Axial Spondyloarthritis Without Radiographic Evidence of AS (nr-axSpA)

HUMIRA is indicated for the treatment of adults with severe axial spondyloarthritis without radiographic evidence of AS but with objective signs of inflammation by elevated CRP and / or MRI, who have had an inadequate response to, or are intolerant to nonsteroidal anti-inflammatory drugs.

Enthesitis-related Arthritis (ERA)

HUMIRA is indicated for the treatment of active enthesitis-related arthritis in patients, 6 years of age and older, who have had an inadequate response to, or who are intolerant of, conventional therapy.

Reference : 1. HUMIRA [summary of product characteristics]. AbbVie Ltd.

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ABSTRACT 27 (15S 120) POSTER PRESENTATION

Title of Paper: Changing surgical trends in the management of Gastric GISTs – a 10 year experience.

Author(s): McIlmunn, C; Clements, J; Carey, D; Kennedy, A; Kennedy, R; Clements, B.

Department(s)/Institution(s): Upper Gastrointestinal Surgical Unit, Belfast City Hospital, BHSCT.

Introduction: Since the term GIST was first coined in 1983, a considerable body of evidence has informed the development of structured 'GIST Guidelines'. Complemented by the advent of Speciality MDTs, GISTs are having specifically targeted multimodal treatment strategies devised.

Aims/Background: A retrospective review was carried out for gastric GISTs examining changing trends with regard to surgical management over a decade in the Belfast Trust.

Method: All GISTs were sourced from the Trust Path records January 2004-April 2015. Primary GISTs arising in other sites, recurrent disease and small incidental GISTs were excluded. A group of 53 primary gastric GISTs were divided into two cohorts [Pre and Post 2012]. Electronic care records were reviewed and pertinent demographics, GIST characteristics, mode of surgical resection, pathological features and oncological input recorded.

Results: There was no sexual preponderance [M28:F25]. The median age at presentation was 65 years [22-89 years]. All surgical resections were R0 [Open 26: Laparoscopic 25: Lap-Open 2]. Pre-2012 [n=33], 33% of resections were carried out laparoscopically compared with 75% post-2012 [n=20]. The mean maximal diameter of GIST carried out laparoscopically and open pre-2012 was 40.8mm and 81.1mm respectively, compared with 53.7mm and 91.4mm post-2012. Six had adjuvant imatinib and three neoadjuvant pre-2012 compared with four adjuvant and one neoadjuvant imatinib post-2012.

Conclusions: These data demonstrate a changing surgical trend in the management of gastric GISTs. Since the advent of the UGI MDT in 2012 there has been a clear move towards laparoscopic resection with 75% of patients having their safe oncological resection carried out laparoscopically.

ABSTRACT 28 (15S 121) POSTER PRESENTATION

Title of Paper: Marsh I and Marsh II Lesions: Marsh (Must) It Be Celiac Disease?

Author(s): Nawawi KN, Affendi NA, Kearney C, Egan BJ, O'Donnell LJ

Department(s)/Institution(s): Gastroenterology & Hepatology Department, Mayo General Hospital Castlebar

Introduction: Modified Marsh Classification is frequently used to describe the histologic findings in celiac disease. While Marsh III lesion is typically considered as classic celiac lesion, Marsh I and II lesions do pose dilemma to the clinicians. This is due to its increasingly common finding, as well as a wide differential diagnosis associated with the lesions.

Background: Aims To determine the frequency of Marsh I and II lesions in celiac disease coded duodenal biopsies, and to look for possible conditions associated with the lesions.

Method: Total of 90 duodenal biopsies over 7 years period were studied retrospectively (histology code: celiac disease), and patients with Marsh I and II lesions were identified. All but two identified patients were interviewed over the phone, and additional clinical information were sought from their clinical records and lab database.

Results: 5 of 90 patients had Marsh I lesion and 6 of 90 patients had Marsh II lesion (total of 11 out of 90 patients; 12.2%). No known drug association was found in those patients.

NUMBER OF PATIENTS	OSSIBLE ASSOCIATION	ANTI tTG LEVEL
3	Seronegative celiac disease or non-celiac gluten sensitivity	<1
2	Gastric Helicobacter pylori infection	<1
2	Irritable Bowel Syndrome	<1
1	Crohn's disease	NA
1	Autoimmune thyroiditis	<1
1	Treated celiac disease (on GFD)	2
1	Unknown	NA

Conclusions: Over 12% of patients with histology suggestive of celiac disease had Marsh I and II lesions.
Awareness of its wide differential diagnosis is very important; since the diagnosis of celiac disease will requires the patients to commit on lifelong gluten restriction and long term follow up.

ABSTRACT 29 (15S 124) POSTER PRESENTATION

Title of Paper: Low Infliximab trough levels are not predictive of disease activity in clinical practice.

Author(s): S Kirthi[2, 1]; B Hall [2, 1]; M Hussey [2, 1]; J Gilmer [3]; J Wang [3]; C Medina [3]; D McNamara, [2,1]

Department(s)/Institution(s): 1. Trinity Academic Gastroenterology Group(TAGG), Dublin, Ireland. 2. Department of Gastroenterology, AMNCH, Tallaght, Dublin 24, Ireland. 3. School of Pharmacy, Trinity College Dublin, Dublin,Ireland

Introduction: Infliximab (IFX), a chimeric monoclonal IgG1 anti-TNFα antibody, has been widely used in patients with moderate to severe Inflammatory Bowel Disease (IBD) to induce and maintain remission. However, approximately 1/3rd of patients experience primary treatment failure, and another 1/3rd later lose response over time.

Aims/Background: We wished to examine the correlation between IFX drug trough levels and clinical activity defined by clinical and biochemical parameters.

Method: Patients currently receiving IFX, between 18 and 80 years were recruited from the IBD service. Physical and clinical parameters including height and weight, Harvey–Bradshaw Index (HBI), Partial Mayo Score(PMS), CRP and additional medication use were recorded. Two serum samples were collected from each

patient ≤ 48 hours prior to the next scheduled IFX dose. Serum trough levels were measured using ELISA method. Primary antibodies (Serotec) to the therapeutic antibody were treated with appropriately diluted serum samples. Captured drug was detected with horse radish peroxidase (HRP) conjugated detection antibody (Serotec). Rabbit anti-mouse polycolonal F(ab') products were used to quantitate captured drug. A drug trough level less than 1μg/mL was considered low. A HBI of >5 and a PMS of > 3 were defined as clinically active disease.

Results: In total, 43 patients have been included; mean age 28 (ranges 18-69). In all, 46% (n=20) were female and 79% (n=34) had CD. The mean height and weight were 171.5 cm and 75.9kg, 23(55%) were overweight BMI > 25 and 8(18.6%) were obese BMI > 30. The mean duration of therapy was 3 years with 23 (53%) on concomitant immunosuppressants. The majority of patients were on 5mg/kg with 4 receiving 10mg/kg. The mean HBI score, PMS and CRP were 4, 1 & 3.3mg/dl (range 1-28) respectively. Overall mean IFX trough level was 3.6μg/ml. In total, 13(30%) had clinically active disease while 8 (18.6%) had low serum trough levels, mean 0.57μg/mL. Of note, weight or dose was not associated with low levels, 2 (50%) of patients on 10mg/kg versus 6 (18%) on the 5mg/kg and 0 obese, 3 (38%) overweight versus 5(63%) normal BMI. A low trough level was not associated with biochemical activity (CRP 2.8 vs 3.3).While, 4 (50%) had clinically active disease in the low trough versus 9(26%) in the normal trough group. This difference did not reach statistical significance, OR 3.3, P=0.08.

Conclusions: 72% of patients had normal trough IFX levels. In our cohort a single point low serum trough level does not appear to be clinically relevant. However, further follow up of this cohort may demonstrate a correlation with disease outcomes.

ABSTRACT 30 (15S 126) POSTER PRESENTATION

Title of Paper: Anti-TNF antibody induced psoriasiform skin lesions in patients with Inflammatory Bowel Disease; an Irish cohort study.

Author(s): S Kirthi [1,2], M Hussey[1], M Pistone[1], AM Tobin[1,2], D McNamara[1]

Department(s)/Institution(s): 1. Trinity Academic Gastroenterology Group(TAGG), Dublin, Ireland. 2. Dept of Gastroenterology, AMNCH, 3. Dept of Dermatology, AMNCH

Introduction: TNF-α inhibitors have been widely used for the treatment of Inflammatory Bowel Disease (IBD). Studies have suggested an association between anti-TNFα and reactive psoriasis. This association appears paradoxical as TNF is a pivotal molecule in the pathophysiology of psoriatic skin lesions and anti-TNFα agents have been approved for treatment of psoriasis.

Aims/Background: To determine the prevalence of psoriasis in an IBD cohort with reference to clinical characteristics and anti-TNFα use.

Method: A retrospective cohort study design. Patients with a diagnosis of psoriasis and IBD were identified from a database at Tallaght Hospital from 2000 to 2015. Demographic and clinical data were recorded including diagnosis, age, gender, smoking status, anti-TNF-α therapy. Prevalence rates of concomitant and reactive psoriasis were calculated and compared using a students T-test. A p value of <0.05 was considered significant.

Results: In total, 1384 IBD patients were identified ; female 49%(n=682), ever smoked 19% (n=261), 30%(n=403) anti-TNF ? therapy, 59%(n=237) and 41%(n=166) on Infliximab and Adalimumab respectively, 35%(n= 483)had Ulcerative Colitis(UC) and 65% had (n=901) with Crohn's disease(CD). A higher number, 21%(n=189) of the CD group smoked compared to 15%(n=72) in the UC cohort, p=0.0001, 95% CI 0.15-0.21. The overall prevalence rate of IBD and psoriasis was 2.4% (n=33). Of the 33 patients with psoriasis, mean age 46 years (range 18-66), 24% (n=8) had reactive psoriasis, ie. psoriasiform lesions occurring after commencement anti-TNF? therapy. The prevalence rate of psoriasis in the non-biologic and biologic cohort were similar 2.5% (25 of 981) and 2% (8 of 403) respectively. Overall, psoriasis occurred more frequently in patients with UC (5.2%), Odds Ratio (OR)=6, p<0.001, 95% CI=2.72-13.61. However, subjects with CD were more likely to develop reactive psoriasis, OR=34.5, p=0.0013, 95% CI 3.99-297.99. Of note, there was a trend towards higher rates of reactive psoriasis in Adalimumab users which was 3.6% (6 of 166) vs. 0.8% (2 of 237), OR=4.4 (P=0.07). However, overall relatively more CD patients, 44% vs. 31% with UC were prescribed Adalimumab, p=0.02, 95% CI 0.02-0.25. In addition, in our cohort, smoking was not associated with any form of psoriasis in IBD, OR=1.39, p=0.06.

Conclusions: In our large study, the prevalence rate of reactive psoriasis was similar to the background rate of psoriasis in the overall IBD cohort (2.0% vs 2.4%). However, our overall rate of reactive psoriasis was lower than previously reported (5%) 1 and could reflect the retrospective study design. Although it remains a possibility, especially as both are autoimmune TNFα mediated diseases, that our findings reflect the natural history of the two diseases. A 2% prevalence rate represents a common adverse event that clinicians should be aware of and our data suggests an increased rate of CD in particular which may reflect smoking status in this group.There is an increasing awareness of the phenomenon of reactive psoriasis in patients with biologics. However, further work to better elucidate the pathophysiology is required.

ABSTRACT 31 (15S 127) POSTER PRESENTATION

Title of Paper: An Audit of Bowel Preparation for Endoscopy in a large Tertiary Hospital Endoscopy Unit

Author(s): John O'Grady, Orla Crosbie

Department(s)/Institution(s): Cork University Hospital

Introduction: The authors sought to audit current bowel preparation use and success rates in our endoscopy unit and compare this to available data and standards. A review of the different types of bowel preparation available for clinical use was also carried out.

Aims/Background: To determine to success rate of bowel preparation in our endoscopy unit for colonoscopy as well as the pattern of use of various bowel preparations.
To evaluate which factors, if any, predict better bowel clearance for colonoscopy.

Method: Analysis of the one hundred most recent colonoscopies, from February 2015, was performed. All colonoscopy procedures were deemed suitable for inclusion in this audit regardless of indication, outcome or performing endoscopist.

Results: There were forty nine (49) females and fifty one (51) males. Ninety (90) patients were prepped with Moviprep, six (6) with a combination of Picolax and Kleanprep and four (4) with Picolax alone. Of those who were successful the majority used Moviprep. There were twelve (12) failed clearances. Of these, seven (7) were over 60 years of age. 14% of inpatient preparations failed compared with 11% of outpatients.

Conclusions: Our unit uses PEG containing preparations more so than other available preparations. This is consistent with current guidelines and recommendations.

This audit shows that bowel preparation is least successful in inpatients, male patients and those over sixty years of age. This is consistent with the available literature and provides targets to improve colonoscopy success rates.

ABSTRACT 32 (15S 128) POSTER PRESENTATION

Title of Paper: Correlation between the liver function tests checked at one year post liver transplantation and the survival of the patients

Author(s): Dr.Elgail Elrayah, Prof.Aiden McCormick

Department(s)/Institution(s): Liver Unit , St Vincent's University Hospital, Dublin, Ireland

Introduction: Liver transplantation is an attractive option for the treatment of appropriately selected patients with end stage liver disease. Continuous follow up and monitoring of LFTs is required in the post-transplant period. Late complications of liver transplantation, may cause abnormal LFTs, and contributes to decreased patients and graft survival.

Aims/Background: To study the correlation between the LFTs checked one year after the liver transplantation and the survival of the patients.

Method: retrospective study involves 219 patients who had a liver transplant in the period between 01/01/2006 - 31/12/2009, data collected from the medical and laboratory records.LFTs one year after the liver transplant was recorded, patients categorised into those with Normal LFTs, and those with abnormal LFTs . Death reported from the time of the OLT, survival followed up to 31/12/2014. Correlation between LFTs and the survival of the patients was estimated using the Fischer Exact test,

Results: 141 patients had abnormal LFTs at one year, 37 patients died within more than a year, Of whom 33 patients had abnormal LFTs at one year time, post hepatitis C cirrhosis is the common indication for transplant in this group, with recurrence of malignancy being the common cause of death, in comparison to patient with normal LFTs at one year, only 4 patients died within more than a year (p0.02)

Conclusions: Liver transplant Patients with abnormal LFTs at one year , have less survival than those with normal LFTs. Close follow up of patients with abnormal LFTs at one year is required.

ABSTRACT 33 (15S 129) POSTER PRESENTATION

Title of Paper: Lymph node yield from pancreatico-duodenectomy (Whipple's) specimens; a three year audit assessing the impact of neo-adjuvant therapy.

Author(s): Di-Capua DM, Murphy J, Geoghegan J, Maguire D, Hoti E, Conlon K, Sheahan K, Swan N.

Department(s)/Institution(s): St. Vincent's University Hospital

Introduction: Pancreaticoduodenectomy (PD) is the primary surgical treatment for neoplastic diseases of the pancreas, ampulla and distal biliary tract. Pathological examination of the PD surgical specimen including lymph node dissection (LND) is essential for accurate diagnosis and staging of tumours. A LND yield of ≥10 in PD specimens is one of the key performance indicators (KPI) set by the National Cancer Control

Aims/Background: Our primary aim was to determine if LND in PD specimens in our laboratory has met the NCCP KPI. Secondarily, we assessed the effect of pre-operative neo-adjuvant therapy on LND yield.

Method: All PD specimens at St. Vincent's University Hospital (SVUH) between 2012 and 2014 were retrieved via a SNOMED search of the laboratory information system (n=190). Pathology reports were reviewed to obtain the LND yield and neo-adjuvant chemotherapy status of the patient. Mean, median, and percent of cases that met the KPI were obtained. Data was also stratified yearly to track trends.

Results: The median and mean LND yield for all PD specimens was 12 and 13 with 76% of neoplastic cases achieving a LND yield ≥ 10. The mean LND yield increased from 12.8 to 13.2 over the three year period. Neo-adjuvant cases (n = 16) had a mean and median LND yield of 11.8 and 11 with 56% achieving a LN yield ≥ 10.

Conclusions: Adequate LND in PD specimens is being achieved in the majority of cases with an improvement over time but with a negative impact of neo-adjuvant therapy identified.

ABSTRACT 34 (15S 132) POSTER PRESENTATION

Title of Paper: Correlation between Radiological findings and Double Balloon Enteroscopy

Author(s): M Hussey, G Holleran, B Hall, R Lean, D McNamara.
Dept(s)/Inst(s):Academic Gastroenterology Group, Department of Clinical Medicine, TCD

Introduction: Direct visualisation of small bowel mucosa has become possible due to both Video-Capsule Endoscopy (VCE) and Double Balloon Enteroscopy (DBE), with DBE providing an additional benefit of histopathological tissue analysis as well as therapeutic intervention. Indications for Double Balloon Enteroscopy vary but can include suspected small bowel pathology based on abnormal imaging reports. With the advent of radiological techniques over the years, radiologically suspected small bowel pathology has become more frequent.

Aims/Background: To determine the correlation between abnormalities detected on radiological small bowel imaging and actual DBE and histopathological findings.

Method: A retrospective review of the endoscopic data base was conducted at Tallaght Hospital. All Double Balloon Enteroscopies performed from 2012 to 2014 were identified. Cases where an abnormal radiological finding was reported as an indication were included. Patient demographics ,endoscopic, histological and initial radiological findings were all recorded. Prior Video Capsule Endoscopy results were also noted if applicable. Endoscopic and histological results were correlated with findings suggested from small bowel radiological imaging.

Results: Overall 190 DBEs were performed. In all, 21% (n=39) of DBEs were indicated for the further investigation of abnormal imaging, the remaining indications for DBE were as follows; 51% (n=97) for OGIB, 6% (n=12) suspected Crohn's Disease, 12% (n=24) other enteropathies, , 6% (n=11) unexplained GI symptoms, 2% (n=4) polyposis syndromes, 2% (n=3) malignancy follow-up. Of the 39 patients with suspicious imaging, 56% (n=22) were females and the mean age was 49 years (range 20-80yrs). In total, 74% (n=29) of the DBE performed for this indication, were anterograde procedures. The mean depth of insertion was 2.5m (range 0.7-3.2m) and the average sedation required was 10mg of midazolam and 100mcg of fentanyl. The small bowel imaging types were; CT Abdomen/Pelvis 74% (n=29), MR Enterography 15% (n=6), Small Bowel Follow Through 8% (n=3), Barium Enema (BE) 3% (n=1). The small bowel radiological findings were as follows; small bowel thickening 41% (n=16), inflammation 21% (n=8), small bowel lesion 10% (n=4), stricture 10 %(n=4), polyps 10% (n=4), intussception 8% (n=3). There was a high false positive rate observed for radiological investigations with only 49% (n=19) of DBEs performed showing positive results and 58% (n=11) of biopsies confirming radiological findings. Correlation was therefore deemed to be only moderate with a κ of 0.51, 95% CI 0.35-0.68. On subgroup analysis positive DBE findings were correlated in only 52% (n=15) of the reported abnormal CTs, 33% (n=2) of MREs, 33%(n=1) of SBFT. Expectantly correlation was greatest between MRE and SBFT and DBE compared with CT. Table 1. The strongest correlation was observed in those with suspected polyps (n=3,75%) and suspected strictures (n=3, 75%). Interestingly only 2 patients with abnormal imaging underwent CE prior to DBE and findings were positive in 1 of these. The effect of interval between tests on correlation may account for some of these findings.

Table 1. Correlation between Imaging and DBE/Histological findings

	DBE positive	DBE negative	Histology positive	Histology negative	Kappa Value	95% CI
Overall	19(49%)	20(51)	11(58%)	8(42%)	0.51	0.35-0.68
CTAP (n=29)(74%)	15(52%)	14(48%)	9(31%)	20(69%)	0.52	0.32-0.71
MRE (n=6)(15%)	2(33%)	4(67%)	1(17%)	5(83%)	0.67	0.28-1.00
SBFT (n=3) (8%)	1(33%)	2(67%)	1(33%)	2(67%)	0.67	0.10-1.0
BE (n=1) (3%)	1(100%)	0	1(100%)	1(100%)		

CTA/P (CT abdomen/Pelvis, MRE (MR Enterography),SBFT (Small bowel follow through),BE (Barium Enema)

Conclusions: Double Balloon Enteroscopy is an extremely useful diagnostic and therapeutic tool for suspected small bowel pathology, however it can be invasive and time consuming. Clinicians should be aware of the potential for false positive findings based on Radiological Imaging and where possible small bowel CE should be utilised prior to proceeding to DBE.

ABSTRACT 35 (15S 133) POSTER PRESENTATION

Title of Paper: Comparison of non-invasive tests; Stool HpSA Elisa and C13Urea breath test in the diagnosis of Helicobacter pylori infection in a low prevalence cohort.

Author(s): Omorogbe J, Brennan D, Smith S, Alsaffar M, Mcnamara D

Department(s)/Institution(s): Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin.

Introduction: Non-invasive testing for H. pylori infection has allowed for cost effective and safer ways to diagnose infection in both primary care and hospital settings. The reduced prevalence of H. pylori infection in the Irish population in keeping with other developed nations, can negatively impact on the diagnostic accuracy of a given test. Frequent evaluation and comparison of commercially available tests has been recommended and should be performed to ensure that the most sensitive and specific are used in clinical practice.

Background: Non-invasive testing for H. pylori infection has allowed for cost effective and safer ways to diagnose infection in both primary care and hospital settings. The reduced prevalence of H. pylori infection in the Irish population in keeping with other developed nations, can negatively impact on the diagnostic accuracy of a given test. Frequent evaluation and comparison of commercially available tests has been recommended and should be performed to ensure that the most sensitive and specific are used in clinical practice.

Aims: To evaluate and compare two non-invasive H. pylori tests; premier platinum HpSA and C13UBT in an Irish cohort.

Method: Adult patients referred for a C13UBT at the Adelaide and Meath Hospital were prospectively recruited. Patients on recent antibiotics, regular PPI or who had previously received a course of eradication therapy were excluded. Following informed consent patients were asked to collect and bring in a stool sample on the day of their C13UBT testing. HpSA ELISA testing was carried out in accordance with manufacturer's instructions (Meridian Biosciences, Germany). An absorbance cut off of ≥0.140 (at 450nm) was considered positive. C13 UBT was considered as the gold standard and a delta value of ≥4% was deemed positive.

Results: To date 124 patients mean age 41 years, male gender 87(30%) have been recruited. In all 45(36%) percent where H.pylori positive on C13UBT . Overall the performance of HpSA was disappointing with only 29(23%) positive tests. In all there were 17 false negative and 1 false positive HpSA test. As such the sensitivity, specificity, positive and negative predictive values for HpSA compared with C13UBT were 62%, 99%, 97% and 82% respectively. Overall correlation between these two non-invasive tests was poor κ 0.13, 95% CI 0.016 – 0.242. The low sensitivity may reflect specific collection and storage requirements which are a common problem for many faecal tests.

Conclusions: HpSA performance in this study does not meet international guidelines for a diagnostic test for H.pylori infection and cannot be recommended for regular clinical use. The accuracy of UBT appears to be less affected by the relatively low prevalence of H.pylori infection in our community, however formal comparison with invasive modalities should be undertaken to assess its accuracy. C13UBT testing continues to remain the first line non-invasive diagnostic tool in detection of H.pylori infection.

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REFER TO THE SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) BEFORE PRESCRIBING

Presentation: A box containing two transparent bags, each containing two separate sachets, A and B. Sachet A contains macrogol 3350 100g; sodium sulphate anhydrous 7.5g; sodium chloride 2.691g and potassium chloride 1.015g as white to yellow powder. Sachet B contains ascorbic acid 4.7g and sodium ascorbate 5.9g as white to light brown powder. MOVIPREP also contains aspartame (E951), acesulfame potassium (E950) and a lemon or orange flavour. **Uses:** Bowel cleansing prior to any clinical procedure requiring a clean bowel. **Dosage and administration:** *Adults and elderly:* A course of treatment consists of two litres of MOVIPREP. A further litre of clear fluid is recommended during the course of treatment. A litre of MOVIPREP consists of one Sachet A and one Sachet B dissolved in water. This reconstituted solution should be drunk over a period of one to two hours. This should be repeated with a second litre of MOVIPREP. The two litres of MOVIPREP may be consumed either as a divided dose, 1L the evening before the procedure and 1L in the early morning of the procedure, or as a single dose the evening before the procedure. There should be at least one hour between the end of intake and the start of the procedure. No solid food should be taken from the start of the treatment and until after the procedure. *Children:* Not recommended in children below 18 years of age. **Contraindications, warnings etc:** Contra-indications: Known or suspected gastrointestinal obstruction or perforation; disorders of gastric emptying, ileus; phenylketonuria; glucose-6-phosphodehydrogenase deficiency; toxic megacolon complicating severe inflammatory conditions of the GI tract or hypersensitivity to any of the ingredients. Do not use in unconscious patients. Warnings: Diarrhoea is an expected effect. Administer with caution in fragile patients in poor health or serious clinical impairment such as severe renal insufficiency, cardiac impairment (NYHA grade III or IV), severe acute inflammatory disease or dehydration and those with an impaired gag reflex or impaired consciousness. Dehydration, if present, should be corrected before using MOVIPREP. Patients prone to aspiration should be closely monitored during administration, particularly if this is via a naso-gastric tube. If symptoms indicating shifts of fluid or electrolytes occur, plasma electrolytes should be measured and any abnormality treated appropriately. In decilitated fragile patients, patients with poor health, those with clinically significant renal impairment and those at risk of electrolyte imbalance, the physician should consider performing baseline and post-treatment electrolyte and renal function test. If patients experience symptoms which make it difficult to continue the preparation, they may slow down or temporarily stop consuming the solution and should consult their doctor. MOVIPREP containing orange flavour is not recommended for patients with glucose and galactose malabsorption. **Interactions:** Oral medication should not be taken within one hour of administration as it may be flushed from the GI tract and not absorbed. **Pregnancy and lactation:** There is no experience of use in pregnancy or lactation so it should only be used if judged essential by the physician. **Side effects:** Very common or common: abdominal pain, nausea, abdominal distension, anal discomfort, malaise, vomiting, dyspepsia, hunger, thirst, sleep disorder, headache, dizziness, and rigors. Uncommon or unknown: Dysphagia, discomfort, abnormal liver function tests, allergic reactions including rash, urticaria, angioedema and anaphylaxis, electrolyte disturbances which are more common in patients taking concomitant medication affecting the kidneys, convulsions associated with severe hyponatraemia, transient increase in blood pressure, flatulence and retching. Refer to the Summary of Product Characteristics (SmPC) for full list and frequency of adverse events. **Overdose:** In case of gross accidental overdosage, conservative measures are usually sufficient. In the rare event of severe metabolic derangement, intravenous rehydration may be used. **Pharmaceutical Particulars:** *Sachets:* Store in the original package below 25°C. Reconstituted solution: Keep covered. May be stored for up to 24 hours below 25oC or in a refrigerator. **Legal Category:** UK – Pharmacy only, Ireland - Prescription medicine. **Packs:** One pack of MOVIPREP or MOVIPREP Orange contains a single treatment. **Basic NHS Price:** UK £8.87, Ireland €13.26 **Marketing Authorisation Number:** UK: PL 20142/0006 (MOVIPREP), PL 20011/0006 (MOVIPREP Orange), IE: PA 1336/1/1(MOVIPREP), PA 1336/1/2 (MOVIPREP Orange). **For further information contact:** Norgine Pharmaceuticals Ltd, Moorhall Road, Harefield, Middlesex, UB9 6NS. Tel: 01895 826606. E-mail: medinfo@norgine.com MOVIPREP® is a registered trademark of the NORGINE group of companies. Date of preparation/revision: MP/3201/DEC/12.

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 Informationat Norgine Pharmaceuticals Ltd on 01895 826 606.

Ireland

Adverse events should be reported to Medical Information at Norgine Pharmaceuticals Ltd on +44 1895 826606.

References:

1. Worthington J et al. Curr Med Res Opin 2008;24(2):481–488.
2. Sloan A et al. Aliment Pharmacol Ther 2006;24:1631–42.
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Date of preparation: May 2014.

NORGINE

UKMP0514/0008

ABSTRACT 36 (15S 134) POSTER PRESENTATION

Title of Paper: The use of capsule endoscopy in the investigation of iron deficiency anaemia: young vs old

Author(s): M Hussey, G Holleran, E Hausen, G Shrestha,S Hearne, D Yusuf,D McNamara

Department(s)/Institution(s): Trinity Academic Gastroenterology Group, Department of Clinical Medicine, Trinity College Dublin

Introduction: The BSG has recommended Capsule endoscopy (CE) as the first second-line investigation for iron deficiency anaemia (IDA) in patients over 50 years of age, due to the higher prevalence of pathology in older patients. There are currently no guidelines on the use of CE for IDA in younger patients, however; recent small case series have reported high rates of small bowel malignancies in these patients. To date there have been no comparative studies looking at the diagnostic yield (DY) and clinical relevance in each age group, which would helpful to guide clinical practice.

Aims/Background: To compare the diagnostic yield and clinical relevance in younger and older patients undergoing CE for the investigation of IDA.

Method: A retrospective cross sectional observational study employing the CE database at Tallaght Hospital from 2011 was undertaken. Anaemia was defined as either a low haemoglobin (Hb)(?13g/dl for males, 12g/dl for females) or a low ferritin(?15 ng/ml) . Patients with obscure overt bleeding or any other indication for CE were excluded. All patients had undergone full investigation for IDA prior to VCE including upper and lower endoscopy, coeliac serology and a haematological work up. A chart review of identified patients was undertaken and patient demographics, Hb levels and CE findings were recorded. Patients were categorized according to age, with the younger group defined as <50 years. Diagnostic yield was calculated and compared between the two groups using a student's t-test with a p value of <0.05 considered significant.

Results: In all 271 patients with IDA as an indication for CE were identified. A total of 67 (25%) were excluded , 8 with a known significant GI comorbidity, the remaining 59 due to the unavailability of recent haematological values. Of the remaining 204, 79 (39%) were <50yrs. The mean age of the overall group was 66 years (17-102 yrs) and 49% (n=100) were female. Of note however there were significantly more women in the younger age group compared with the older group (61%, n=48 vs 42%, n= 52, p=0.008) Overall there was no significant difference in the DY between the two age groups (51.9% vs 53.6%). There were however differences in the positive findings between the two groups, with angiodysplasias more common in the >50 group (30% vs 12% p=0.04), and small bowel tumours more common in the <50 group (17% vs 3% p=0.01). Of the 7 younger patients with small bowel tumours, gender and Hb level were not predictive clinical factors.

Table 1: Demographics and CE findings

	<50 years n=79	>50 years n=125	P value
Mean age	42	67	
Gender Female	61% (n=48)	42% (n=52)	**0.008 (95% CI 0.05-0.33)**
Pre-CE Hb level (g/dL)	9.6 5.7-12.2	10.5 6.2-12.9	0.1
CE completion rate	95% (n=74)	87% (n=109)	0.07
Diagnostic yield (DY)	51.9% (n=41)	53.6% (n=58)	0.8
Positive findings: Inflammation Angiodysplasia Small bowel tumour Active bleeding ? cause	 69% (n=28) 12% (n=5) 17% (n=7) 6% (n=4)	 61% (n=41) 30% (n=20) 3% (n=2) 2% (n=1)	 0.7 **0.04 (95% CI -0.19- -0.0)** **0.01 (95% CI 0.01-0.13)** 0.4

Conclusions: Our study suggests CE us a useful investigation for IDA irrespective of age group or gender. Although we have not identified any predictive clinical factors, clinicians should be aware of the potential for sinister findings in young anaemic patients.

ABSTRACT 37 (15S 138) POSTER PRESENTATION

Title of Paper: Fibroscan and Non-Alcoholic Fatty Liver Disease: A Biopsy is Still Required to Confirm Cirrhosis

Author(s): Matthew McKenna-Barry, Audrey Dillon, Stephen Stewart

Department(s)/Institution(s): Centre for Liver Disease, Mater Misericordiae University Hospital, Dublin 7

Introduction: Transient elastography (TE) measurement of liver stiffness has allowed for non-invasive assessment of fibrosis in Non Alcoholic Fatty Liver Disease (NAFLD). Biopsy is now not routinely performed with a low score as the negative predictive value for advanced fibrosis is very high. However, steatosis and inflammation effect liver stiffness.

Aims/Background: The aim was to determine the accuracy of TE in the patients that we are currently biopsying.

Method: All patients who had undergone a successful Fibroscan examination for NAFLD from 2008 to 2013 were identified from the machine's database and cross referenced with all patients who underwent liver biopsy in the same period. Patient's electronic records were accessed for demographic and clinical details.

Results: Complete datasets were obtained on 25 patients (68% male, age mean 49.5 years, median 52 years). 44% had a diagnosis of diabetes mellitus and 36% had diagnosis of hypertension. Table 1 shows fibrosis stage based on TE or on biopsy. No patient had a higher fibrosis stage on biopsy than TE. Only 9 patients had advanced fibrosis (F3-F4) on biopsy of the 24 predicted by TE. Similarly, only 6 patients had cirrhosis (F4) of the 18 predicted by TE. The Positive Predictive Value for TE in diagnosing cirrhosis is low at 33%.

Fibrosis Stage	Transient Elastography		Biopsy	
	N	%	N	%
0	1	4	7	28
1			6	24
2			3	12
3	6	24	3	12
4	18	72	6	24

Table 1 Fibrosis Stage Using Transient Elastography and Biopsy. 7 (28%) of patients had equivalent TE and Biopsy stages.

Conclusions: In this retrospective group of patients, who had liver biopsies performed to stage NAFLD following TE, TE overestimates advanced fibrosis and poorly correlates to biopsy. Given the lifelong requirements for surveillance, and a biopsy is still required to confirm cirrhosis in NAFLD.

ABSTRACT 38 (15S 139) POSTER PRESENTATION

Title of Paper: Impact of Minimum per Unit Pricing of Alcohol on Heavy Drinkers Presenting with Alcohol Related Health Problems and Medical Students

Author(s): Audrey Dillon, Sean Fennessy, Matthew McKenna-Barry, Des O'Neill, Stephen Stewart

Department(s)/Institution(s): Centre for Liver Disease, Mater Misericordiae University Hospital, Dublin 7

Introduction: Minimum per Unit Pricing (MUP) is a proven public health mechanism for reducing alcohol consumption, particularly amongst the heaviest drinkers.

Aims/Background: The aim of this study was to examine the effect of the proposed introduction of MUP in Ireland on patients who present to our service with alcohol related problems.

Method: Patients who presented with alcohol related medical problems were interviewed about their most recent typical week of drinking. A group of medical students were also surveyed.

Results: 50 patients were interviewed. The average alcohol intake was 154 units per week (range 50 – 900 units). The majority of patients drank alcohol purchased off licence (80%). The mean percentage spend on alcohol was 46% of weekly income (range 2-90%). 54% described themselves as an alcoholic with 56% having experienced withdrawal symptoms in the past.
The overall mean price per unit spent was €1.34 (range €0.29 - 4). A significant proportion of patients would be affected by the introduction of a MUP policy as illustrated in Figure 1, with 38% spending less than 90c, and 52% spending less than 110c.
35 medical students were surveyed and had a mean intake of 19 units/week (range 2 – 40). The mean price per unit was €1.28 (range 0.5 – 4.50). 42% of medical students spend 90c or less on their main alcoholic beverage.

Impact of Minimum per Unit Pricing of Alcohol on Heavy Drinkers Presenting with Alcohol Related Health Problems and Medical Students

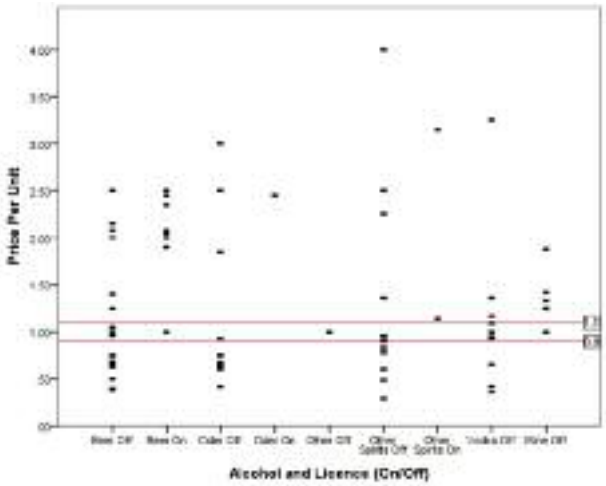


Figure 1 Price Per Unit spent on Type of Alcohol and Where Purchased (On-Off Licence). Approximately half spend less than the proposed MUP (90c to 110c).

Conclusions: A minimum unit pricing policy would significantly impact on medical students and hazardous drinkers. It should therefore impact on their alcohol consumption.

ABSTRACT 39 (15S 141) POSTER PRESENTATION

Title of Paper: Impairment of Thrombin Generation in Compensated Cirrhosis

Author(s): Audrey Dillon1, Karl Egan2, Zita Galvin1, Barry Kevane2,3, Elaine Neary2,4, Stephen Stewart1, Fionnuala Ni Ainle2,3.

Department(s)/Institution(s): 1. Liver Centre, Mater Hospital, Dublin, Ireland 2. School of Medicine and Medical Sciences, University College Dublin, Ireland. 3. Department of Haematology, Mater Hospital, Dublin, Ireland 4. Depa

Introduction: Decompensated cirrhosis is associated with coagulation abnormalities that increase the risk of thrombosis and bleeding, it is unclear if or when coagulation abnormalities appear in early cirrhosis. Transient elastography using FibroScan™ generates a liver stiffness measurement (LSM) that associates with portal hypertension and clinical outcomes.

Aims/Background: To measure and compare thrombin generation with the severity of liver disease in patients with compensated cirrhotic liver disease of mixed aetiology.

Method: Compensated cirrhotic patients underwent Fibroscan examination and same day plasma collection. Thrombin generation was measured using a Fluoroskan Ascent plate reader with Thrombinoscope software. Full blood count, albumin/bilirubin levels, prothrombin time, and disease staging were assessed.

Results: Thrombin generation was compared between patients with a LSM below and above 35kPa (16±1 ,n=47 vs. 53±5, n=10). There was no significant difference between the groups in any other parameter of liver function. Despite comparable prothrombin times (35kPa;12±1 sec), thrombin generation was impaired in patients with a stiffness score >35kPa. There was a decrease in peak thrombin generation (194±9nM vs. 133±18nM, $p<0.05$).

Conclusions: In a cohort of well compensated cirrhotic patients of mixed aetiology, thrombin generation is impaired as liver disease progresses and before any change in PT. This may act as a marker of future decompensation or serve as a future therapeutic target.

ABSTRACT 40 (15S 142) POSTER PRESENTATION

Title of Paper: In-Patient Variceal Bleeding Carries a Higher Mortality Rate than Outpatient Presentation: Time for More Aggressive Management in Cirrhotic In-Patients?

Author(s): Sean Fennessy, Audrey Dillon, Stephen Stewart

Department(s)/Institution(s): Centre for Liver Disease, Mater Misericordiae University Hospital, Dublin 7

Introduction: Variceal bleeding has a reported in hospital mortality of 10-15%. It is not known if developing a variceal bleed while an in-patient increases mortality in comparison to presenting with a variceal bleed.

Aims/Background: The aim was to determine if there is a mortality difference between presenting with, or developing an in-patient variceal bleed.

Method: A retrospective chart review was performed on all patients admitted with an acute variceal bleed between 2003 and 2013 admitted to our institution.

Results: 98 patients, with 116 acute variceal bleeding episodes were included (median age 52.5 years, range 24-87). 65% (76) patients were known to have cirrhosis at presentation, with 60% of these known to have varices. Of those with known varices, only 23% were on beta-blocker therapy on admission. 106 (91%) presented with a variceal bleed and only 10 (9%) patients developed a variceal bleed while an in-patient.

Total in-patient mortality was 19% and 3 month mortality was 26%. There was a significant difference in in-hospital mortality between those who presented with a variceal bleed and those who developed a bleed during admission (16% vs 50%, p=0.009).

Conclusions: When variceal bleeding develops in in-patients, they have a higher mortality. There is a need to improve recognition of high risk in-patients and to develop more aggressive portal hypertension management with beta-blockers and should perhaps be considered for primary endoscopic variceal ligation or early TIPS insertion.

ABSTRACT 41 (15S 144) POSTER PRESENTATION

Title of Paper: Audit of patient satisfaction in the endoscopy unit and day ward of St Luke's Hospital
Kilkenny.

Author(s): Grace Chan, Jun Liong Chin, Fatima Azad, Osama Hamid, Aman Afridi, Mary Hackett Brennan, Genevieve Corrigan, Mary O'Sullivan, Abdur Rahman Aftab, Garry Courtney.

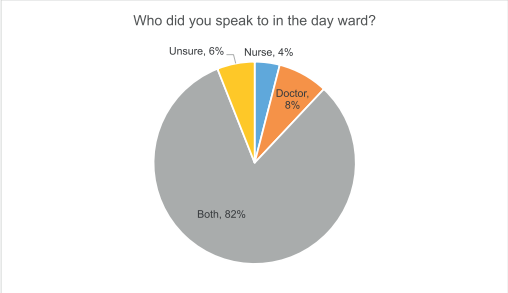
Department(s)/Institution(s): Gastroenterology Department, St Luke's General Hospital, Kilkenny.

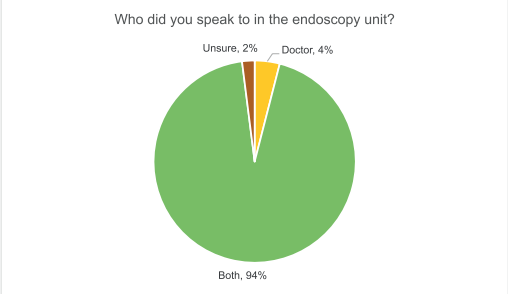
Introduction: The quality assurance programme in endoscopy attempts to ensure the provision of a high quality, timely and accurate service which results in improved patient experience. Patient satisfaction surveys help record the realization of this goal and allows for ongoing improvement in service provision.

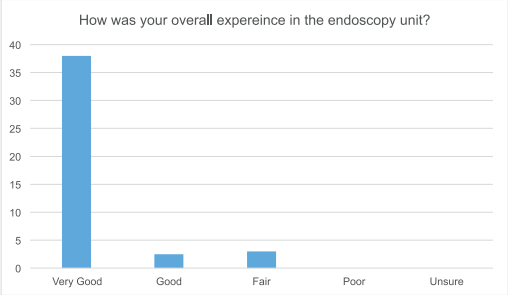
Aims/Background: To evaluate patient satisfaction following endoscopy in our centre.

Method: Patient satisfaction questionnaires were handed out to 97 randomly selected patients undergoing endoscopy between 30th September 2014 and 18th November 2014. The 21-item Patient Satisfaction Questionnaire was based on previously validated modified Group Health Association of America-9 (mGHAA=9) questionnaire which was further expanded to meet the quality review purpose.

Results: 52(53.6%) questionnaires were returned. Mean age was 49.9 ± 14.9 years. 19 underwent OGDs, 1 had a sigmoidoscopy, 25 had colonoscopies, 6 had both OGDs and colonoscopies and 1 underwent a proctoscopy. Of these, 48(92.3%) patients could correctly identify the procedure they underwent. With regards to communication, 51(98.1%) patients received a procedure leaflet and 49(94.2%) thought the information provided was clear and easy to understand. 47(90.4%) patients were able to consent for their procedures on the ward before their procedure rather than in the endoscopy unit. All patients felt that the procedure was adequately explained to them. All patients undergoing OGDs and sigmoidoscopies were aware of the possibility of undergoing their procedure without sedation. 81.1% and 94.2% of patients had the opportunity to speak to a doctor and nurse in the day ward and endoscopy unit respectively. With regards to comfort, 41(80.8%) patients felt that their experience was acceptable and only 2(3.8%) patients classified their experience as being very difficult. Post procedure, the majority of patients (94.2%) felt that the results were adequately explained to them and almost all patients (98.1%) felt that they were treated politely and with dignity. With regards to overall endoscopic experience, 48(92.3%) patients had good/very good overall experience on the day ward and 38(71.7%) patients had a similar experience in the endoscopy unit. Only 9.6% patients felt that their experience could have been improved and importantly, almost all (96.2%) patients felt that their concerns were taken into consideration. One of the main negative feedbacks (19.2%) was due to the long wait for a bed prior to procedure, likely due to lack of protected endoscopy day beds.







Conclusions: Patients are generally very satisfied with their endoscopic experience. There was great patient satisfaction with regards to communication, comfort and discharge process. However this did not appear to translate into a better overall experience for patients, presumably due to the long delays in obtaining a bed. With the new endoscopy unit and day ward due to open in the third quarter of 2015, it is expected that this delay will be avoided due to protected day procedure beds.

ABSTRACT 42 (15S 146) POSTER PRESENTATION

Title of Paper: Should money follow the patient? Nationwide audit of Gastroenterology Outpatient activity

Author(s): Iqbal N, Kale V, Anwar A, Murray FE, Patchett S, Harewood G.

Department(s)/Institution(s): Department of gastroenterology & hepatology Beaumont hospital, Dublin.

Introduction: Out-patient waiting time is a significant factor in determining patient satisfaction. Increasing patient demand and limited resources have led to long waiting times for gastroenterology clinics in many Irish hospitals.

Aims/Background: This study aimed to characterise the demand and activity levels among gastroenterology outpatient departments in Irish hospitals. Specifically, we reviewed the variation in activity, including new : return (N:R) patient ratios, non-attendance rates, among major Irish hospitals.

ABBREVIATED PRESCRIBING INFORMATION

INDICATIONS

Ulcerative Colitis

Entyvio is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis 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.

Crohn's Disease

Entyvio is indicated for the treatment of adult patients with moderately to severely active Crohn's disease 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.

IMPORTANT SAFETY INFORMATION

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).

Infusion-related Reactions and Hypersensitivity Reactions

- 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.

Introducing Entyvio: the first and only gut-selective biologic for patients with moderately to severely active ulcerative colitis (UC) or Crohn's disease (CD)[1]

TREAT WITH PRECISION

The first and only gut-selective biologic[1]

- Achieved remission at Week 52 in:
  - 42% of UC patients vs 16% for placebo in patients responding at Week 6 ($P<0.001$)
  - 39% of CD patients vs 22% for placebo in patients responding at Week 6 ($P<0.001$)
- Targeted mechanism of action[1] different from anti-TNFα therapies
- One dose for all patients[1]: 300-mg IV infusion

References: 1. Entyvio Summary of Product Characteristics. Takeda Pharmaceuticals Ireland Ltd. www.medicines.ie accessed September 2014

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DATE OF PREPARATION: APRIL 2015

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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.

Prior and Concurrent Drug Exposures
- 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.

Adverse Reactions
- 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 on 1800 237 970.

Method: The national outpatient clinic database (HSE website) was reviewed and data was retrieved on referral rates, attendance rates (new, return patients), non-attendance rates and delayed appointment times (> 3 months) for the 10 gastroenterology outpatient departments in Irish hospitals for 2013.

Results: There was a significant variation (4-fold), among outpatient departments for activity levels ranging from 784 patients /consultant to 3380 patients /consultant; mean 2008. There were also, 7-fold variation in N:R rates (ranging from 0.12 to 0.92), 27-fold variation in non attendance rates (ranging from 195 to 5363) and 52-fold variation in delayed appointments (ranging from 15 to 787). Of note, there was no association between N:R rates, delayed appointments, non attendance rates and activity levels for any hospital. Those hospitals with higher numbers of consultant gastroenterologists demonstrated lower N:R rates (i.e. higher rates of return patients) likely reflecting the referral nature of their patient profile. As expected, there was a strong correlation between activity levels and number of consultant gastroenterologists (r = 0.77). Higher new patient non attendance rates were noted in institutions with longer OPD waiting time (r = 0.57).

Conclusions: Significant variations exist in activity levels and practice patterns among gastroenterology outpatient departments in Irish hospitals. No consistent predictors of prolonged outpatient waiting times were observed. This study did not take account of other factors (such as NCHD involvement, patient complexity level, consultants' other clinical responsibilities) which influence outpatient activity levels. The strong correlation of consultant numbers with activity suggests that resources should be directed towards hospitals with longer waiting times (i.e. "money following need") to address this issue rather than allocating further funding to outpatient departments with highest levels of activity (i.e. "money following the patient").

ABSTRACT 43 (15S 148) POSTER PRESENTATION

Title of Paper: Percutaneous endoscopic gastrostomy tube related complications: Lessons to be learn

Author(s): Grace Chan, Catherine Keenan, Jun Liong Chin, Aman Afridi, Osama Hamid, Garry Courtney, Abdur Rahman Aftab.

Department(s)/Institution(s): 1.Nutrition and Dietetics Department, St Luke's Kilkenny 2.Gastroenterology Department, St Luke's Hospital Kilkenny.

Introduction: Percutaneous endoscopic gastrostomy (PEG) feeding provides an invaluable means for feeding in patients suffering with swallow disorders but who retain enteric absorptive function. The dietitians in our hospital have excellent experience in the management of PEG tube related complications and are usually the first department to be contacted with these problems.

Aims/Background: To study the nature of PEG-related referrals to the dietetics department in order to provide targeted staff education in order to manage PEG related complications.

Method: All PEG- related referrals to the dietetics department in 2014 were reviewed.

Results: 59 referrals for PEG related complications were received by the dietetics department in 2014. Of these, 21 (35.6%) were from the adult wards, 14(23.7%) were from the paediatric wards, 8(13.6%) were from the medical assessment unit (MAU) and 16(27.1%) were from the outpatients department. 33(55.9%) were male and 26(44.1%) were female patients. In the adult population, the mean age was 57 ±19 years and in the paediatric population, the mean age was 4.4 ±2.4 years. The main indications for referral were PEG tube dislodgement (37.3%), erythema around PEG site (5.9%), damaged PEG component (13.6%), routine PEG change (10.1%), discomfort at PEG site (67.8%) and cessation of PEG requirement (3.4%). 31(52.5%) of the referrals were resolved by insertion of a new PEG tube in the form of a CORFLO gastrostomy feeding tube, CORFLO cuBBy® low profile gastrostomy device or MIC-KEY® gastrostomy feeding tube. A further 8(13.6%) patients required adjustment of their pre-existing PEG. 5(8.5%) patients required treatment of their hypergranulation with either topical steroids or silver nitrate.

Conclusions: PEG related referrals are common and by educating nursing staff regarding management of PEG related complications, referrals can be reduced significantly. This will also allow patients' feeding needs to be addressed without delay and reduce the workload for dietitians and gastroenterologists.

ABSTRACT 44 (15S 149) POSTER PRESENTATION

Title of Paper: Pre-biologic screening for opportunistic infection in Inflammatory Bowel Disease: A single centre audit.

Author(s): R Abdelhaq, A Malik, C Kiat, B Hall, Y Bailey, S Byrne, N Breslin, B Ryan, D McNamara

Department(s)/Institution(s): Department of Gastroenterology, Adelaide and Meath Hospital, Tallaght, Dublin 24

Introduction: Monoclonal antibodies have become a mainstay of therapy in patients with inflammatory bowel disease (IBD); both ulcerative colitis (UC) and Crohn's disease (CD). Despite the efficacy of biologic therapies, patients being commenced on these medications are at risk of numerous complications; in particular certain opportunistic infections. European Crohn's and colitis organisation (ECCO) guidelines note the importance of screening for numerous opportunistic infections prior to commencement of any biologic therapy. Furthermore, ECCO guidelines also highlight the role of the IBD nurse specialist in the co-ordination and management of biologic therapy initiation and maintenance

Aims/Background: 1. To assess physician adherence to ECCO guidelines protocol 2. To assess the overall positivity of investigations performed prior to biologic initiation.

Method: Patients commencing biologic therapy between January 2014 and December 2014 were retrospectively identified from our IBD database. As per AMNCH guidelines, all patients were required to have a pre-biologic assessment form completed consisting of the following; quantiferon level +/- mantoux skin test, hepatitis B + C, VZV and HIV serology and chest x-ray. Physician adherence to the screening protocol was recorded. Any positive investigations performed as part of the screening protocol were also recorded.

Results: In total, 46 patients were screened for commencement of biologic therapy during the duration of the audit. Overall physician adherence rate to performing the full assessment was 78%. All patients had at least one investigation performed for tubeculosis (mantoux skin test or quantiferon level). In total, 43 (90%) patients had a sole quantiferon performed while 3 (6%) patients had both mantoux and quantiferon level checked. Overall, only one patient had a positive investigation for tuberculosis (quantiferon) and was not commenced on biologic therapy. In total, 4 (9%) patients did not have a chest x-ray performed in the 6 months prior to biologic

commencement. With regards to other opportunistic infections; 1 (2%) did not have VZV serology checked; 9 (20%) did not have HIV serology checked; 2 (4%) did not have hepatitis C serology checked and 9 (20%) patients did not have hepatitis B serology checked. No patients were found to have positive viral serology prior to commencement of biologic treatments. Of note, all patients had a full screen performed prior to actual commencement of biologic therapy.

Conclusions: Interestingly the number of positive investigations performed is small at 2%. This audit shows that physician adherence to screening protocol failed to comply fully with ECCO guidelines, overall adherence was 78%. However, the use of a screening checklist coupled with an IBD nurse specialist limits the risk of commencing biologic therapies in a patient cohort at risk of opportunistic infections.

ABSTRACT 45 (15S 151) POSTER PRESENTATION

Title of Paper: MLH1 hypermethylation assay differentiates sporadic colon tumours with microsatellite instability and Lynch syndrome

Author(s): Margaret B. Walshe 2, Catherine Clabby 3, Rosie O' Shea 1, Andrew J. Green 3, Padraic Mac Mathuna 2, David J. Gallagher 1

Department(s)/Institution(s): 1. Department of Clinical Genetics, Mater Private Hospital/MMUH. 2. GI Unit MMUH. 3 NCMG Crumlin

Introduction: Tumours from patients with Lynch syndrome have characteristic features resulting from the underlying molecular involvement of defective MMR, that is, the presence of microsatellite instability (MSI) and the absence of MMR protein expression by immunohistochemistry (IHC) corresponding to the mutated gene [1]. However, most colorectal cancers with MSI arise through biallelic somatic hypermethylation of the MLH1 promoter in older patients with no family history of CRC, which is clinically and molecularly defined as sporadic MSI [2]. This form of colorectal cancer, which accounts for approximately 12% of all colorectal cancers, arises through a process that involves the CpG island methylator phenotype (CIMP) [3] which is an epigenetic event that silences MLH1 gene expression without genetic changes at the DNA sequence level and is usually associated with BRAF mutations. The presence of BRAF (V600E) mutation argues against the presence of a germline mutation in either the MLH1 or MSH2 gene in Lynch syndrome associated colorectal cancers [4]. In addition, "germline epimutation" represents a novel mechanism for disease in which the affected allele of a gene is rendered silent in the germline by an epigenetic aberration.

Aims/Background: In this pilot study we describe the molecular workup to differentiate between sporadic colon tumours with MSI and Lynch syndrome.

Method: Our material consists of a clinic based cohort referred for molecular workup/ cancer genetic risk assessment because of diagnoses of colon cancer demonstrating loss of expression of the MMR proteins MLH1 and PMS2 by IHC. Six cases had BRAF studies, MLH1 hypermethylation assays undertaken on both tumour and lymphocytic DNA and diagnostic sequencing of MLH1 and PMS2.

Results: Six cases (4 women and 2 men) had full molecular workup including genetic testing. Median age of diagnosis was 62.5 years. No pathogenic mutations were detected however one variant of uncertain (VUS) was characterised. All six cases were wildtype for the BRAF activating mutation yet all tumours showed hypermethylation of greater than 10% which is considered significant. One male had significant MLH1 promoter hypermethylation detected in lymphocyte DNA which is consistent with Lynch syndrome due to a constitutional MLH1 epimutation. This proband was diagnosed with synchronous colon tumours at age 39 with no family history of cancer.

Conclusions: Although a BRAF mutation is reported to be present in the majority of sporadic deficient mismatch repair tumours, MLH1 promoter hypermethylation may be a more sensitive assay to discriminate between sporadic MSI colon tumours and Lynch syndrome. Cases with gemline epimutation of MLH1 are distinguishable from the more frequent sporadically arising MSI tumours in older individuals as the latter have localized biallelic MLH1 methylation which is essentially confined to the tumour. Additional data/cases will be presented at conference.

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ABSTRACT 46 (15S 153) POSTER PRESENTATION

Title of Paper: Retrospective review of presentations with severe alcoholic hepatitis to the Mater over a 5 year period - a high risk population

Author(s): F. Jones, J. Legge, S. Murphy, S. Stewart

Department(s)/Institution(s): Centre for Liver Disease, Mater Misercordiae University Hospital

Introduction: Severe alcoholic hepatitis (DF >32) has a high short-term mortality. Recent data suggests that steroids are beneficial, but only in those with the most severe disease.

Aims/Background: We sought to review the incidence, management, and short to medium-term survival of severe alcoholic hepatitis in the Mater hospital from 2009-2014.

Method: 521 electronic records were evaluated with 466 excluded based on lack of severity or an alternative diagnosis. Of the remaining patients, 52 were diagnosed on clinical grounds and 3 on liver biopsy.

Results: Mean age was 50 (29-79), 35 male, 20 female. Mean DF was 62.4. 31 patients received prednisolone, 16 pantoxifylline and 8 both. Complication rates were as follows: 3 patients had a variceal bleed, 40 had ascites, 28 had encephalopathy and 7 had hepatorenal syndrome. 54.5% had a documented infection.

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- *Gut*
- *Journal of Clinical Gastroenterology*
- *Immunology*
- *Cellular Immunology*
- *Clinical and Translational Gastroenterology*

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Overall 30-day and 6-month mortality rates were 29.6% and 46% respectively. In patients with a GAHS 9 30-day mortality was 44.4% and 6-month mortality 57.7%

In patients with GAHS 9 30-day mortality was 35.3% in those treated with steroid and 60% in those not treated with steroid.

Conclusions: We found that the mortality from severe alcoholic hepatitis was very high, perhaps reflecting the overall health of the local patient population. We found that GAHS was accurate in predicting short and medium-term mortality and that steroids are of no benefit unless the GAHS is >9.

ABSTRACT 47 (15S 154) POSTER PRESENTATION

Title of Paper: Maintenance Anti-TNF Therapy has a beneficial effect on Bone Mineral Density in Patients with Inflammatory Bowel Disease

Author(s): C Kiat, R Ebdelhaq, A Malik, Y Bailey, N Breslin, D McNamara, S Veerappan, BM Ryan

Department(s)/Institution(s): Department of Gastroenterology, Tallaght Hospital, Dublin 24

Introduction: It has been well established that patients with inflammatory bowel disease (IBD), both ulcerative colitis (UC) and Crohn's disease (CD), are at increased risk of osteoporosis. Prior studies have shown that both Adalimumab and Infliximab have beneficial effects on bone metabolism in patients with CD in the short term. However, no data is available on the longer term effect of maintenance anti-TNF on bone mineral density (BMD) in patients with IBD.

Aims/Background: To evaluate the medium to long-term impact of maintenance anti-TNF therapy on BMD in patients with IBD.

Method: This was a retrospective observational cohort study of patients with IBD who were commenced on anti-TNF therapy (either Infliximab or Adalimumab). All patients underwent BMD measured (DEXA scan) prior to commencement of anti-TNF therapy. BMD was then measured at variable intervals following commencement of therapy, with a minimum of one year prior to repeat BMD. A detailed chart review of patients' demographics, disease phenotypes and concomitant treatments was performed. This review is on- going and to date data for 30 patients has been analysed. A paired t-test was performed to evaluate the changes in BMD in patients on Adalimumab or Infliximab.

Results: To date, data for 30 patients as been analysed. There were 18 female patients and the mean age for the cohort was 45 years (SD +/- 12.8). 28 patients have CD and 2 have UC. 16 patients were on maintenance Infliximab and 12 on Adalimumab. Mean T score prior to commencement of biologic therapy was -1.68 (SD +/- 1.10). The mean T-score at follow up DEXA was -1.41 (SD +/- 1.15). The mean interval between BMD measurements was 2.9 years (SD +/- 1.5). There was a significant improvement in T score between initial and follow up BMD, P=0.039 (CI:-0.531,-0.014).

Conclusions: In this study we show a significant improvement in T scores of IBD patients following commencement of maintenance anti-TNF therapy.

ABSTRACT 48 (15S 155) POSTER PRESENTATION

Title of Paper: The Top 100 Influential Manuscripts in Colorectal Cancer: A Bibliometric Analysis

Author(s): Dr. Paula Wrafter MB, BCh, BAO, Dr. Tara M. Connelly, MB, BCh, MSc, Dr. Jody Khan, MB, BCh, BAO, Mr. Liam Devane, MD, MRCS, Professor William Joyce MD FRCSI

Department(s)/Institution(s): Departments of Surgery, Galway Clinic, University Hospital Galway, Beaumont Hospital, St. Vincent's University Hospital,

Introduction: Colorectal cancer (CRC) is a significant cause of mortality and morbidity worldwide. There is a large body of evidence on the topic. Bibliometric citation analysis has been used to determine the most influential papers in several surgical fields. To date, no study has been undertaken to determine the most influential papers in the field of CRC.

Aims/Background: To analyse the 100 most cited manuscripts in the field of CRC to highlight the key topics and studies which have led to the current understanding and treatment of the disease.

Method: A search of the Thomson Reuters Web of Science database was completed using the search terms 'colorectal cancer,' 'colon cancer,' 'rectal cancer,' 'colorectal carcinoma,' 'colon carcinoma,' 'rectal carcinoma' or 'colonoscopy." Only English language and full manuscripts were included. The 100 most cited papers were further analysed by topic, journal, author, year and institution.

Results: 146,833 eligible papers were returned. Of the top 100, the most cited paper (by Hurwitz) focused on chemotherapy(5340 citations). The New England Journal of Medicine published the highest number of papers in the top 100 (n=24, 37,858 citations). The country and year with the greatest number of publications were the USA (n=60) and 2004 (n=13) respectively. The most covered topic was genetics in CRC (n=51), followed by chemotherapy (n=21) and surgical management (n=6).

Conclusions: These most cited manuscripts have contributed to the current understanding and treatment of CRC. We provide an analysis and reference of what could be considered the most influential papers in CRC

ABSTRACT 49 (15S 157) POSTER PRESENTATION

Title of Paper: Actual versus instructed patient fasting practices: An audit of compliance with local guidelines.

Author(s): Karen Boland, Patrick Boland, Caoimhe Murray, Glen Doherty

Department(s)/Institution(s): St Vincent's University Hospital

Introduction: There is a lack of consistency between actual and instructed fasting times which may lead to inadequate or prolonged fasting. This is associated with patient discomfort and adverse effects through insulin resistance and induction of the acute-phase inflammatory response, evidenced by higher CRP levels [1]. The previous tradition of an npo after midnight order has been challenged and is no longer universally recommended.

Aims/Background: We audited compliance with patient information leaflets used in our department. We sought to evaluate compliance with recommended fasting times among inpatients and

outpatients. We also aimed to assess whether patients followed advice regarding continued self-administration of their regular medications with a few clearly stated exceptions. Our overall goal was to assess patient understanding of our advice and information and subsequently address deficits or areas for improvement.

Method: 101 patients were included, 42 of male gender. The median age was 61 years. Procedures undergone by the patients are outlined below.A prospective audit of adult patients attending the endoscopy department of a tertiary hospital was carried out over 5 non-consecutive days. We devised a questionnaire recording patient demographics and procedure type, time of admission, procedure and time to next meal. Questions put to patients included their understanding of why fasting was necessary, from when to fast, last solids taken and time of pre-fasting meals, drinks and medications. During the process of data evaluation, patients undergoing therapeutic gastroscopy requiring prolonged fasting and inpatients with active bleeding or with npo orders for other indications were excluded from the audit.

Results: The median time from admission to procedure was 1 h (0.25-3). Excluding patients with prescribed prolonged fasting, the median time until next meal was 1.5 h (0.5-8). 17 patients were noncompliant with recommended fasting times for solids. 12/17 misunderstood the patient information, 1 did not read provided documentation, and 4 inpatients received inaccurate verbal guidance. 18/101 patients were inpatients. 4/8 inpatients having OGDs were fasted excessively. The fasting times for patients awaiting colonoscopy were variable and not consistently aligned with instructions. The median time from last solids was 25 h (11-42) and from fluids was 12.5 h (3.5-29). 12/41 colonoscopy patients were noncompliant with a low-residue diet, potentially limiting quality of endoscopy. Patients are given clear advice on continuation of certain medications. 36 patients were prescribed these medications and 10 stopped these unnecessarily. 9 patients did so without seeking advice, and 1 patient did so as advised by his GP.

Conclusions: Patient comprehension and recall may limit adherence leading to prolonged or abbreviated fasting times despite patients reporting understanding of fasting practices in question. Patients are currently questioned on last meal and fluids to minimise risk of aspiration. Prolonged fasting from solids and particularly fluids may be associated with a negative experience and adverse events. We noted that 12/17 patients did not follow recommended fasting practices. Giving inpatients written information on procedures should be considered alongside re-educating staff to avoid prolonged npo orders and improve patient comfort. Although the number of eligible patients included undergoing OGD was small (n = 8), 50% were fasted excessively underline a need to re-educate staff members in this area.

ABSTRACT 50 (15S 158) POSTER PRESENTATION

Title of Paper: Efficacy of Re-induction in Inflammatory Bowel Disease Patients Experiencing Relapse on Maintenance Adalimumab Therapy

Author(s): Daniel Schmidt-Martin, Margaret Walshe, Zita Galvin, Una Kennedy, Nasir Mahmud, D Kevans .

Department(s)/Institution(s): Department of Gastroenterology, St James's Hospital, Dublin

Introduction: Adalimumab (ADA) is a monoclonal antibody to Tumour necrosis factor α (TNF) with proven efficacy in Inflammatory Bowel Disease (IBD). In patients losing response to ADA maintenance therapy, the utility of dose optimization is well described however, data on the efficacy of re-induction dosing regimes in this setting are few.

Aims/Background: To evaluate the efficacy of an ADA re-induction regime in patients losing response to maintenance ADA therapy.

Method: From a cohort of n=65 IBD patients receiving maintenance ADA therapy at a single insitution, n=7 were identified who had received an ADA re-induction dosing regimen. Re-induction was undertaken where patients experienced clinical relapse on maintenance ADA therapy despite dose optimization. Re-induction was administered as a 160mg followed 2 weeks later by an 80mg ADA dose, thereafter maintenance therapy was continued. Endpoints were defined as clinical response assessed by the treating physician at Week 8, reduction in CRP at week 8, rates of ADA discontinuation during follow up and safety.

Results: N=7 patients {4 ulcerative colitis; 3 Crohn's Disease; 4 male gender; age (years) median [range], 50 [21 – 61]; 7 ADA weekly dosing; ADA therapy duration (weeks) median [range], 78 (6 – 245); 29% receiving prednisolone; 29% receiving azathioprine}. 5 of 7 (71%) patients achieved a week 8 response. Median CRP reduced from 20 g/dL at baseline to 6 g/dL at week 8 post re-induction. ADA was discontinued in 5 of 7 (71%) patients during follow up at a median (range) of 9 (4 – 18) weeks after re-induction. 1 of 7 (14%) of treated patients experienced an adverse reaction developing a self-limiting viral illness.

Conclusions: Adalimumab re-induction recaptures short term clinical response in the majority of IBD patients experiencing disease relapse on maintenance therapy. This effect is durable in only the minority of patients however and therefore the cost-effectiveness of this strategy remains uncertain and requires further evaluation.

ABSTRACT 51 (15S 160) POSTER PRESENTATION

Title of Paper: Detecting Immunity to Measles, Mumps and Rubella in IBD patients commencing Biologic Therapy

Author(s): R. Stack1,2, U. Kennedy1, D. Schmidt1,2, M. Walshe1,2, F. MacCarthy1,2, N. Mahmud1,2, S. McKiernan1,2, D Kevans1,2

Department(s)/Institution(s): 1. Department of Gastroenterology, St James Hospital, Dublin, Ireland 2. School of Medicine, Trinity College Dublin, Dublin, Ireland

Introduction: Serological testing to confirm immunity to varicella zoster and hepatitis B is established practice in Inflammatory Bowel Disease (IBD) patients where the use of immunomodulators or biologics are anticipated. Data are few, however, on the seronegativity rates for measles, mumps or rubella (MMR) in IBD patient populations. MMR vaccine is live and therefore cannot be administered to immunosuppressed patients. Currently, there is uncertainty as to whether immunity to these viruses should be routinely tested in IBD patients

Aims/Background: In Ireland, the first MMR vaccine is administered at 12 months of age and a second vaccine is given at 4 - 5 years of age. While MMR incidences are low outbreaks continue to occur. We aimed to determine seroprevalence rates to MMR in a population of IBD patients commencing anti-TNF therapy

Method: 98 IBD outpatients due to commence biologic therapy with available MMR serology were identified from an institutional database. Enzyme-linked immunosorbent assays were used to determine anti-rubella IgG, anti-measles IgG, anti-Mumps IgG and anti-varicella zoster IgG. Seroprevalance for each virus was expressed as a percentage of the individuals with available serological data for a given virus. A national MMR immunization programme was instituted in 1988: Subjects born after 1981 were considered to have participated in the MMR immunization programme. MMR seroprevalence rates were compared between cohorts pre and post MMR immunization programme

Results: The study cohort comprised of n=60 Crohn's Disease and n=38 Ulcerative Colitis patients [median age 42.7 years (18-72.9); female gender n=53, 53%]. N=72, 73% were born prior to 1981 and therefore were not considered to have received the MMR vaccination. The proportion of the cohort seronegative to measles, mumps, rubella and varicella were 1%, 6%, 9% and 0% respectively. Seronegative rates in the pre-MMR (n=72) versus post-MMR(n=28) cohorts were ; 0% v 4%, 1% vs 19% and 8% vs 12%, respectively.

Conclusions: A significant proportion of IBD patients are seronegative to measles, mumps and rubella virusees, despite previous immunization. These patients must be considered at higher risk of opportunistic MMR infection while receiving immunosuppressant agents. Confirmation of MMR immunity status should be routinely performed in all IBD patients, irrespective of immunization history, prior to commencing immunomodulatory or biologic agents.

ABSTRACT 52 (15S 161) POSTER PRESENTATION

Title of Paper: 7 year audit of Fibroscan validity at a single Irish centre

Author(s): McShane C, El-Sherif O, Bergin C, McKiernan S, Norris S

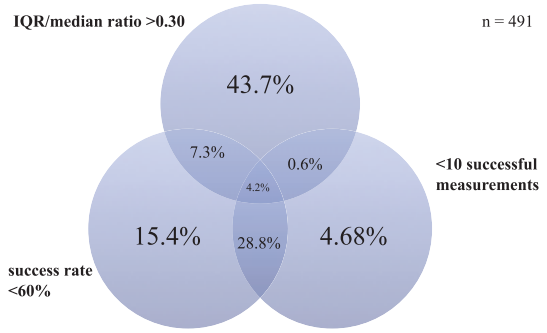
Department(s)/Institution(s): Department of Hepatology, St. James's Hospital, Dublin.

Introduction: Assessment of the severity of liver fibrosis is an important step in evaluating and managing patients with chronic liver disease. Liver stiffness measurement (LSM) by Transient Elastography (Fibroscan, Echosens) allows for rapid non-invasive assessment of liver fibrosis. A reliable LSM requires (i.) ≥10 successful measurements, (ii.) success rate ≥ 60%, and (iii.) IQR/median ratio <0.30 according to the manufacturer's guidance. Obtaining a reliable LSM has been shown to result in better correlation with liver fibrosis. Recent published data suggests that less stringent criteria may be applied to assess for reliability.

Aims: The aim of this audit was to assess the rate of Fibroscan fulfilling LSM validity criteria, and the quality criteria responsible for unreliable examinations.

Method: Data from Fibroscans performed at our centre between 2007-2014 were reviewed and included in this analysis. A LSM was deemed unreliable if the exam failed any of the three validated quality criteria. Cirrhosis was defined by an LSM cut-off of > 12.5 kPa. All scans were performed using the Fibroscan M-probe.

Results: In the 7 year period a total of 2031 LSMs were performed. Of these, 249 (12.3%) were LSM failures, 491 (24.2%) were reliable LSMs and 1291 (63.6%) were unreliable LSEs. An IQR/median ratio > 0.3 was the most common indication of an unreliable LSM [figure 1]. LSM measurement was less likely to meet LSM validation criteria in patients with a liver stiffness of > 12.5 kPa (n=310) compared to a liver stiffness of > 12.5 kPa (n=1472) [60%% vs 75.1%, p <0.01].



Conclusions: The majority of Fibroscans performed at our institute were reliable by quality criteria. Implementation of the updated validity criteria would further reduce the rate of unreliable scans to below 20%, which is in keeping with International published series. Routine use of an XL probe in technically difficult examinations may reduce the LSM failure and unreliability rates even further. Where the IQR/median ratio is > 0.3, a diagnosis of cirrhosis by LSM should be interpreted in junction with other markers of fibrosis (e.g. APRI, Fibrotest).

ABSTRACT 53 (15S 162) POSTER PRESENTATION

Title of Paper: Infliximab monotherapy and in combination with thiopurines significantly reduces neutrophil counts in IBD patients.

Authors: Parihar V, Maguire S, Safaya K, Shahin A, Ahmed Z, Kennedy M, O'Callaghan M, Smyth C, Farrell R.

Department(s)/Institution(s): 1 Gastroenterology Connolly Hospital, 2 Medicine, RCSI, Dublin, Ireland

Introduction: While the myelosuppressive effects of thiopurines are well known, the effects of anti-TNF therapy, either as monotherapy or in combination with thiopurines, on bone marrow suppression in inflammatory bowel disease (IBD) patients are not as well studied.

Methods: We performed a retrospective cohort study measuring the neutrophil and other white blood count (WBC) subsets in a cohort of IBD patients treated with infliximab monotherapy and in combination with thiopurines. IBD patients who completed at least 12 months of stable-dose 5mg/kg infliximab therapy were enrolled. Patients were excluded if their dose of 5-aminosalicylate (ASA) or thiopurine was changed in the 3 months prior to or during the 12 months of infliximab therapy. Patients WBC and differential counts were measured at baseline, after completing 6 weeks and 52 weeks of infliximab therapy. Clinical response and adverse effects were also assessed.

Results: Thirty IBD patients [20 Crohn's disease, 10 ulcerative colitis; 16 females, 14 males, mean age at diagnosis 31 years (range 17-51)] were enrolled in the study. 23 patients were on concomitant oral 5-ASA therapy while 17 patients were on concomitant thiopurine therapy. Results are summarised for patients on infliximab monotherapy (Figure 1) and for those patients on concomitant thiopurine (Figure2). There was a statistically significant decrease in the WBC and neutrophil counts in patients starting infliximab monotherapy post induction which persisted at

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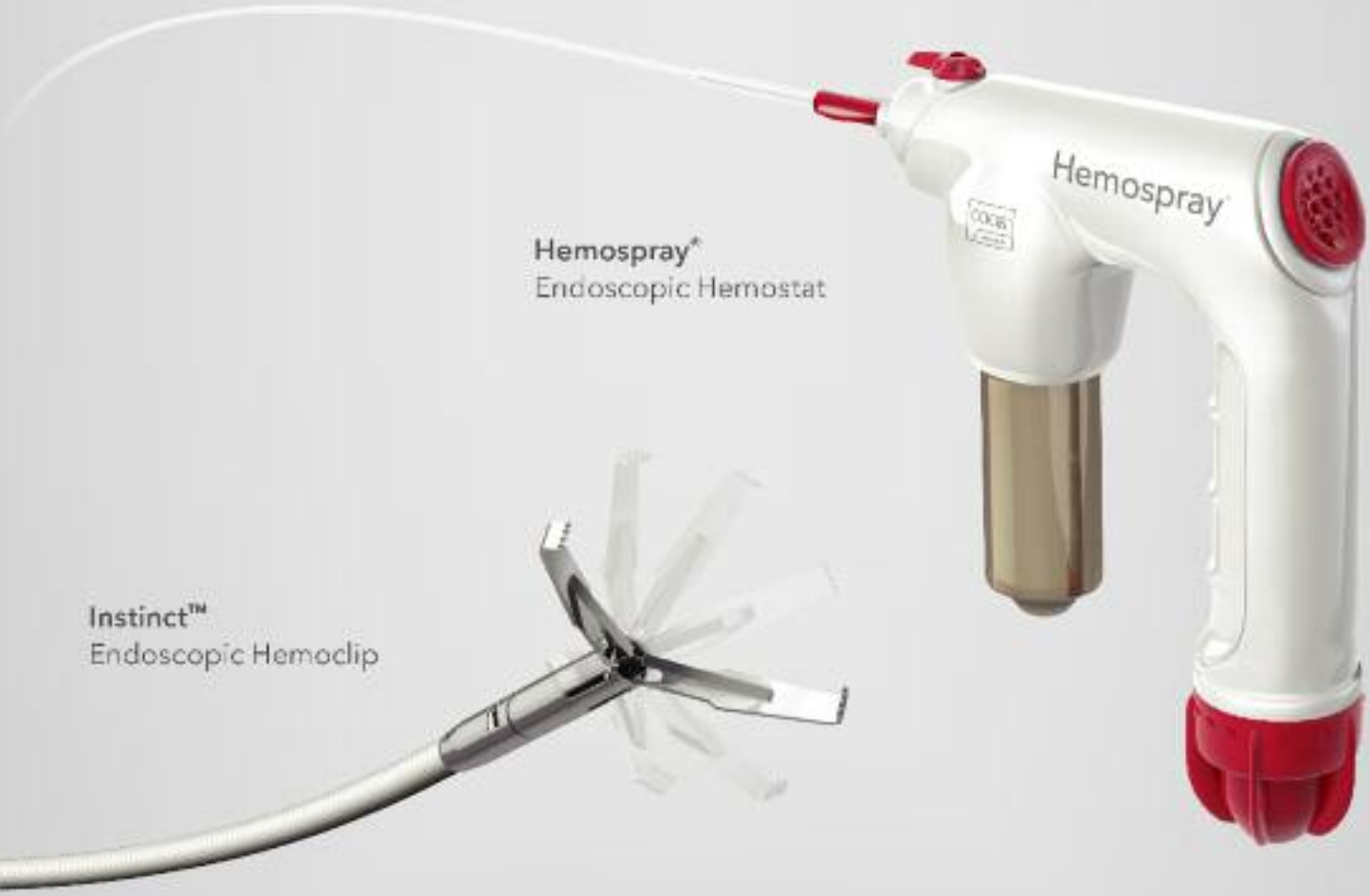

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52 weeks, $p<0.05$. Decrease in WBC and neutrophil counts were more pronounced in patients on concurrent thiopurine, $p<0.01$. There were no significant effects on lymphocyte counts.

Figure1: Infliximab 5mg/kg Monotherapy (n=13)

Average count	Pre induction	Week 6	Week 52
WCC	9.5	7.3	7.4
Neutrophils	6.2	4.5	4.5
Lymphocytes	2	1.9	2.5

Figure 2: Infliximab 5mg/kg + Thiopurines (n=17)

Average count	Pre induction	Week 6	Week 52
WCC	8.8	6.2	5.9
Neutrophils	5.6	3.5	3.4
Lymphocytes	1.9	1.7	2.5

Conclusion: There was a significant decrease in neutrophil counts in patients receiving infliximab post-induction which persisted at 52 weeks. The reduction in neutrophil counts was more pronounced in patients on concurrent thiopurines. FBC should be closely monitored in all patients starting inflximab therapy in particular patients receiving concomitant thiopurines. The pharmacodynamics effects of combining infliximab with thiopurines on neutrophils merits further study as this has the potential for both beneficial and adverse effects with combination therapy shown in randomized clinical trials to significantly improve efficacy in IBD patients albeit at a cost of increased opportunistic infections in some patients.

ABSTRACT 54 (15S 163) POSTER PRESENTATION

Title of Paper: Outcome of Golimumab Therapy in Ulcerative Colitis – An Initial Experience

Author(s): Z Galvin[1], C Rowan[2], M Forry[3], M Walshe[1], D Schmidt[1], U Kennedy[1], D Keegan[2], K Byrne[2], S McKiernan[1,4], F MacCarthy[1,4], N Mahmud[1,4], P MacMathuna[5,6], B Kelleher[5,6], J Leyden[5,6], G Harewood[3,7], FE Murray[3,7], S Patchett[3,7], H Mulcahy[2,6], G Doherty[2,6], G Cullen[2,6], D Kevans[1,4]

Institutions: 1. St James's Hospital, Dublin; 2. St Vincent's University Hospital, Dublin; 3. Beaumont Hospital, Dublin; 4. School of Medicine, Trinity College Dublin; 5. Mater Misericordiae University Hospital, Dublin 6. School of Medicine & Medical Sciences, University College Dublin; 7. School of Medicine, Royal College of Surgeons in Ireland.

Introduction: Subcutaneous Golimumab (GLB) is a fully human monoclonal antibody to tumour necrosis factor-α (TNF). While large randomized controlled trials have demonstrated the efficacy of GLB as an induction and maintenance agent for ulcerative colitis (UC), data are few on the utility of this agent in routine clinical practice.

Aim: To evaluate the efficacy and safety of GLB therapy for UC in routine clinical practice in Ireland.

Methods: Patients with UC or inflammatory bowel disease-unclassified (IBD-U) receiving GLB therapy at four Irish Inflammatory Bowel Disease centres were identified. Baseline demographic data, GLB therapy response, GLB therapy discontinuation, and adverse events were obtained by a combination of chart review and interrogation of institutional databases. GLB response was defined as a significant clinical improvement following the introduction of treatment as adjudicated by the treating physician. Study endpoints were: proportion of GLB responders, GLB discontinuation rates, requirement for dose escalation and adverse events.

Results: N=27 ambulatory outpatients (n=26 UC; n=1 IBD-U) met inclusion criteria: 41% receiving concomitant immunomodulator therapy; 48% anti-TNF naïve; 11% with exposure to 2 anti-TNF agents previously; 12% proctitis, 37% left-sided colitis, 51% extensive colitis. Baseline albumin and C-reactive protein (median [range]) were 41 g / L [36 - 42] and 2.9 mg / L [0.6 -39.9] respectively. The median [range] follow up time (weeks) post commencement of GLB was 43 [8 - 72]. 20 of 27 (74%) of the cohort were GLB responders; 9 of 27 (33%) subjects discontinued GLB during follow up; and 3 of 27 (11%) required dose optimization. 1 subject experienced an adverse event developing neurological symptoms while receiving GLB.

Conclusions: In routine clinical practice Golimumab is an effective and safe therapy for ambulatory patients with moderately active ulcerative colitis.

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Remicade® 100mg Powder for Concentrate for Solution for Infusion (infliximab) *Prescribing Information (Refer to full SPC not before prescribing Remicade (infliximab))* **Indications:** *Rheumatoid Arthritis (RA)* Remicade, in combination with methotrexate (MTX), is indicated for the reduction of signs and symptoms, as well as the improvement in physical function, in adult patients with active RA when the response to disease-modifying anti-rheumatic drugs (DMARDs), including MTX, has been inadequate, and in adult patients with severe, active and progressive disease not previously treated with MTX or other DMARDs. In these patient populations, a reduction in the rate of the progression of joint damage, as measured by X-ray, has been demonstrated. *Adult Crohn's Disease (CD)* Remicade is indicated for the treatment of moderately to severely active CD in adult patients who have not responded to, or are intolerant of, a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant; and fistulising active CD in adult patients who have not responded despite a full and adequate course of therapy with conventional treatment (including antibiotics, drainage and immunosuppressive therapy). *Paediatric Crohn's Disease (CD)* Remicade is indicated for the treatment of severe, active CD in children and adolescents aged 6 to 17 years who have not responded to conventional therapy including a corticosteroid, an immunomodulator and primary nutrition therapy; or who are intolerant to or have contraindications for such therapies. *Ulcerative Colitis (UC)* Remicade is indicated for the 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. *Paediatric Ulcerative Colitis (UC)* Remicade is indicated for treatment of severely active UC, in children and adolescents aged 6 to 17 years, 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. *Ankylosing Spondylitis (AS)* Remicade is indicated for the treatment of severe, active AS, in adult patients who have responded inadequately to conventional therapy. *Psoriatic Arthritis (PsA)* Remicade is indicated for the treatment of active and progressive PsA, in adult patients when the response to previous DMARD drug therapy has been inadequate. Administration should be in combination with MTX or alone in patients who show intolerance to MTX or for whom MTX is contraindicated. A reduction in the rate of progression of peripheral joint damage in patients with polyarticular symmetrical subtypes of PsA has been measured by X-ray. *Psoriasis (PsO)* Remicade is indicated for the treatment of moderate to severe plaque PsO in adult patients who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, MTX or PUVA. **Dosage and administration:** To improve the traceability of biological medicinal products, the trademark and the batch number of the administered product should be clearly recorded in the patient file. Remicade should be administered intravenously, initiated and supervised by physicians experienced in the diagnosis and treatment of RA, CD, UC, AS, PsA and PsO. Remicade should be administered intravenously over a 2 hour period. All patients administered Remicade should be observed for at least 1 to 2 hours post infusion for acute infusion-related reactions by appropriately trained healthcare professionals. *Shortened infusions in non-adult indications:* In carefully selected adult patients who have tolerated at least 3 initial 3-hour infusions of Remicade (induction phase) and are receiving maintenance therapy, consideration may be given to administering subsequent infusions over a period of not less than 1 hour. If an infusion reaction occurs in association with a shortened infusion, a slower infusion rate may be considered for future infusions if treatment is to be continued. Shortened infusions at doses >5 mg/kg have not been studied. *RA:* 3 mg/kg given as an intravenous infusion followed by additional 3 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. *Adult moderately to severely active CD:* 5 mg/kg given as an intravenous infusion followed by an additional 5 mg/kg infusion 2 weeks after the first infusion. If a patient does not response after 2 doses, no additional treatment should be given. *Adult, fistulising, active CD:* 5 mg/kg intravenous infusion followed by additional 5 mg/kg infusions at 2 and 6 weeks after first infusion. If a patient does not respond after 3 doses, no additional treatment should be given. *UC:* 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. Clinical response is usually achieved within 14 weeks of treatment (3 doses). *AS:* 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 6 to 8 weeks. If a patient does not respond after 2 doses, no additional treatment should be given. *PsA:* 5 mg/kg given as an intravenous infusion period followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. *PsO:* 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks. If a patient shows no response after 4 doses, no additional treatment should be given. *Readministration:* Remicade can be readministered within 16 weeks following the last infusion. The safety and efficacy of readministration after a Remicade-free interval of more than 16 weeks has not been established in either CD or RA. The safety and efficacy of readministration in AS, other than every 6 to 8 weeks and in PsA and UC, other than every 8 weeks, has not been established. Readministration with one single Remicade dose in PsO after an interval of 20 weeks suggests reduced efficacy and a higher incidence of mild to moderate infusion reactions when compared to the initial induction regimen. Limited experience from retreatment, using a induction regimen suggests a higher incidence of infusion reactions, some serious, when compared to 8 weekly maintenance treatment. In case maintenance therapy is interrupted in any indication, and there is a need to restart treatment, Remicade should be reinitiated as a single dose followed by the maintenance dose recommendations. *Paediatric administration:* CD (6 to 17 years): 5 mg/kg given as an intravenous infusion followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. If a patient does not respond by 10 weeks, no additional treatment should be given. UC (6 to 17 years): 5 mg/kg given as an intravenous infusion over a 2-hour period followed by additional 5 mg/kg infusion doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. Available data do not support further infusion treatment in paediatric patients not responding within the first 8 weeks of treatment. **Contra-indications:** Tuberculosis or other severe infections such as sepsis, abscesses and opportunistic infections; patients with a history of hypersensitivity to infliximab, other murine proteins or any of the excipients; patients with moderate or severe heart failure (NYHA class IIIb/IV). **Precautions and Warnings:** *Infusion reactions:* Acute infusion reactions including anaphylactic reactions may develop during (within seconds) or within a few hours following infusion. If acute infusion reactions occur, the infusion must be interrupted immediately. Emergency equipment, such as adrenaline, antihistamines, corticosteroids and an artificial airway must be available. Antibodies to infliximab may develop and have been associated with increased frequency of infusion reactions. Symptomatic treatment should be given and further Remicade infusions must not be administered. In clinical studies, delayed hypersensitivity reactions have been reported. Available data suggest an increased risk for delayed hypersensitivity with increasing Remicade-free intervals. *Infections:* Patients must be monitored closely for infections, including tuberculosis, before, during and up to 6 months after treatment with Remicade. Exercise caution with use of Remicade in patients with chronic infection or a history of recurrent infection. Patients should be advised of potential risk factors for infections. Suppression of TNFα may mask

- Remicade is manufactured by MSD in Brinny, Co. Cork
- Over 1,700,000 patients treated[1]
- More than 13 years of market experience[2]
- Experience in a broad range of indications including CD, UC, RA, PSA and AS with a well-established safety and tolerability profile[2]
- Several thousand listed REMICADE (infliximab) clinical papers[3]
- Hundreds of registered clinical studies[4]

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symptoms of infection such as fever. Tuberculosis, bacterial infections including sepsis and pneumonia, invasive fungal, viral and other opportunistic infections, have been observed, some of which have been fatal. Infections were reported more frequently in paediatric populations than in adult populations. There have been reports of active tuberculosis in patients receiving Remicade. Patients should be evaluated for active or latent tuberculosis before Remicade treatment. All such risks should be recorded on the Patient Alert Card provided with the product. If active tuberculosis is diagnosed, Remicade therapy must not be initiated. If latent tuberculosis is diagnosed, treatment with anti-tuberculosis therapy must be initiated before initiation of Remicade. Patients on Remicade treatment should be advised to seek medical advice if symptoms of tuberculosis appear. *Invasive fungal infection* such as aspergillosis, candidiasis, pneumocystosis, histoplasmosis, coccidioidomycosis or blastomycosis should be suspected in patients if a systemic fungal disease is developed, a physician with expertise in the diagnosis and treatment of invasive fungal infections should be consulted at an early stage. Patients with fistulising CD and acute suppurative fistulas must not initiate Remicade therapy until possible source of infection is excluded. *Hepatitis B (HBV) reactivation:* Reactivation of HBV occurred in patients receiving Remicade who were chronic carriers. Some cases had a fatal outcome. Patients should be tested for HBV infection before initiating treatment with Remicade. *Hepatitis/Very rare:* Very rare cases of jaundice and non-infectious hepatitis, some with features of autoimmune hepatitis have been observed. Isolated cases of liver failure requiring liver transplantation or death have occurred. *Vaccination:* It is recommended that live vaccines not be given concurrently. Prior to initiating Remicade therapy it is recommended that paediatric patients be brought up to date with all vaccinations. *Autoimmune processes:* If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Remicade and is positive for antibodies against double-stranded DNA, treatment must be discontinued. *Neurological events:* Anti-TNFα agents have been associated with cases of new onset or exacerbation of clinical symptoms and/or radiographic evidence of peripheral and CNS demyelinating disorders, including Guillain-Barré syndrome and multiple sclerosis. In patients with a history of demyelinating disorders, the benefits and risks of anti-TNF treatment should be carefully considered before initiation of Remicade therapy. Discontinuation of Remicade should be considered if these disorders develop. *Malignancies and lymphoproliferative disorders:* A risk of the development of lymphomas and other malignancies in patients (including children and adolescents) cannot be excluded. Caution is advised in patients with history of malignancy and in patients with increased risk for malignancy due to heavy smoking. Rare post-marketing cases of hepatosplenic T-cell lymphoma have been reported which were usually fatal. All Remicade cases have occurred in patients with CD or UC treated concomitantly with AZA or 6-MP. Caution should be exercised in patients with PsO and a medical history of extensive immunosuppressant therapy or prolonged PUVA treatment. Patients with UC at increased risk for, or with a prior history of dysplasia or colon carcinoma should be screened for dysplasia before therapy and at regular intervals throughout their disease course. Malignancies and Merkel cell carcinoma have been reported, periodic skin examination is recommended, particularly for patients with risk factors for skin cancer. *Heart failure:* Remicade should be used with caution in patients with mild heart failure (NYHA class III) and discontinued in face of new or worsening symptoms of heart failure. *Others:* Patients requiring surgery while on Remicade therapy should be closely monitored for infections. *Haematologic reactions:* Discontinuation of Remicade therapy should be considered in patients with confirmed cytopenia manifesting in abnormalities, including pancytopenia, leucopenia, neutropenia and thrombocytopenia. *Special populations:* Particular attention should be paid when treating the elderly (>65 years) due to a greater incidence of serious infections seen in Remicade treated patients. Some of these had a fatal outcome. **Interactions:** No interaction studies have been performed. Combination of Remicade with other biological therapeutics used to treat the same conditions as Remicade, including anakinra and abatacept is not recommended. It is recommended that live vaccines and therapeutic infectious agents should not be given concurrently with Remicade **Fertility, Pregnancy and Lactation:** Women of childbearing potential should use adequate contraception and continue its use for at least 6 months after the last Remicade treatment. Administration of Remicade is not recommended during pregnancy or breast-feeding. Administration of live vaccines to infants exposed to infliximab in utero is not recommended for 6 months following the mother's last infliximab infusion during pregnancy. Effects of infliximab on fertility and general reproductive function are unknown. **Side effects:** *Very Common (≥1/10):* Viral infection, headache, upper respiratory tract infection, sinusitis, abdominal pain, nausea, infusion related reaction, pain. *Common (≥1/100 to <1/10):* Bacterial infections, neutropenia, leucopenia, anaemia, lymphadenopathy, allergic respiratory symptoms, depression, insomnia, vertigo, dizziness, hypoaesthesia, paresthesia, conjunctivitis, tachycardia, palpitation, hypotension, hypertension, ecchymosis, hot flush, flushing, lower respiratory tract infection, , dyspnoea, epistaxis, gastrointestinal haemorrhage, diarrhoea, dyspepsia, gastroesophageal reflux, constipation, hepatic function abnormal, transaminases increased, new onset or worsening psoriasis including pustular psoriasis (primarily palm & sole), urticaria, rash, pruritus, hyperhidrosis, dry skin, fungal dermatitis, eczema, alopecia, arthralgia, myalgia, back pain, urinary tract infection, chest pain, fatigue, fever, injection site reaction, chills and oedema. In phase 3 clinical studies, 18% of infliximab-treated patients compared with 9% of placebo-treated patients experienced an infusion related reaction. In post-marketing spontaneous reporting, infections are the most commonly serious adverse event. The most frequently reported opportunistic infections with a mortality rate of >5% include pneumocystosis, candidiasis, listeriosis and aspergillosis. **Other less common and rarely reported side effects are listed in the SPC. Overdose:** No case of overdose has been reported. Single doses up to 20mg/kg have been administered without toxic effects. **Package Quantities:** Type I vials, with rubber stoppers and aluminium crimps protected by plastic caps, containing a lyophilised powder (infliximab) 100mg. **Legal Category:** POM **Marketing Authorisation Number:** EU/1/99/116/001 **Marketing Authorisation Holder:** Janssen Biologics B.V., Einsteinweg 101, 2333 CB Leiden, The Netherlands **Date of Revision: July 2013** Further information is available on request from MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 or from www.medicines.ie. Date of preparation: May 2014.

References: 1. Data on file MSD PSUR 26. 2. Remicade SmPC, May 2014. 3. http://www.ncbi.nlm.nih.gov/pubmed/?term=Remicade+Infliximab. Accessed 26 June 2013. 4. http://www.clinicaltrials.gov/ct2/results?term=Remicade+Infliximab. Accessed 26 June 2013. AZA = azathioprine; 6-MP; CD = Crohn's disease; PsO = psoriatic arthritis; RA = rheumatoid arthritis; UC = ulcerative colitis

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Prof Eamon Quigley in Pensive mood

Poster Awards, Neil Power Abbvie, Dr Finbar McCarthy, Dr S Sengupta, Dr Aongas Lavelle, Ms Marian Rowland, Eoin Murphy AbbVie

Neil Power Abbvie, Aongas Lavelle, Humphrey O'Connor, Dr S Sengupta, Eoin Murphy AbbVie

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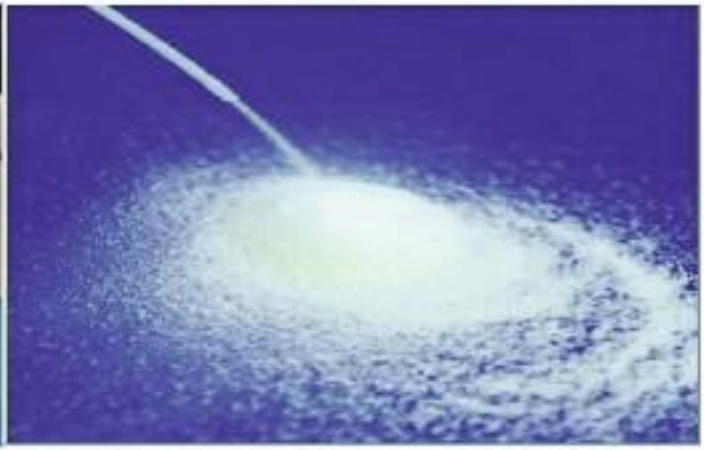

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Section of Audience

Dr Aman Yadav presenting an oral paper

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Prof Ann Marie Lennon, John Hopkins Univ of Medicine

Mr Justin Geoghegan, Hepatobiliary & Transplant Surgeon SVUH

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Audience view

Dr Niall Swan SVUH

Prof Peter Hayes, Royal Infirmary, Edinburgh

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Humphrey O'Connor & Dr Parnel Keeling

Dr Alan Smith, Director of Performance Improvement SDU at HSE

Cook Medical Representatives

Dr Nick Kennedy & Dr Noirin Noonan

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Ms Karen Cassidy - on Dangers of Student Alcohol Consumption

Coeliac Representatives

Profs. Peter Whorwell, Ted Dinan and Eamon Quigley on IBS Panel

Prof Paud O'Regan Clonmel making his point

Prof Roger Chapman, John Radcliff Hosp, Oxford

Prof Jeffrey Alexander, Mayo Clinic Minnesota

Dr Glen Doherty and Dr Barbara Ryan

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Prof Paul Ridgeway & Dr Tony Tham in the chair

Prof Roland Valori, Royal Hospital Gloucester

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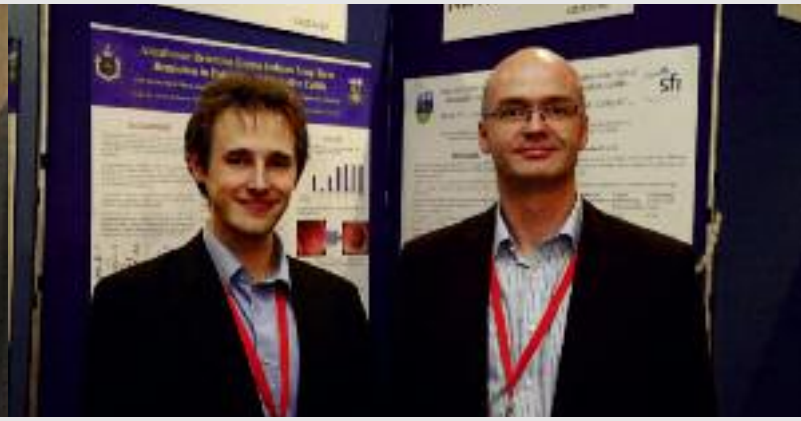

Dr Andrew Spence and Dr Paul Lynch Board member ISG

Dr Nicolein Schepers, Dutch Pancreatitis Study.

Audience view

Dr Niall Swan, Prof Ann Marie Lennon & Mr Justin Geoghegan

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*For adult patients with moderately to severely active ulcerative colitis (UC)**

*For adult patients with moderately to severely active Crohn's Disease (CD)**

*HUMIRA is indicated for treatment of moderately to severely active Crohn's disease, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or who are intolerant to or have medical contraindications for such therapies. HUMIRA is indicated for the treatment of severe active Crohn's disease in paediatric patients (from 6 years of age) who have had an inadequate response to conventional therapy including primary nutrition therapy, a corticosteroid, and an immunomodulator, or who are intolerant to or have contraindications for such therapies. HUMIRA is indicated for treatment of moderately to severely active ulcerative colitis in adult patients who have had an inadequate response to conventional therapy including corticosteroids and 6-mercaptopurine or azathioprine, or who are intolerant to or have medical contraindications for such therapies.

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