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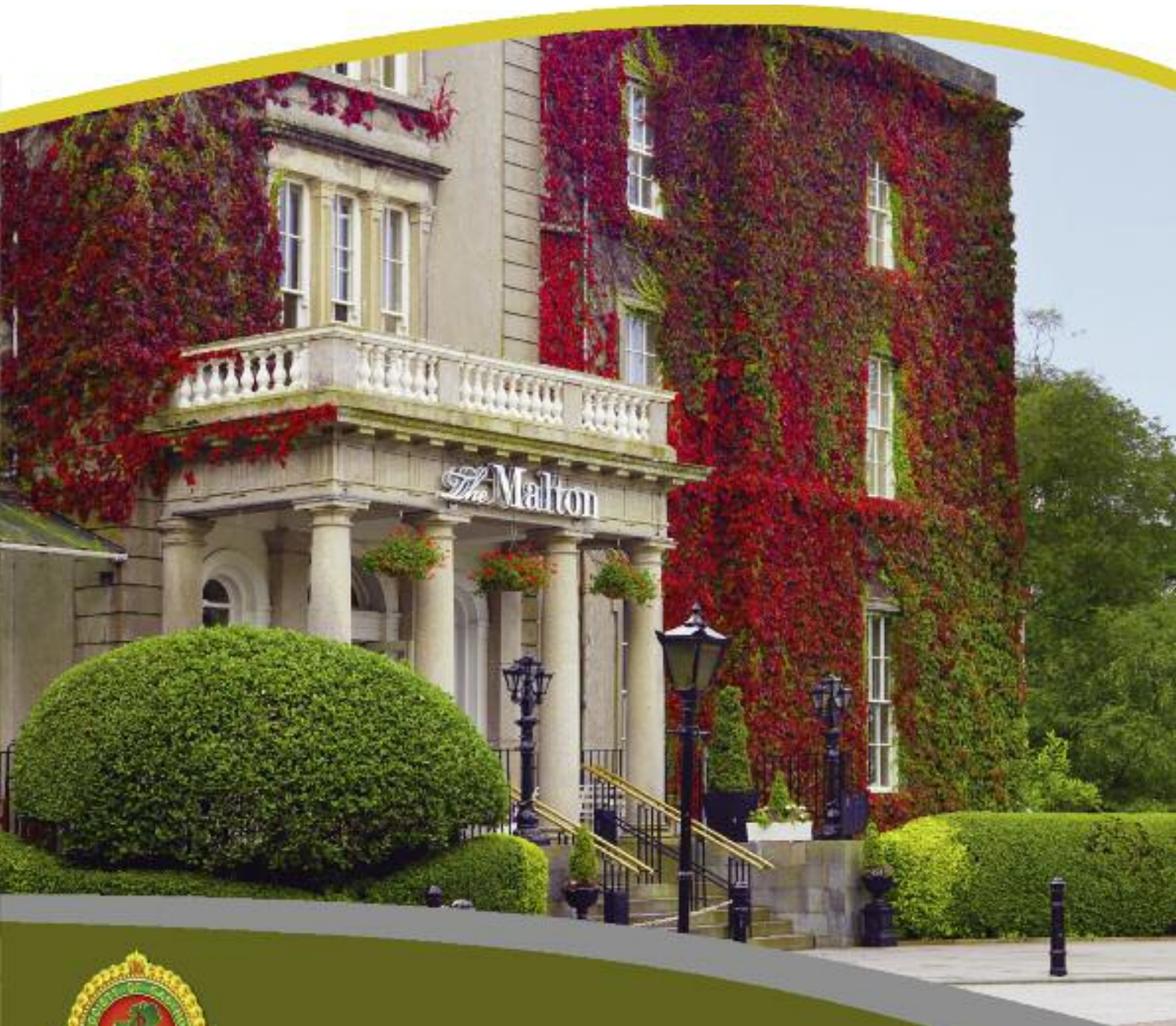

Irish Society of Gastroenterology

Winter Meeting

22-23 November, 2013
The Malton Hotel,
Killarney.

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Welcome Message from the President Professor Humphrey O'Connor

Dear Members and Guests,

It is indeed a pleasure to welcome you all to Killarney and to my home county. I sincerely hope that you will enjoy the experience and find it both educational and enjoyable.

It is a great honour for me to assume the Presidency of the Irish Society of Gastroenterology and I am conscious of the great work which has been done by my predecessors who have worn this chain of office with distinction.

The Irish Society of Gastroenterology has a proud history and tradition. Arguably its main strength lies in the cross-speciality involvement of medical gastroenterologists, surgical gastroenterologists, pathologists, radiologists, scientists and specialist nurses. Our combined focus is in the understanding of the mechanisms of gastrointestinal disease and the clinical management of our patients.

It is my hope during the Presidency to build on our strengths and to continue to develop the inter-relationships between our members. It is our collective responsibility to raise public awareness of gastrointestinal disease. The ISG must support the profession in delivering high quality care to patients and lobby to influence health policy for the common good.

We have put together a most interesting academic programme for this meeting. I look forward with great interest to hearing Prof Adam Cheifetz from Harvard and Prof Einar Bjornsson from Iceland. These are two of the foremost presenters in their field.

The IrSPEN presentation on Nutrition will add an interesting variety to our meeting and Dr Jon Shaffer will be excellent. Well done to John Reynolds and Orla Crosbie for their immense contribution in this area.

The Pancreatitis Symposium on Saturday should be an excellent presentation. Prof Jakob Izbicki from Hamburg is a great attraction and will be ably supported by Barbara Ryan and Sinead Duggan with Profs Kevin Conlon and Martin Buckley managing the contributions. I am sure that the contribution from Garret Cullen and Alan Coss will also be well received and worth listening to as will the presentations of our other homebased contributors.

Prof Cathy Nelson-Piercy from Guys & St. Thomas in London will give us her insights into the area of Obstetric Cholestasis and other Pregnancy specific liver problems. Not a subject we cover too often, we are very pleased that she could come over to us.

I believe that we have within the society world class professionals delivering state of the art services to the public. We also have many recently appointed colleagues with novel skills and a cohort of outstanding trainees.

It is my intention to showcase the excellence of Irish Gastroenterology over the next few years.

I look forward to meeting with all of you in Killarney renewing old acquaintances and making new ones and above all enjoy the educational and social interaction!

Humphrey O'Connor
President I.S.G.
Consultant Gastroenterologist

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Asacolon® GR Tablets 400mg & 800mg: Reddish brown, oblong, coated tablets each containing 400mg or 800mg mesalazine.
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In severe generalised ulcerative colitis affecting the rectum or rectosigmoid and in cases slow to respond to oral therapy, one suppository may be used morning and evening as an adjunct to oral therapy. **Elderly patients:** As for adults, unless renal function is severely impaired. **Children:** Limited data available. **CONTRAINDICATIONS:** History of allergy to salicylates, hypersensitivity to mesalazine or any excipient. Severe hepatic or renal impairment. Gastric and duodenal ulcers. Children aged under two years. **PRECAUTIONS AND WARNINGS:** Prior to therapy evaluate renal function and conduct haematological investigations, including complete blood count. During therapy regularly monitor hepatic and renal function, and haematological values. Not for use in patients with renal impairment. Patients with pulmonary disease, particularly asthma, must be carefully monitored. Caution in patients with raised blood urea, proteinuria, liver impairment, previous myo- or pericarditis or allergic background, and in the elderly. Not for use in patients with a history of mesalazine-induced cardiac hypersensitivity. Monitor closely in patients sensitive to sulfasalazine, immediately discontinue treatment and seek medical attention for acute symptoms of intolerance such as abdominal cramps or acute pain, fever, severe headache or rash or symptoms of blood dyscrasia such as unexplained bleeding, haematuria, purpura, anaemia, persistent fever or sore throat. Data in children (aged 6 to 18) are limited. **Tablets only:** Tablets contain lactose (78mg/150mg); not for lactose-intolerant patients. Intact tablets in stool may be empty tablet coating. **INTERACTIONS:** Sulfasalazine decreases absorption of digoxin, but no data on interaction of digoxin with mesalazine. 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Very rare: blood dyscrasias, bone marrow depression, eosinophilia, blood disorder, hypersensitivity reactions such as allergic exanthema, drug fever, lupus erythematosus syndrome, pericarditis, peripheral neuropathy, allergic and toxic lung reactions, pneumonitis, interstitial pneumonitis, eosinophilic pneumonia, lung disorder, acute pancreatitis, changes in liver function , hepatitis, blood bilirubin increased, alopecia, myalgia, arthralgia, impairment of renal function, nephrotic syndrome, renal failure (possibly reversible), oligospermia (reversible), chest pain. Frequency not known: exacerbation of colitis, Lupus-like syndrome with pancolitis, pleuropericarditis, rash and arthralgia.
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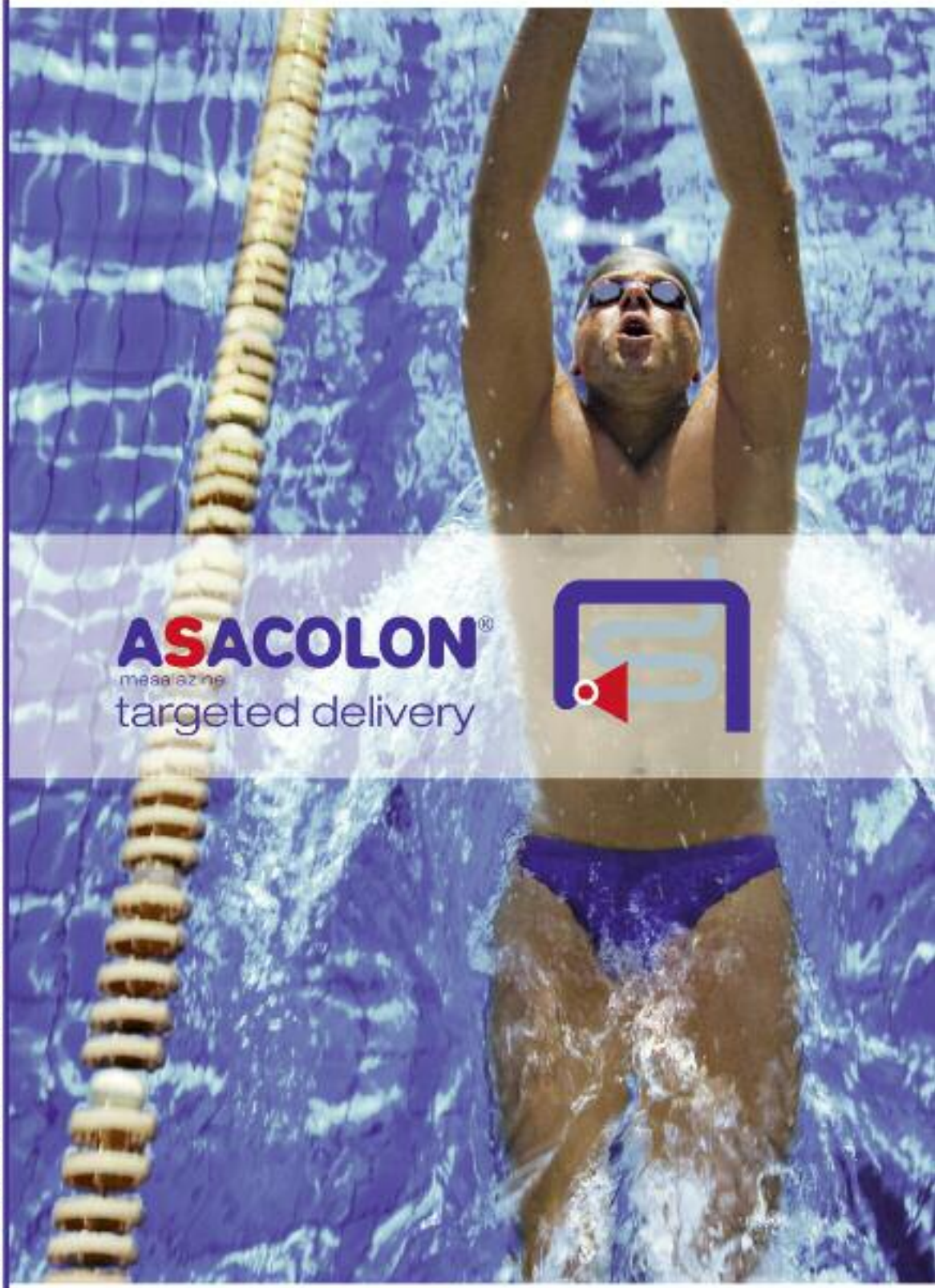

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Irish Society of Gastroenterology – Winter Meeting 2013
at The Malton Hotel, Killarney on 22nd. & 23rd. November 2013

Programme

Friday 22nd November

08.30 **Registration**

10.00 **Chairs: Dr Tony Tham, Dr Alan Coss**

Oral Free papers (1-5)

11.00 **Break, Poster Viewing & Exhibition Time**

11.30 **Plenary Session 1 – IBD**

Chairs: Dr Glen Doherty, Dr Geraldine McCormack.

Severe Ulcerative Colitis
Professor Adam Cheifetz, Assoc Prof. of Medicine
Director Centre for IBD
Beth Israel Deaconess Medical Centre
Harvard Medical School. Boston.

Ulcerative Colitis Dysplasia
Dr Garret Cullen
Consultant Gastroenterologist
St Vincents University Hospital.

12.15 **Plenary Session 2: Liver**

Chairs: Professor Humphrey O'Connor, Professor Suzanne Norris

Case Study: Induced Liver Injury
Dr Donal Sheehan
Sp Reg Gastroenterology
Cork University Hospital.

Drug-induced liver injury, clinical aspects
Professor Einar Björnsson
Prof. of Gastroenterology & Hepatology,
University of Iceland. Reykjavik.

13.00 **Lunch, Poster Viewing & Exhibition Time**

14.15 **Chairs: Dr Gavin Harewood, Dr Karen Hartery**

Oral Free Papers (6 - 11)

15.30 **Break, Poster Viewing & Exhibition Time.**

16.00 **Plenary Session 3: IrSPEN Forum.**

Chairs: Professor John Reynolds, Dr Orla Crosbie

Opening Address - Nutrition matters
Professor John V Reynolds,
Academic Head of Department of Clinical Surgery,
St. James's Hospital

16.10 ***Adult Intestinal Failure Services in England, -trials, triumphs and food for thought.***
Dr Jon Shaffer,
Consultant Gastroenterologist,
Salford, Royal NHS Foundation Trust. UK

16.45 ***Nutrition Strategies for Enhanced Recovery***
Dr Claire Donoghue
Sp Reg. St James Hospital.

17.05 ***Dilemmas in Managing IF and HPN- case studies***
Case Study: Dr Orla McCormack,
Sp Reg Surgery.
St James Hospital. Dublin

17.20 ***Closing Address - IrSPEN activities for the future***
Dr Orla Crosbie,
Consultant Gastroenterologist,
Cork University Hospital

Saturday 23rd November

08.45 **Chairs: Dr Johnny Cash, Dr Gavin Harewood**

Oral Free Papers (12- 15)

09.35 **Plenary Session 4: Chronic Pancreatitis Symposium**

Chairs:
Professor Kevin Conlon, Professor Martin Buckley

Endoscopic Management of Chronic Pancreatitis
Dr Barbara Ryan
Consultant Gastroenterologist,
Adelaide & Meath Hospital. Dublin

The Nutritional Management of Patients with Chronic Pancreatitis
Ms Sinead Duggan, Nutritionist.
Adelaide & Meath Hospital. Dublin

Surgical effects on patients with Chronic Pancreatitis
Professor Jakob Izbicki. Prof of Surgery,
University of Hamburg. Germany.

11.05 **Break, Poster Viewing & Exhibition Time**

11.35 **Plenary Session 5: Obstetric Cholestasis**

Chairs:
Professor Humphrey O'Connor, Dr Barbara Ryan

Obstetric Cholestasis & other Pregnancy Specific Liver Problems
Professor Catherine Nelson Piercy
Consultant Obstetric Physician
Guys & St Thomas Hospital. London

12.15 ***Social Media for the Gastroenterologist- What you need to know***
Dr Alan Coss
Consultant Gastroenterologist, Galway Clinic

12.45 **Prize giving and close of meeting.**

Irish Society of Endoscopy Nurses

FRIDAY 22nd NOVEMBER 2013 MALTON HOTEL KILLARNEY

Time	Speaker	Topic
0830-0900	Registration	
0900-0905	Deirdre Clune ISEN Chairperson	Introduction
0905-0915	Mary Fitzgerald ADON Kerry General Hospital	Welcome to Kerry
0915-0945	Mr. Fiachra Cook Colorectal Consultant Waterford Regional Hospital	Polyps to Cancer (The Journey)
0945-1015	Mr Andrew Coveney Surgical SpR Kerry General Hospital	Guidance for Surveillance of Colonoscopies
1015-1045	Dr. Glen Doherty Consultant Gastroenterologist St. Vincent's University Hospital, Dublin	Anticoagulants and Endoscopy
1045-1125	**COFFEE**	**Visit Industry Representatives**
1125-1155	Dearbhla Reid Operational Manager National Cancer Screening Service	National Bowel Screen Programme– one year on.
1155-1230	Dr. Anne Kelly Consultant Gastroenterologist Wexford Regional Hospital	All you need to know about Coeliac Disease
1230-1240	Leah Palado Clinical Facilitator St. Vincent's University Hospital, Dublin	Post Graduate opportunities for Endoscopy Nurses
1240 - 1345	**LUNCH**	**Visit Industry Representatives**
1345–1430	Irene Dunkley Nurse Consultant & Tutor in Gastroenterology and Endoscopy Hinchingbrooke Hospital NHS UK	Is there a role for nurses in Endoscopy?
1430–1500	Jennifer Hewson CNS Gastroenterology MWRH - Nenagh	Bowel Preparations The Good, the Bad and the Ugly!
1510–1520	Anne Tarleton, Connolly Hospital Sinead Horgan, CUH	ESGENA Update- Berlin
1520–1530	Deirdre Diver ISEN Committee	Education Update
1540–1550	Eddie Myers ISEN Treasurer	Treasurer Report and AGM
1550-1600	Close of meeting	

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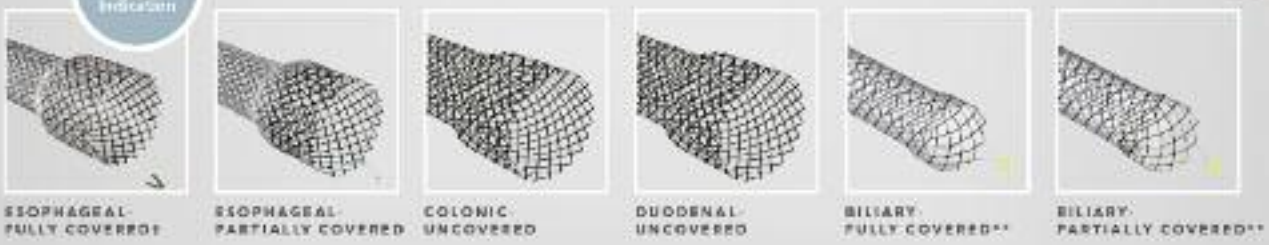

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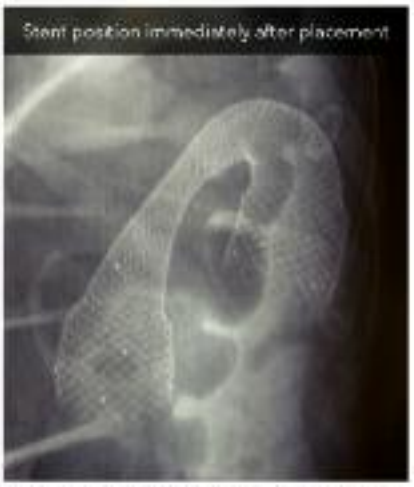

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Speakers Biographical Sketches

Humphrey O'Connor
President I.S.G.
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 Alan Coss
Consultant Gastroenterology, Galway Clinic.

Dr. Alan Coss is a consultant gastroenterologist at the Galway Clinic. A graduate of NUI Galway in 1998, he completed his specialist registrar training at St. Vincent's University Hospital, Beaumont Hospital, and St. Luke's Hospital, Kilkenny, before pursuing endoscopy fellowship training at Vancouver General Hospital and St. Paul's Hospital, Vancouver. He was awarded an MD by UCD on molecular markers of disease progression and treatment response in colorectal cancer. He took up his current position in Galway in 2010.

Prof Catherine Nelson-Piercy
MA FRCP FRCOG

Catherine Nelson-Piercy is a Consultant Obstetric Physician at Guy's and St. Thomas' Hospitals Trust and Queen Charlotte's and Chelsea Hospital in London. Her undergraduate studies were at King's College, Cambridge University and St Bartholomew's Hospital. She trained as a physician, and was taught Obstetric Medicine by Professor Michael de Swiet. She specialises in the care of women with medical problems in pregnancy. Professor Nelson-Piercy runs special joint clinics for women with renal disease, cardiac and rheumatic disorders, hypertension and epilepsy in pregnancy. She offers pre-pregnancy counselling for women with pre-existing medical problems and those with problems in previous pregnancies.

Professor Nelson-Piercy has been involved in the development of several evidence-based National Guidelines notably for "Contraception in Women with Heart Disease", BTS / SIGN "Asthma in Pregnancy" and RCOG Green top guideline on "Reducing the risk of thromboembolism during pregnancy, birth & the puerperium". She has over 200 publications and has edited five books and written the successful Handbook of Obstetric Medicine, now in its fourth edition. She was also one of the central assessors for maternal deaths and chapter author for Heart Disease in 'Saving Mothers Lives', CEMACH (Confidential Enquiry into Maternal and Child Health) 2000-02, 2003-5 and 2006-8.

Professor Nelson-Piercy is the President of the International Society of Obstetric Medicine (ISOM), sat on the Education Committee and Executive Committee of the British Maternal and Fetal Medicine Society (BMFMS) and was the first Flexible Working Officer for the Royal College of Physicians of London, with responsibility for flexible / part-time training and working. She is editor in chief of a new journal 'Obstetric Medicine: the medicine of pregnancy.' Professor Nelson-Piercy was awarded the FRCOG ad eundum in 2007 and is the youngest ever recipient of this honour. In 2010 she was awarded the title of Professor of Obstetric Medicine at King's College London.

Prof Adam Cheifetz
Assoc Prof of Medicine
Director Centre for IBD
Beth Israel Deaconess Medical Centre
Harvard Medical School. Boston.

Adam Cheifetz graduated magna cum laude from Brown University before earning his M.D. from Cornell University Medical College. Dr. Cheifetz completed his internship and residency in Internal Medicine at Yale-New Haven Hospital and his fellowship in Gastroenterology at Yale University before serving as the Present-Levinson Fellow in Inflammatory Bowel Disease at the Mount Sinai Medical Center in New York City.

Dr. Cheifetz is currently the Director of the Center for Inflammatory Bowel Disease at Beth Israel Deaconess Medical Center and Associate Professor at Harvard Medical School. He specializes in the diagnosis and treatment of Crohn's disease, ulcerative colitis, and other forms of inflammatory bowel diseases. He has been cited in Boston Magazine as one of Boston's Top Doctors on numerous occasions. In addition to his clinical work, he is involved in multiple research projects relating to IBD and has published over 75 articles and chapters on the subject. Dr. Cheifetz is an active member of the Crohn's and Colitis Foundation of America (CCFA) and serves as the current Chairman of the New England chapter medical advisory committee. He is currently a section editor of Inflammatory Bowel Diseases and Contributing Associate Editor in Chief of the World Journal of Gastroenterology. Dr. Cheifetz is also actively involved with teaching and mentoring of medical students, residents, and fellows and runs a monthly inter-departmental Inflammatory Bowel Disease Conference. In addition, he is Director of the Harvard Medical School Gastroenterology Clerkship Elective and Assistant Director of the Advanced Fellowship in Inflammatory Bowel Disease at Beth Israel Deaconess Medical Center.

Dr Paul Lynch
FRCP PhD

Consultant gastroenterologist at Antrim and Causeway Hospital with a particular interest in therapeutic endoscopy and ERCP. He had the privilege to be the Honorary Secretary of the USG from 2009 to 2012 as well as being the organizing chair for the BIG meeting held in Belfast in April this year. He graduated from Queen's University of Belfast in 1995 and undertook his gastroenterology training within the Northern Ireland Deanery; this was followed by an endoscopy fellowship at Westmead Hospital, Sydney. He has been working within the Northern HSC Trust for 7 years and is the endoscopy lead and bowel cancer screening lead for the trust.

Dr Paul Lynch has just been elected to the board of the Irish Society of Gastroenterology.

Professor John V Reynolds
Chairman of IrSPEN

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

Professor Reynolds has obtained numerous research awards and has published widely in cancer research, with over 250 publications and approximately ¤5m research grant income. His clinical interest is in diseases of the oesophagus and stomach. His research interest is in four areas: (1) pathogenesis of Barrett's oesophagus and progression; (2) prediction of response and resistance to chemotherapy and radiation therapy; (3) obesity, altered metabolism, and cancer; (4) malnutrition and peri-operative nutrition.

Dr Orla Crosbie
MD FRCPI

Dr. Orla Crosbie is a Consultant Gastroenterologist at Cork University Hospital. Dr Crosbie leads the Hepatology service at CUH and has research interests in Hepatitis C epidemiology and molecular virology. Dr Crosbie also has a busy Endoscopy Practice, carrying out diagnostic and therapeutic endoscopy including ERCP. Dr Crosbie was the National Speciality Directors for SpR training in Gastroenterology at the Royal College of Physicians from 2009 to 2012 and now serves on the Council in the Royal College of Physicians. During her time as NSD she has organised and run a number of study days for the gastroenterology SpRs including an annual Nutrition Study Day, which is now a compulsory part of Spr training given the importance of Nutrition in the Management of all patient groups. Dr. Crosbie is also Medical Advisor for the National Committee to develop endoscopy reporting systems in Ireland and is Lead Clinician for the Hepatology subgroup of the Irish Society of Gastroenterology.

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.

Ms. Sinead Duggan
Nutritionist, Adelaide & Meath Hospital. Dublin

Sinead graduated with a first class honours degree in Nutrition & Dietetics in 2002 and completed a post-graduate diploma in Medical Statistics with TCD in 2005. Following 8 years as a Clinical Dietitian in Tallaght Hospital, Sinead commenced her PhD studies in Nutrition in Pancreatitis with the help of a Meath Foundation grant and subsequently a HRB Health Professionals Fellowship. Following completion of her PhD studies this year under the supervision of Professor Kevin Conlon, a further successful Meath Foundation grant supports post-doctoral work.

As well as peer-reviewed publications, Sinead has co-authored a chapter in the UK PENG book and has presented widely throughout Ireland, Europe and the United States. Sinead sits on the council of the Pancreatic Society of Great Britain and Ireland, and co-founded the Nutrition Interest Group of the same society, which involves the organisation of an annual 'Nutrition in Pancreatic Disease' symposium during the Pancreatic Society annual conference.

Dr Claire Donoghue
Sp Reg. St James Hospital

Dr Claire Donohoe has recently completed a PhD, examining the role of the insulin-like growth factor axis in carcinogenesis in oesophageal cancer under the supervision of Prof John Reynolds, Professor of Surgery, Trinity College Dublin. She is a medical graduate of Trinity College Dublin and is currently a specialist registrar in general surgery. She plans to pursue a career as a consultant upper gastrointestinal surgeon in the future. She is the first author of 19 research papers and co-author on a further 17 papers.

Prof Einar Björnsson
Prof of Gastroenterology & Hepatology,
University of Iceland. Reykjavik.

Einar S. Björnsson was born in Iceland 1958. He studied psychology and philosophy at the University of Iceland for three years. He finished medical school 1989 at the same University and then moved to Sweden. He spent almost 20 years in Gothenburg Sweden. Defended his PhD in 1994. Spent a post-doc in Ann Arbor Michigan 1996-1997. Became a Professor of Gastroenterology and Hepatology in Gothenburg in 2006. Senior registrar at the John Radcliffe hospital in Oxford in 2001. Sabbatical at the Mayo Clinic Rochester Minnesota 2006 and 2008-2009. He became the chief of Gastroenterology and Hepatology and Professor of Medicine at the National University of Iceland in Reykjavik in 2009 He is author of more than 200 publications, that is original articles, editorials and book chapters and has been supervisor of 6 individuals who have finished their PhD degree.

Dr. Jon Shaffer
Consultant Gastroenterologist
Salford, Royal NHS Foundation Trust. UK

Jon Shaffer is a Gastroenterologist based at Salford Royal (formally known as Hope) Hospital in Manchester. He helped establish the Home Parenteral Nutrition service in 1980. The unit has experience of over 600 patients, many of which have survived more than 20 years. He promoted the concept of "Intestinal Failure" and has lectured and advised nutrition societies all over the world in all aspects of intestinal failure. He has recently "semi –retired "from clinical work but still chairs the ESPEN Special interest group in Acute Intestinal Failure.

Dr Garret Cullen
Consultant Gastroenterologist

Dr Garret Cullen is a Consultant Gastroenterologist at St. Vincent's University Hospital in Dublin. He received his medical degree from University College Dublin in Ireland and was subsequently awarded an MD by thesis for research in inflammatory bowel disease (IBD). Having completed gastroenterology training at St. Vincent's University Hospital and Beaumont Hospital, he completed two years of advanced IBD training at Massachusetts General Hospital and Beth Israel Deaconess Medical Center in Boston, MA. Dr. Cullen was subsequently appointed as an attending gastroenterologist at BIDMC and Assistant Professor of Medicine at Harvard Medical School before returning to Dublin to take up his current post. Dr Cullen is involved ongoing clinical research in IBD, focusing on clinical trials in addition to risks and outcomes related to immunosuppression. He has authored a number of peer-reviewed articles, book chapters and reviews in IBD. Dr. Cullen is a Clinical Editor for the IBD Monitor, an author for the IBD section of UpToDate and has served as a reviewer for a number of medical journals including the New England Journal of Medicine, Gut and the American Journal of Gastroenterology.

Dr Glen Doherty
Consultant Gastroenterologist

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

Dr Tony C.K. Tham
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.

Dr Johnny Cash
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 Gavin Harewood
Secretary ISG
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 serves as the Secretary for the Irish Society of Gastroenterology. 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 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.

Prof Jakob Izbicki
Prof of Surgery,
University of Hamburg. Germany.

CLINICAL AND SCIENTIFIC BACKGROUND

1998-present
Chairman Dept. of General, Visceral and Thoracic Surgery, University of Hamburg

1994-present
Professor of Surgery, Dept. of General, Visceral and Thoracic Surgery, University of Hamburg

1992-1998
Senior Attending Physician and Deputy Director, Dept. of General Surgery, University of Hamburg (Prof. Dr. Dr.h.c. Ch.E. Broelsch)

1991
Associate Professor of Surgery, Dept.of Surgery, Ludwig-Maximilians-University of Munich Klinikum Innenstadt (Prof.Dr.L.Schweiberer).

1991-1992
Attending Surgeon Gastrointestinal and Thoracic Surgery and Surgical Oncology. Dept.of Surgery, Ludwig - Maximilians - University of Munich Klinikum Innenstadt (Prof.Dr.L.Schweiberer).

1990
Venia Legendi in Surgery and appointment as Privat Dozent (Assistant Professor of Surgery).

1989-1990
Instructor in Surgery (Surgical Gastroenterology, Surgical Oncology and Thoracic Surgery) Dept. of Surgery, Ludwig-Maximilians-University of Munich Klinikum Innenstadt

1986-1989
Senior Resident and Postdoctoral Fellow Dept. of Surgery, Ludwig-Maximilians-University of Munich, Klinikum Innenstadt (Prof.Dr.L.Schweiberer).

1982-1986
Resident and Postdoctoral Fellow in Surgical Gastroenterology II. Dept. of Surgery, University of Cologne (Prof.Dr.H.Troidl).

1981-1982
Resident, Dept. of Abdominal and Transplantation Surgery (Prof.Dr.R.Pichlmayr) and Dept. of Pediatric Surgery (Prof. Dr.H.Mildenberger) University Hospital Hannover, Germany

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Email: info@isge.ie

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Date of preparation February 2013 HEU3000

Oral Presentations – Winter Meeting 2013

Ref:	Abstract No	Author(s)	Abstract Title	Day	Time
1	13W101	Dr Barry Hall	Decreased mucosal expression of the E3 ubiquitin ligase, Pellino3, a mediator of NOD2, in a cohort of patients with Crohn's disease	Fri	10.00
2	13W133	Dr Edel McDermott	Global DNA Methylation in Inflammatory Bowel Disease	Fri	10.12
3	13W111	Dr Shaheel Sahebally	Identification of a putative and novel biomarker in Crohn's disease- circulating fibrocytes	Fri	10.24
4	13W167	Mr Frank McDermott	Polyamines induce a morphological effect on colonic mucus, as seen by the movement of nanoparticles through gel layers.	Fri	10.36
5	13W205	Helen Mohan	Microsatellite Instability and Clinicopathological Outcomes in a Series of 1250 Colorectal Cancers	Fri	10.48
6	13W183	Dr David Moore	Endoscopist detection of sessile serrated lesions (polyps) is related to other quality indicators for colonoscopy	Fri	14.15
7	13W151	Dr Paul Moore	Can Radiological Abdominal Cross-Sectional Imaging protect against Bowel Cancer?	Fri	14.27
8	13W171	Mr Stephen Bligh	EndoFLIP® used to evaluate the distensibility of the oesophagogastric junction (OGJ) in normal control subjects before and after muscarinic blockade with atropine and in patients with GORD	Fri	14.39
9	13W104	Dr Grainne Holleran	Long acting Octreotide therapy has a beneficial effect in a cohort of Irish patients with significant gastrointestinal angiodysplasia	Fri	14.51
10	13W108	Dr Vikrant Parihar	A Simultaneous Dual Antral and Corpus Rapid Urease Test Increases the Diagnostic Yield for Helicobacter Pylori Infection	Fri	15.03
11	13W166	Mohd Syafiq Ismail	The effect of paracetamol legislation on admissions for paracetamol overdose in a single referral centre.	Fri	15.15
12	13W114	Helen Heneghan	Preoperative biliary drainage of radiologically resectable malignant biliary tumours	Sat	08.45
13	13W117	Dr Daniel Schmidt-Martin	Have hospital admissions for alcoholic liver disease peaked in Ireland?	Sat	08.57
14	13W144	Dr Rana Haider	Improvement Of Liver Functions Tests (Lfts) In Obstructive Sleep Apnea (Osa) Patients After Cpap Therapy	Sat	09.09
15	13W188	Susanne O'Reilly	Initial experience of the National Colorectal Cancer Screening Programme at St. Vincent's University Hospital	Sat	09.21

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(Please refer to the full Summary of Product Characteristics before prescribing)

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Reference:
1. National Institute for Health and Clinical Excellence. TA211 Constipation (chronic) – prucalopride: guidance. 15 December 2010. (http://guidance.nice.org.uk/TA211/Guidance/pdf/English).

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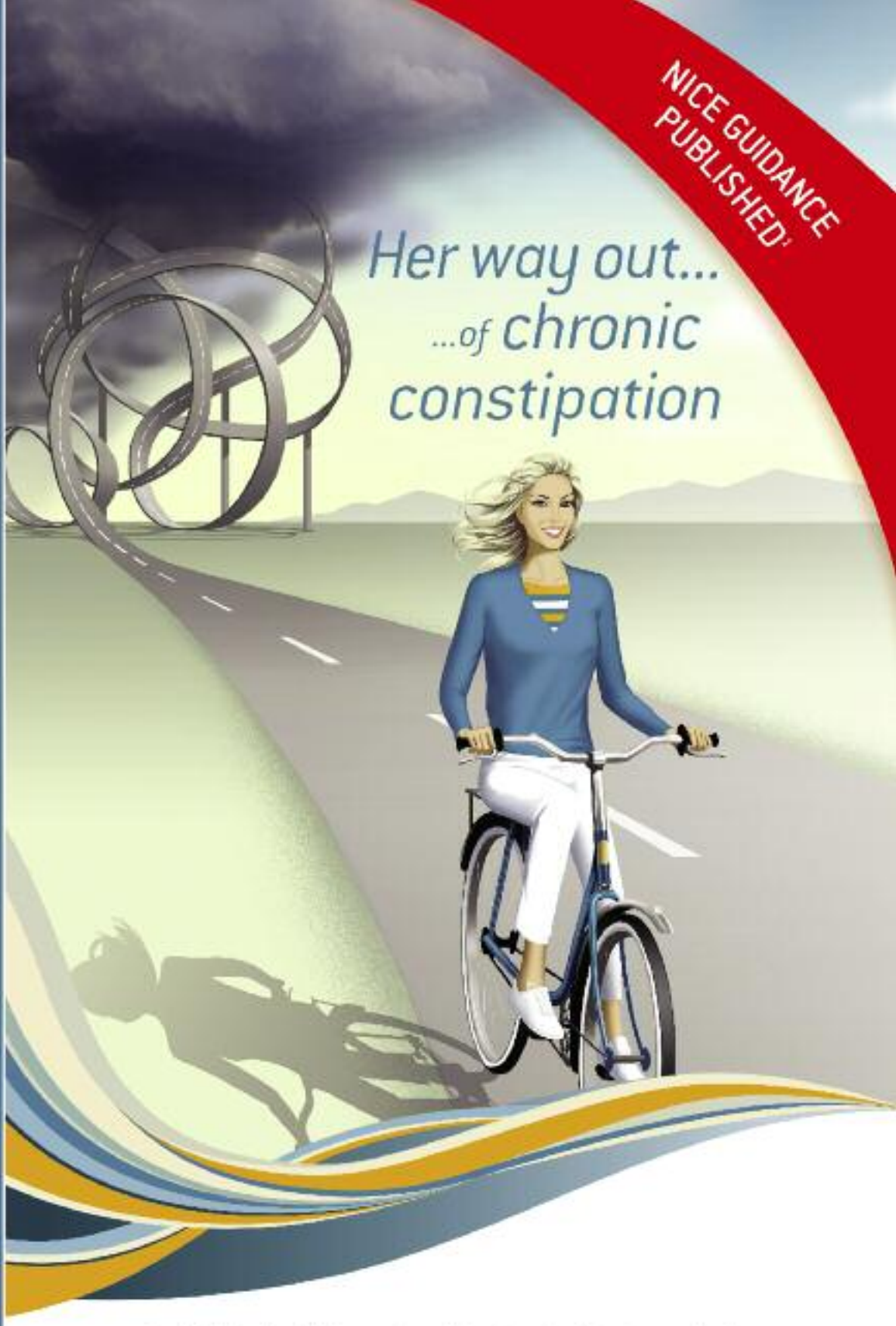
UK/RES/0177/1a August 2012



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ABSTRACT 1 (13W101) ORAL PRESENTATION

Title of Paper: Decreased mucosal expression of the E3 ubiquitin ligase, Pellino3, a mediator of NOD2, in a cohort of patients with Crohn's disease

Author(s): Barry Hall1, Grainne Holleran1, Shuo Yang2, Bingwei Wang2, Fiachra Humphries2, Ruaidhri Jackson2, Marc E Healy2, Ronan Bergin2, Deirdre McNamara1, Paul Moynagh2

Department(s)/Institute(s): 1 Department of Clinical Medicine and Gastroenterology, AMNCH, Tallaght, Dublin 24 2 Institute of Immunology, Department of Biology, National University of Ireland Maynooth, Maynooth, Ireland.

Introduction: The innate immune system is equipped with pattern-recognition receptors that recognize pathogen-associated molecules. Pattern-recognition receptors include cytosolic NOD-like receptors which recognize structures in bacterial peptidoglycan. Loss-of-function mutations in NOD2 have been shown to be associated with Crohn's disease (CD). We have recently shown that the E3 ubiquitin ligase, Pellino3, is critical in the regulation of NOD2 activity with impaired NOD2 signalling being observed in cells from Pellino3-deficient mice. Furthermore we also demonstrated exacerbation of intestinal inflammation in various experimental colitis models in Pellino3 knockout mice. Given such studies indicate a protective role for Pellino3 in mediating intestinal homeostasis; we herein assessed the levels of Pellino3 expression in patients with inflammatory bowel disease (IBD).

Method: Following ethical approval, patients between 18-80 years with no contraindications to biopsy who were undergoing colonoscopy as part of their ongoing care were prospectively recruited. Control subjects were defined as subjects with a normal ileo-colonoscopy and negative histology. Two additional biopsies were collected from the inflamed segment of patients with established IBD and from the left colon in control subjects. Biopsies were 'snap-frozen' and stored anonymously at 80 °C for batch analysis. Immuno-blot analysis was used to assess the expression of Pellino3 in the biopsy samples from both healthy controls and patients with IBD. Patient demographics, medical history, endoscopy findings and routine histology were recorded. Results are expressed as a mean and all statistics were performed using SPSS 19 software.

Results: A total of 30 subjects were enrolled: 19 (63%) with IBD and 11 (37%) controls. Of these, 14 (47%) were male and the mean age was 46 years. There were more women in the control group (7 of 11; 63%) than in the group with IBD (9 of 19; 47%; $P < 0.05$). In the group with IBD, 14 had established CD (10 with ileo-colonic disease and 4 with isolated ileal disease) and 5 had ulcerative colitis (UC). Among the IBD patients, 15 (79%) were on maintenance therapy. Endoscopically, the inflammation was assigned a grade of 'moderate' for 6 (32%) and as 'mild' for the remaining 13 (68%) patients with IBD. Routine histology confirmed active inflammation in 12 IBD patients (63%) and was normal for all 11 control subjects. On immunoblot analysis, there was a significant difference in Pellino3 expression between CD patients and both the control group and those with UC (Table 1). Expression of Pellino3 was consistently lower in all biopsy samples of patients with CD when compared to the remainder of subjects.

Table 1. Pellino3 activity in the three subgroups of patients; CD, UC and controls

	Pellino3 High	Pellino3 Low
Crohn's disease (n=14)	0	14
Ulcerative colitis (n=5)	3	2
Controls (n=11)	11	0

Conclusion: This is the first study in human subjects to show reduced expression of Pellino3, a regulator of NOD2 innate immunity in patients with CD. The difference in Pellino3 expression between CD and UC is in keeping with known NOD2 function. Pellino3 may represent a novel biomarker capable of accurately diagnosing CD and may also be useful as a possible site for future therapeutic interventions.

ABSTRACT 2 (13W133) ORAL PRESENTATION

Title of Paper: Global DNA Methylation in Inflammatory Bowel Disease

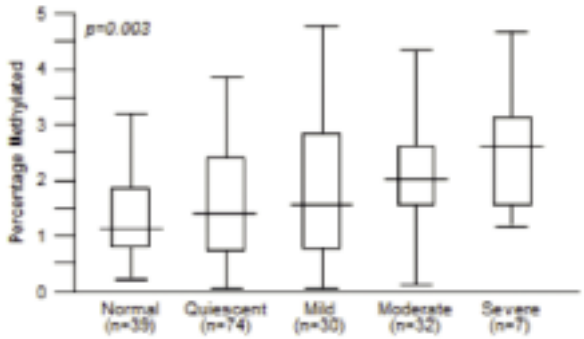
Author(s): E. McDermott, T. Murphy, G. Sexton, D. Keegan, G. Doherty, G. Cullen, H. Mulcahy, E. Ryan.

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

Introduction: The pathogenesis of IBD is unknown. However, it is widely accepted that interactions between environmental influences in genetically susceptible individuals are important. Epigenetics is the mechanism of regulation of DNA, without altering the underlying DNA sequence, and may explain at least some of the interactions between the environment and genetics that result in disease. DNA methylation is one mechanism of epigenetic regulation that involves the addition of a methyl group to a cytosine residue in a CpG site that results in silencing of that gene. It has been demonstrated to be involved in the development of cancer(1) and certain autoimmune diseases(2) and interest in DNA methylation in disease pathogenesis, as a biomarker and, due to its reversible nature, as a treatment target, is growing. However, little is known about DNA methylation in IBD.

Aims/Background: To examine the association between inflammatory bowel disease and global DNA methylation and to assess clinical variables associated with methylation in IBD patients.

Method: 143 IBD patients (84 Male, 83 Crohns disease, median age at study 35 years, median disease duration 6.8 years) were recruited to this study. Patients donated a blood sample and completed a comprehensive questionnaire containing demographic, disease-related and psychosocial variables. Patients were also independently assessed by a physician, who documented disease activity. Peripheral blood mononuclear cells from each patient were isolated and DNA extracted using standard techniques. 40 non-IBD controls were also recruited. Global DNA methylation was assessed using the MethylFlash Methylated DNA Quantification Kit by Epigentek.



Results: DNA methylation decreased with increasing patient age ($r=-0.21$, $p=0.02$). The median global methylation was 1.19 (interquartile range (IQR 0.81-1.8) in controls and 1.69 (IQR 0.84-2.6) in IBD patients. Methylation increased in a stepwise fashion as disease activity increased ($p=0.003$), Figure 1. No other

demographic or disease related factors were associated with methylation. Regression analysis demonstrated that both age and disease activity were independently associated with methylation status.

Conclusion: Methylation patterns are significantly associated with both the presence and activity of IBD. This may have important implications in the pathogenesis and treatment of IBD and merits further research.

References:
1. Esteller M. Epigenetics in Cancer. New England Journal of Medicine. 2008;358(11):1148-59.
2. Greer JM, McCombe PA. The role of epigenetic mechanisms and processes in autoimmune disorders. Biologics. 2012;6:307-27.

ABSTRACT 3 (13W111) ORAL PRESENTATION

Title of Paper: Identification of a putative and novel biomarker in Crohn's disease- circulating fibrocytes

Author(s): Shaheel M Sahebally, Miranda G Kiernan, John P Burke, Colum Dunne, Stewart Walsh, Patrick Kiely, Calvin J Coffey

Department(s)/Institute(s): Department of Surgery, University Hospital Limerick; 4i Centre for Interventions in Inflammation, Infection and Immunity, Graduate Entry Medical School, University of Limerick

Introduction: Although fibrosis in Crohn's disease (CD) is mediated by fibroblasts, their source is unknown. Fibrocytes are bone marrow-derived mesenchymal progenitor cells that are recruited to sites of inflammation, where they differentiate into fibroblasts and deposit extracellular matrix.

Aims/Background: In the first study of its kind we aimed to characterize the role of circulating fibrocytes (cFC) in CD (*).

Method: Following ethical approval and informed consent peripheral blood samples were obtained perioperatively from CD (n=5) patients undergoing an ileocolic resection. A FACS (Fluorescent Activated Cell Sorting)-based technique was optimized to characterize cFC levels by staining for CD45 and Col-1. A culture-based technique was developed whereby mesocolic fibrocytes from CD and controls could be developed and expanded ex-vivo. The adhesive and proliferative capacity of Crohn`s fibrocytes were then established via a real time cell analyzer (RTCA) machine. Data was analyzed using SPSS v21.

Results: When compared with healthy controls, cFC were significantly elevated in CD patients (7.6 [0.64] vs. 0.9 [0.25] %, p=0.009). Of note, following resection, cFC levels dramatically reduced to near normal levels (7.6 [0.64] vs. 1.72 [0.85] %, p=0.105). Mesenteric fibrocyte cultures were obtained from CD patients. These cells appeared to adhere and proliferate more rapidly (9 vs. 18 hours) than those from non-CD patients.

Conclusion: Circulating fibrocytes are increased significantly in patients with active CD. Levels return to near normal following resection. Mesenteric fibrocytes in CD, likely derived from extravasation of cFC, exhibit behavioural differences when compared to non-Crohn`s fibrocyte populations. This combination of findings indicates that fibrocytes may represent a novel biomarker of disease activity.

References:
Sahebally SM, Burke JP, Chang KH, Kiernan MK, O'Connell PR, Coffey JC. Circulating fibrocytes and Crohn's Disease. Br J Surg 2013 (Publication in Press)

ABSTRACT 4 (13W167) ORAL PRESENTATION

Title of Paper: Polyamines induce a morphological effect on colonic mucus, as seen by the movement of nanoparticles through gel layers.

Author(s): McDermott F, Bramini M, Rogers A, Aberg C, Dawson K, Winter D, Baird A

Department(s)/Institute(s): Veterinary Sciences Building, Conway Institute and St Vincents University Hospital

Introduction: The colonic microbiome is an area of great interest in the field of gastroenterological research, with studies suggesting that bacteria influence host health and disease. The colonic mucus is organised into two layers, with a dense inner layer impermeable to bacteria and a looser outer layer as their colonic habitat, but the mechanism through which this structural phenomenon comes about is unclear. Polyamines (e.g. spermine, putrescine) are small cationic molecules produced by colonising bacteria in the colon at millimolar concentrations. Our lab has previously demonstrated that spermine directly alters the morphology of colonic mucus, increasing the thickness fivefold. This study uses fluorescently labelled nanoparticles to visualise the effects of polyamines on mucus in real time.

Aims/Background: To investigate the effects of polyamines on the colonic mucus gel with a novel technique following the movement of nano-particles through the gel with confocal microscopy.

Method: Imaging was performed with a spinning disc confocal microscope (37 °C, 5% CO2, 60% humidity with a 40X oil/immersion objective). Human colonic mucus was harvested from normal sigmoid colon following surgical resection. Optimisation experiments were performed with 100 and 500nm PS-COOH nanoparticles (Invitrogen), at 100 and 5 µg/mL, added to mucus. 2-D high-speed movies and 3-D images through the Z Stack were acquired before and after addition of 1mM spermine.

Results: Polyamine effects on mucus layers overlaying human colonic sheets in vitro included an explosive stimulation of mucus streaming. These observations were further investigated using 500nm particles at a concentration of 5ug/ml producing optimum images for analysis. 1mM spermine induces swelling of the mucus gel in both fresh and frozen mucus samples. Nanoparticles, which were static at the gel surface pretreatment, displayed altered motility profiles within the gel on addition of spermine.

Conclusion: These experiments demonstrate the novel use of nanoparticles with confocal microscopy as a tool for investigating the morphological and physiological characteristics of gastrointestinal mucus. The swelling phenomenon witnessed may explain how bacteria modulate the colonic mucus layer to inhabit it in both health and disease.

ABSTRACT 5 (13W205) ORAL PRESENTATION

Title of Paper: Microsatellite Instability And Clinicopathological Outcomes In A Series Of 1250 Colorectal Cancers

Author(s): MOHAN HM, SHEAHAN KM, GIBBONS D, WINTER DC

Department(s)/Institute(s): Departments of Surgery and Pathology, St. Vincent's University Hospital, Elm Park, Dublin 4, Ireland

Introduction: Colorectal cancer is a leading cause of cancer death. Microsatellite instability(MSI), with generalised instability of short

tandem DNA repeat sequences occur in a subset of colorectal cancers. This study aims to describe whether there is a difference in nodal status, lymph node ratio and pathological features associated with microsatellite instability in a large series of colorectal cancers.

Aims/Background: To compare clinical and pathological features of colorectal cancer in patients with microsatellite instability (MSI) compared to microsatellite stable colorectal cancers in our patient populaiton.

Method: Retrospective analysis of pathological features of patients with colorectal cancer identified on prospectively maintained colorectal and pathology databases at St. Vincent's University Hospital from 2004-May 2012. Ethical approval was obtained from St. Vincent's University Hospital.Chi squared test and unpaired t tests were used for statistical analysis using GraphPad Prism 5.

Results: 1250 cases of colorectal cancer were identified that were tested for microsatellite instaibilty (MSI) by immunohistochemistry. Overall, 11.0% were MSI (n=125), while 89.0% were MSS (n=1113). MSI tumours predominately occurred in female patients (MSI: 70.8% (n=97) female versus MSS: 44.8% (n=499)female, p<0.0001). The mean age was 71.48 +/- 13.72 MSI(95% CI69.2-73.8), versus 67.7 +/- 12.18 MSS(95% CI 66.98-68.42). There was a significantly higher proportion of right sided MSI tumours compared to left (24.5% of right sided tumours were MSI(n=60) while only 3.3% of left sided tumours were MSI (n=26), p<0.0001). MSI tumours had significantly lower rates of lymph node and distant metastases (MSI N+: 24.8% versus MSS N+: 46.2%, RR 2.36, 95% CI 1.59-3.49) p<0.0001; MSI M+: 1.6% versus MSS M+: 9.2%, RR 5.69, 95% CI 1.41-22.69, p=0.0036). Among those with nodal disease (stages III and IV), there was no significant difference in median lymph node ratio between MSS and MSI patients (MSI 0.17 versus MSS 0.17, p-ns).

Conclusion: Microsatellite instability is associated with right sided tumours in female patients, and with a reduced risk of nodal and distant metastases. MSI does not influence lymph node ratio in those with positive nodes.

ABSTRACT 6 (13W183) ORAL PRESENTATION

Title of Paper: Endoscopist detection of sessile serrated lesions (polyps) is related to other quality indicators for colonoscopy

Author(s): David Moore, Aiden Jennings, Blathnaid Nolan, Gareth Horgan, Kieran Sheahan, Hugh Mulcahy, Garret Cullen, Glen Doherty

Department(s)/Institute(s): Centre for Colorectal Disease, St Vincent's University Hospital/School of Medicine and Medical Science, UCD

Introduction: Adenomatous polyps are premalignant lesions and removal at endoscopy prevents progression to colorectal cancer. The ability to detect and remove these polyps during colonoscopy is therefore a key performance measure for endoscopists and adenoma detection rate has been independently associated with the risk of interval cancer.

Aims/Background: Sessile serrated lesions or polyps (SSL) are increasingly viewed in a similar way as important precursor lesions to colonic cancer, but there is little understanding of how detection of these lesions relates to other indicators of quality colonoscopy.

Method: All single endoscopist colonoscopies performed in a single centre during a six month period (January to July 2013) were identified using the Endoraad reporting system. The pathology report for every reported polyp was reviewed and used to calculate the rate of detection of adenoma and SSL. The colonoscopy performance characteristics of endoscopists who detected SSL was compared to those of endoscopists who did not.

Results: 1119 single endoscopist colonoscopies performed by 26 endoscopists (9 consultants and 17 trainees independently performing colonoscopy) were identified. The overall polyp detection rate was 25.2%. 322 adenomas were identified in 181 procedures yielding an adenoma detection rate of 16.1%. 17 SSP were identified in 13 procedures yielding an SSL detection rate of 1.3% (Range 0-7.9%). 6/26 endoscopists identified SSL. The mean total number of procedures was not significantly different between the two groups. The mean caecal intubation rate was higher in the endoscopists who identified SSL (97% versus 94%, p=0.03) and the mean withdrawal time was longer (13 vs 10 minutes, p=0.02). There was a strong trend towards a higher adenoma detention rate in the group of endoscopists who identified SSL (18% versus 11%, p=0.06). There were no significant differences in sedation practice between the two groups.

Conclusion: The identification and excision of SSL in increasingly recognised as important in prevention of right sided colorectal cancer, but only some endoscopists seem to detect these lesions at colonoscopy. This study suggests that there is a relationship between SSL detection and other quality indicators for colonoscopy performance.

ABSTRACT 7 (13W151) ORAL PRESENTATION

Title of Paper: Can Radiological Abdominal Cross-Sectional Imaging protect against Bowel Cancer?

Author(s): Paul Moore[1]; John Feeney[2], Grainne Holleran[1]; Deirdre McNamara[1]

Department(s)/Institute(s): 1. Department of Clinical Medicine, Trinity College Dublin. 2. Department of Radiology, Tallaght Hospital

Aims/Background: A common clinical practice currently in widespread operation is the request of a standard CT scan in a patient presenting with non-specific symptoms such as weight loss. Clinicians are often reassured by a normal report however, the validity of standard CT as an assessment tool for colonic disease in this scenario is lacking. Previous studies have shown that the sensitivity of CT in the detection of primary colorectal cancers (CRC) is variable, particularly with right-sided lesions and is dependent on the size of the tumour. Progression from an adenomatous polyp to CRC is a multistep process taking 10-15 years. From the natural history of CRC, it can be concluded that a normal CT reported in the 10 years prior to a diagnosis of CRC would represent a "missed" lesion. This study aims to test the hypothesis that having a CT scan is protective against developing CRC.

Method: A CRC patient database at Tallaght Hospital since 2009 was retrospectively reviewed. All CT imaging (CT TAP, CT AP, CT KUB) performed in the 6 months to 5 years prior to diagnosis was identified from the hospital radiology database and reviewed. Control patients were recruited from ENT and ophthalmology outpatient lists. The following exclusion criteria were applied 1) Recurrence of previous CRC 2) CT within 6 months of diagnosis 3) Those patients having a CT for the staging or surveillance of a malignancy.. Patient characteristics including gender and age were collated and compared between groups. The CT Rates between both groups were compared using a student t-test using SPSS version 20. A p value <0.05 was considered significant.

Results: In all, 373 new cases of Colorectal Cancer and 1000 controls were identified. The majority of cases 236 (63%) were male with a median age at diagnosis of 65 (Range 26-92 years). Similarly, in the controls there was a male preponderance with 541 (54%) men and a median age of 61. Of the 373 CRC patients, 22 (6%) had a CT performed in the 6 months to 5 years prior to diagnosis. Distribution of CTs was CT KUB n=2(9%), CT TAP n=9(41%), CT AP n=11(50%). When compared with the CRC group, there was a significantly higher rate of CTs performed in the control group 145 (14.5%) p<0.0001 (95% CI 0.05-0.13). Odds ratio - 0.4; p<0.001 (95% CI 0.25-0.64).

Conclusions: CT Scans performed in the preceding 5 years appear to offer some protection from CRC. Whether this is a causal association due to the identification of precancerous lesions in symptomatic cohorts or is linked to a confounding variable will require additional research.

ABSTRACT 8 (13W171) ORAL PRESENTATION

Title of Paper: EndoFLIP® used to evaluate the distensibility of the oesophagogastric junction (OGJ) in normal control subjects before and after muscarinic blockade with atropine and in patients with GORD

Author(s): Barry P McMahon, Stephen Bligh, Anil K. Vegesna, Larry S. Miller

Department(s)/Institute(s): TAGG, School of Medicine, Trinity College Dublin; Digestive Disease Institute, North Shore University Hospital, New York

Introduction: It has previously been shown that the area of the clasp and sling muscle fibres, the distal portion of the oesophagogastric junction (OGJ), is defective in patients with gastro oesophageal reflux disease (GORD). A major abnormality in many GORD patients is the increased compliance of the OGJ, which can allow a greater volume of reflux material to enter the oesophagus. Currently, OGJ function is assessed by using 24 hr pH-metry, manometry, radiographic or endoscopic imaging. None of these modalities can measure the compliance or distensibility of the OGJ region. The EndoFLIP® (Endolumenal Functional Lumen Imaging Probe) imaging system placed in the OGJ has been shown to demonstrate geometric & distensibility differences between healthy controls & patients with GORD. It uses the technique of impedance planimetry to distend a balloon in a lumen and measure the intra-balloon pressure, together with the cross-sectional area at 16 points along the balloon.

Aims/Background: To determine the distensibility of the OGJ using EndoFLIP® in normal control subjects before and after muscarinic blockade with atropine and in patients with GORD

Method: 9 healthy male control subjects were recruited (21 – 28, median age 24). 3 GORD patients were evaluated (2 male, 1 female, age 35, 45 and 51 respectively). After topical anaesthesia with cetacaine spray the EndoFLIP® probe was passed trans-orally into the stomach and positioned across the OGJ. A set protocol was used to distend the balloon with distension volumes of 20, 30 and 40ml. The narrowest cross sectional surface (CSA) area of the balloon at the OGJ was measured and pressure within the balloon was recorded. The normal volunteers underwent distension before and after the administration of atropine (15µg/kg bolus followed by 4µg/kg/hr IV drip) in order to block the muscarinic smooth muscle components of the OGJ, to try to simulate the defective gastric sling and clasp muscle fibers seen in GORD subjects and to investigate the underlying physiology of vagal innervation at the OGJ. GORD subjects underwent distension without atropine.

Results: For the normal subjects, the distensibility curve (pressure vs. minimum CSA) changes dramatically due to the atropine. At 20ml balloon volume, the pressure decreased significantly from 13.4mmHg to 7.4mmHg with a p value of 0.032. At 30ml balloon volume the pressure decreased significantly from 18mmHg to 14.1mmHg with a p value of 0.021. At 40ml the pressure decrease was not significant, decreasing from 27mmHg to 22.3mmHg with a p value of 0.083. The minimum CSA had a small but insignificant increase at all 3 balloon volumes. The distensibility index (measured in mm2/mmHg), increased at 20ml volume with a p-value of 0.022 and increased with no significance at 30ml and 40ml volumes with p-values of 0.424 and 0.779 respectively. Due to the small number of GORD patients, their distensibility curves were presented on a separate graph. GORD patient 1 had ulcers at the gastroesophageal junction on inspection by upper endoscopy and this could explain the abnormal distensibility curve of this patient. The other two GORD patients had distensibility graphs that were similar to graphs for GORD patients in previous studies.

Conclusion: OGJ distensibility for the normal controls changed as a result of the atropine administration, indicating that the OGJ has become looser and more distensible with a reduction in pressure and slight increase in minimum CSA. The minute change in minimum CSA may indicate that the change in the overall shape of the junction may be more important than simply analysing the narrowest CSA.

ABSTRACT 9 (13W104) ORAL PRESENTATION

Title of Paper: Long acting Octreotide therapy has a beneficial effect in a cohort of Irish patients with significant gastrointestinal angiodysplasia

Author(s): Grainne Holleran, Barry Hall, Stella Burska, Niall Breslin, Deirdre McNamara

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

Introduction: Angiodysplasias account for up to 50% of all causes of small bowel bleeding. Due to their relative inaccessibility and the intermittent nature of their bleeding they present a particular therapeutic challenge. Although 90% stop bleeding spontaneously, over 70% re-bleed at unpredictable intervals, leading to debilitating anaemia in an elderly population, exacerbating co-morbidities and carrying an overall mortality rate of 2%. Endoscopic ablation with APC has been shown to be the most efficacious at reducing re-bleeding rates, however, its effect is short-lived and not all small bowel lesions are amenable to APC via DBE. A recent small trial of long acting somatostatin analogues has shown very promising results at reducing re-bleeding rates, and if used in synergy with APC, may be the optimal current therapy for the treatment of small bowel lesions.

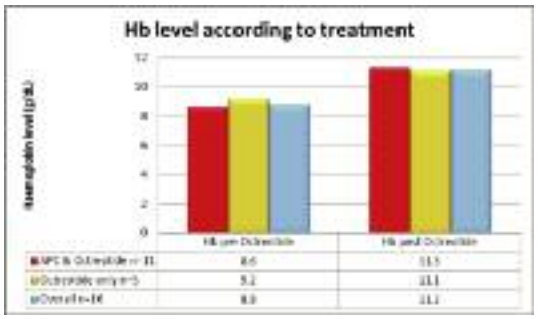
Aims/Background: To evaluate the effect of long acting intramuscular Octreotide on Haemoglobin levels and rates of re-bleeding in patients with small bowel angiodysplasia.

Method: An open label, uncontrolled pilot study of patients with a definite diagnosis of small bowel angiodysplasia identified from our small bowel capsule endoscopy database was undertaken. Only patients with significant disease, defined as recurrent anaemia for at least 6 months and requirement for RCC transfusion were included. Patients who had lesions amenable to APC via DBE and were fit to

undergo the procedure did so prior to commencing therapy. Baseline demographics and Hb level were recorded at inclusion. A dose of 20mg of long acting somatostatin was given intramuscularly on a monthly basis. Patients were assessed at regular intervals and were evaluated for side effects and episodes of bleeding. Repeat Hb levels were checked at 1, 3 and 6 months. An episode of re-bleeding was classified as either overt bleeding or a Hb drop of >1g/dL.

Results: 17 patients, of whom 59% (n=10) were female, with a mean age of 72 years (55-92) have been recruited to the study to date, 10 with isolated small bowel angiodysplasias and 5 with colonic lesions also. Of these, 71% (n=12) underwent DBE and APC prior to commencing treatment. The mean follow up time was 5.1 months (1-9). The average Hb of patients prior to treatment was 8.2g/dL (5-11.1). A minimum of 1 month follow up was unavailable in 1 patient as they withdrew consent. The average Hb in the remaining 16 patients at follow up was 11.2g/dL (10.5-12) which was statistically significant (p<0.00001). There was no significant difference in Hb levels between the group who received dual therapy with APC versus the group receiving Octreotide only (figure 1). Episodes of re-bleeding occurred in 19% (n=3) of patients. Octreotide was discontinued due to side effects in two patients, one who developed an allergic skin reaction within 72hours of administration, and the second, who developed an acute thrombocytopenia after 3 doses, both patients had a complete recovery on withdrawal of treatment.

Figure 1.



Conclusion: Our study has shown that long acting intramuscular Octreotide is a relatively safe medication and is effective at improving Hb levels in patients with refractory small bowel angiodysplasias. A longer follow up interval is needed to further evaluate its impact on re-bleeding rates and transfusion requirements in the longer term.

ABSTRACT 10 (13W108) ORAL PRESENTATION

Title of Paper: A Simultaneous Dual Antral and Corpus Rapid Urease Test Increases the Diagnostic Yield for Helicobacter Pylori Infection

Author(s): Vikrant Parihar, Barry Hall, Grainne Holleran, Nadeem Iqbal,Paul Crotty, Deirdre McNamara

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

Introduction: Rapid Urease Tests (RUTs) provide a simple, sensitive and convenient method of detecting Helicobacter pylori infection. The sensitivity and specificity of biopsy urease tests has been reported to be over 95% [1]. False negative results can occur in patients with recent gastrointestinal bleeding, gastric atrophy or with the use of PPIs, H2 antagonists and antibiotics. H. pylori infection may spread proximally in the stomach during profound acid inhibition [2]. In addition H.pylori infection rates are reported to be falling and this in addition to more frequent PPI (proton pump inhibitor) use could seriously affect the accuracy of a standard antral RUT.

Aims/Background: [1] To compare the yield of single antral versus simultaneous dual antral and corpus RUT's. [2] To assess the rate and factors associated with false negative RUT's.

Method: Patients undergoing a gastroscopy aged 18-80 years were included. Patient demographics, endoscopy findings, adverse events and PPI use were recorded. Patients with any contraindication to biopsy or previous negative tests for H. Pylori were excluded. Endoscopy was performed as standard. During endoscopy a single biopsy was taken from the antrum and placed in a CLO (Campylobacter like Organism, Ballard Medical, Draper) test. A further single biopsy from both the antrum and corpus were taken and placed together in another CLO test. Additional biopsies were taken from the antrum and corpus for histological examination. CLO tests were examined and interpreted at 30 minutes in accordance with manufacturer's guidelines by an independent observer. H pylori infection was defined by one positive test of either RUT's or histology The positivity rates for single antral and dual antral and corpus CLO tests were compared using a Fisher's exact test. A p value of <0.05 was considered significant. The positive and negative predictive values for RUT were assessed by comparison with histological data. The effect of diagnosis and PPI use and patient demographics on outcome were assessed by multivariate analysis.

Results: A total of 50 patients, 30 (60%) men, aged 20-80 years; (mean 55 years +/- 14.2 years) have been recruited. Endoscopy findings included gastritis n=24 (48%); Peptic ulcer disease (PUD)n=6(12%); Gastric Oesophageal Reflux Disorder(GORD)n=7(14%) and others n=4(8%). In all 39 (78%) histology results were available at the time of submission. The overall rate of H.Pylori infection in our cohort on RUTs was 22% (11/50). In all 6 (54%) patients were positive on simultaneous dual antral and corpus RUT only, this finding was significant, p value < 0.006. All positive antral RUT's were positive on dual RUT. In all 19 (38%) patients were on regular PPI. PPI use was associated with a significant reduction in H.Pylori infection, 2/19 (11%) versus 9/31 (29%) in those who were not on PPI, p< 0.05. Older age (>50 years) was not associated with higher H. pylori infection. In the cohort with available histology significantly more were diagnosed with infection by histological staining compared to single RUT 28% versus 10%, p<0.02. Dual RUT increased detection to 21% which was not statistically different from histological examination. Overall the PPV (positive predictive value) and NPV(negative predictive value) of dual and single RUT's compared to histology was 75% and 88% and 75% and 77% respectively.

Conclusion: A single antral RUT will miss a significant proportion of H.pylori infection if used in isolation in particular in patients on regular PPI use. A simultaneous dual antral and corpus RUT can significantly increase diagnostic yields and negative predictive value without increasing cost and may become the standard practice.

References:

1.Chey WD, Wong BC, Practice Parameters Committee of the American College of Gastroenterology. American College of Gastroenterology guideline on the management of Helicobacter pylori infection. Am J Gastroenterol 2007; 102:1808. 2 AE Berstad, JG Hatlebak

ABSTRACT 11 (13W114) ORAL PRESENTATION

Title of Paper: Preoperative biliary drainage of radiologically resectable malignant biliary tumours

Author(s): Heneghan HM, Redmond C, Kelly R, O'Toole D, Conlon KC, Traynor O, Geoghegan J, Maguire D, Hoti E.

Department/Institution(s): National Surgical Centre for Pancreatic Surgery, St Vincent's University Hospital, Elm Park, Dublin

Introduction: A proportion of patients with radiologically resectable biliary tumours present with biliary obstruction, necessitating preoperative decompression. This can be achieved endoscopically (ERCP) or percutaneously (PTC). Our aim was to report our experience with preoperative biliary drainage (PBD) prior to pancreaticoduodenectomy and to compare the outcomes of patients who underwent ERCP and PTC prior to pancreaticoduodenectomy.

Methods: A retrospective review of a prospectively collected national pancreatic database was conducted. All patients referred to the national centre for pancreatic cancer surgery were identified, and their clinical and operative details reviewed.

Results: Between Jan 2010-July 2012, 159 pancreaticoduodenectomy procedures were performed for biliary tumours. Of these, 83% underwent PBD. ERCP was more commonly performed than PTC (77% vs. 23%). The time from biliary drainage procedure to surgery was significantly longer after ERCP compared to PTC (71±109 days vs. 34±35 days, p=0.019). Successful decompression of biliary obstruction after a single intervention was more likely after PTC than ERCP (90% vs. 76%, p=0.18). Among the ERCP group, the sequelae of requiring >1 procedure included a delay in time to surgery and more advanced tumour size at the time of surgery. Procedure-related morbidity was similar for ERCP and PTC (23% vs. 33%, p=0.395). An additional cohort of patients (n=12) was identified who were referred with radiologically resectable tumors, but who became unresectable after resolution of ERCP-induced pancreatitis

Conclusion: Early referral of biliary cancers to the national pancreatic centre is critical to achieve the optimal surgical outcome. Patients who undergo multiple ERCPs may incur a significant delay in the time to pancreaticoduodenectomy and thereby could have more advanced disease at that time.

ABSTRACT 12 (13W117) ORAL PRESENTATION

Title of Paper: Have hospital admissions for alcoholic liver disease peaked in Ireland?

Author(s): Schmidt-Martin D, Long J*, Elgaily E, Mongan D*, McCormick PA.

Department(s)/Institute(s): Liver Unit, St Vincent's University Hospital, Elm Park, University College Dublin and The Health Research Board*, Dublin, Ireland

Introduction: There has been a dramatic increase in alcohol related liver disease in Ireland in recent years. In patients over 15 years of age alcohol related morbidity and mortality increased by 190% between 1995 and 2007. In general it takes years for alcoholic liver disease to develop. We have previously shown that there is a 5 year lag before increased levels of alcohol consumption in the general population are reflected in an increase in hospital admissions with alcoholic liver disease. In contrast decreases in per capita have been shown to be associated with rapid reductions in alcohol related liver mortality. This has been shown in a number of countries. There has been a recent decline in alcohol consumption in Ireland.

Aims/Background: Our aim was to determine if this change was associated with a reduction in alcohol related hospital admissions.

Method: Information on hospital discharges for alcohol related liver disease and alcohol dependence was obtained from the Hospital In-Patient Enquiry system (HIPE) from the ESRI. Data on per-capita alcohol consumption was extrapolated from excise duty and census data.

Results: Per capita alcohol consumption peaked in Ireland in 2001 at 14.3 litres annually. Since then it has declined by approximately 17% to 11.7 liters/per capita/per annum. Total admissions with alcohol related liver disease increased from 750 in 1995 to a peak of 3,262 in 2008. There was a slight decline to 2,877 in 2009, a peak of 3,412 in 2010 and a further decline to 2,853 in 2011. Similar patterns of a peak followed by stabilisation or a slight decline were seen across all age categories, for males and females and for both emergency and elective admissions. A similar pattern was seen for admissions related to alcohol dependence. These increased from 7,557 in 2003 to a peak of 15,482 in 2010 before declining slightly to 14,239 in 2011.

Conclusion: These data suggest that the progressive increase in admissions to Irish hospitals with alcohol related disease may at last be levelling off or beginning to decline. Such a development would be very welcome. In contrast to other countries we appear to be witnessing a delayed rather than an immediate effect. This could suggest that the Irish public are consuming alcohol in a more hazardous fashion than previously. This may be mitigating the beneficial effects of an overall decrease in alcohol consumption.

ABSTRACT 13 (13W144) ORAL PRESENTATION

Title of Paper: Improvement Of Liver Functions Tests (Lfts) In Obstructive Sleep Apnea (Osa) Patients After Cpap Therapy

Author(s): Rana Bakhtyar Haider, Sidra Khattak, Anne Marie O'connell, Ahsan Naqvi, Joan Power, Humphrey John O'connor, Mohammed Azam.

Department(s)/Institute(s): Naas Hospital

Introduction: Obstructive sleep apnoea (OSA) is recurrent obstruction of the upper airways during sleep leading to intermittent hypoxia (IH). OSA has been associated with metabolic syndrome as well as with non-alcoholic fatty liver disease with abnormal LFTs [1].

Aims/Background: In this study we looked at prevalence of abnormal liver functions in OSA patients and effects of Continuous positive airway pressure (CPAP) therapy on liver functions tests.

Method: In this retrospective study we did chart review of 60 patients in a hospital based study .We noted their age, weight, body mass index (BMI), alcohol intake status, liver functions tests 3-18 months prior and after therapy, liver Ultrasound (US) findings and their cholesterol levels.

Results: Patients were commenced on CPAP during the years of 2008 to 2013. Patients with OSA were in the age group of 39-82 with an average age of 57.5 years. Women were 15 % and 85 % were men. Their average BMI was 37.5. Average Epworth score on the start of CPAP therapy was 13.89 with 18.33 % of patients starting Epworth score was not recorded and after therapy it improved to 4.84 with no record of 46.6 % of patients after therapy. Apnea

Hypopnea Index (AHI) average score was 37.01 which improved to 4.69. (41.66 % had no recorded AHI after therapy). We noted that prior to commencing on CPAP therapy 31.66% patients had abnormal Alanine transaminase (ALT), 40% abnormal Gamma-glutamyltransferase (GGT), and 5% abnormal Alkaline phosphatise. After CPAP therapy 18 %, 17% and 4 % had abnormal ALT, GGT and Alkaline phosphatase respectively. Only 13.3 % of abnormal LFT patients were from alcohol consumer group and rest were non-alcohol consumer group. Bilirubin levels of all patients were normal. Only 20% patients had alcohol intake history including patients with occasional intake. 38.33 % had fatty liver reported on abdominal ultrasound (US). 18.3% had normal liver US and 43.34 % had no US done. 40 % were diagnosed with diabetes and prevalence of other metabolic conditions was also high. There was no change noted in BMI pre and post therapy.

Conclusion: Overall prevalence of patients with abnormal LFTs was 68.66 % which included either of ALT, GGT, and alkaline phosphatase or in combination. Overall abnormal LFTs in treated patients were 40 % which represents improvement. Improvement in AST and GGT was significant; only a small number of patients had raised alkaline phosphatase pre-treatment and there was no significant difference in alkaline phosphatase level after CPAP. We think that optimal assessment and treatment of OSAP leads to liver function improvement as noticed and further studies including larger number of patients over prolonged period of time are required. Perhaps, once OSA is well under control, a major effort to lose weight may lead to further improvement of LFTs (and +/- OSA).

References:

Obstructive sleep apnoea and non-alcoholic Fatty liver disease: is the liver another target? Mirrakhimov AE, Polotsky VY .Front Neurol. 2012 Oct 17; 3:149. doi: 10.3389/fneur.2012.00149. eCollection 2012.

ABSTRACT 14 (13W166) ORAL PRESENTATION

Title of Paper: The effect of paracetamol legislation on admissions for paracetamol overdose in a single referral centre.

Author(s): M.S Ismail, O. Omar, S Sengupta, J. Keohane

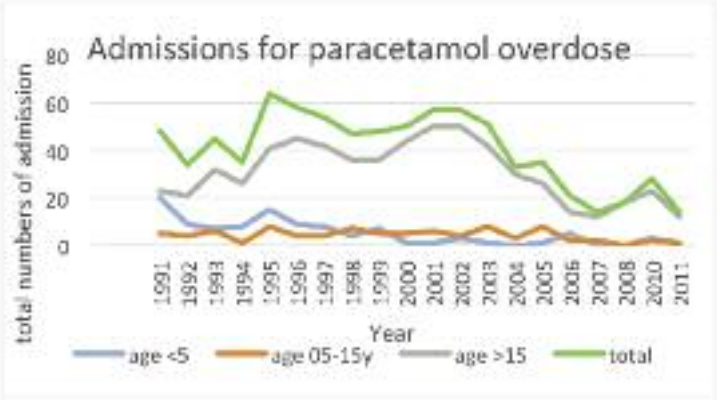
Department(s)/Institute(s): Department of Gastroenterology, Our Lady of Lourdes Hospital Drogheda

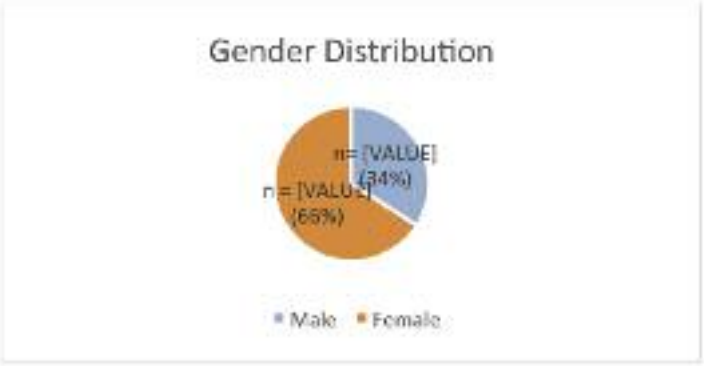
Introduction: Paracetamol is one of the most common substances taken in overdose . The effect of paracetamol overdose is devastating with potentially fatal consequences. Paracetamol overdose can also cause irreversible liver injury requiring liver transplantation . Since the year 2001, Ireland has introduced legislation regarding the packaging of paracetamol in order to limit the access to this drug where a maximum pack size of 24 tablets can be bought in pharmacy and 12 tablets in non-pharmacy outlet. Only one pack can be purchased on each transaction.

Aims/Background: The study was conducted to review whether the paracetamol legislation has reduced the rates of admissions from paracetamol overdose in Our Lady of Lourdes Hospital, Drogheda.

Method: Admission data from 10 years before and 10 years after paracetamol legislation was obtained through the HIPE database. Patients were divided into 3 different age groups. Data was analysed using Graph Prism v5 (Graphpad, San Diego, CA, USA). Descriptive statistics are expressed as percentages for categorical data. Parametric data were compared using an unpaired t -test. A p value < 0.05 was considered to be statistically significant.

Results: The results obtained showed a total of 776 patients admitted over a 20 year period. 492 patients were admitted from the year 1992 to 2001 and 286 patients admitted from the year 2002 to 2011. 265 (34%) patients were male and 513 (66%) patients were female. There was a significant difference between the mean number of overdoses in the decade before and after the introduction of legislation (49.2 ± 3.1 vs. 28.6 ± 4.9; p value 0.0011).





Conclusion: In our referral centre, there was a statistically significant reduction in admissions from paracetamol overdose after paracetamol legislation. The difference is likely to be larger due to recent reconfiguration of hospitals in the north east. A further study should be done to see if the same results are reciprocated in other hospitals.

ABSTRACT 15 (13W188) ORAL PRESENTATION

Title of Paper: Initial experience of the National Colorectal Cancer Screening Programme at St. Vincent's University Hospital

Author(s): Susanne O'Reilly, Karen Boland, Joanna Rea, Kieran Sheahan, Hugh Mulcahy, Glen Doherty, Garret Cullen.

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

Introduction: The Irish National Cancer Screening Service (NCSS) commenced a phased introduction of colorectal cancer screening based on faecal immunohistochemical testing (FIT) in adults aged 65-69 in 2013. In the initial five months of the BowelScreen programme, our centre performed colonoscopy in 133 patients with a positive FIT.

Aims/Background: This retrospective, observational study aims to report the initial experience of BowelScreen at a single institution by analysing procedural details and the incidence of adenomas and advanced neoplasia.

Method: BowelScreen patients were identified from the electronic

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endoscopy reporting system using their unique NCSS number (COR ID). Endoscopy reports were analysed for data including sedation, patient comfort score, caecal intubation and pathology detected. A diagnosis of adenoma or colorectal carcinoma was confirmed by histology.

Results: 133 patients (82 male) underwent screening colonoscopy between February and July 2013 at our centre. The caecal intubation rate was 100%. The median (interquartile range) dose of midazolam was 3.3mg (3.0-4.0mg) and the median (IQR) dose of fentanyl was 62mg (50-77mg). The median patient comfort score was 1 and the median (IQR) withdrawal time was 14 minutes (10-21 minutes). Pathology was identified in 77% (102/133). The polyp detection rate was 73% (97/133) with an adenoma detection rate of 65% (86/133). The mean number of polyps per patient was 2.2 (range 0-10). Twenty-three (17%) patients had an adenoma greater than 1cm in size. Sessile serrated lesions were detected in four patients (3%). Detected adenomas were removed at the index colonoscopy in 94% (81/86). Three patients required a second procedure to clear the colon and two underwent surgery for an adenoma. Twelve patients (9%) had colorectal carcinoma; ten have had surgery (two stage I, four stage II, four stage III). There were no significant complications related to colonoscopy.

Conclusion: The initial experience of the BowelScreen programme at our centre has been positive with high completion and adenoma detection and removal rates. Analysis of the national data in due course will give a clearer picture of the programme outcomes.

ABSTRACT 16 (13W100) POSTER PRESENTATION

Title of Paper: Nutritional status of newly diagnosed adult coeliac patients in St Vincent's University Hospital

Author(s): Yvonne Hickey & Clodagh McAlister

Department(s)/Institute(s): Department of Nutrition and Dietetics, St Vincent University Hospital

Introduction: Coeliac disease is an autoimmune disease in which the mucosa of the small intestine is damaged by gluten. Treatment is life long avoidance of gluten. Initial dietetic advice and regular reviews are essential to improve understanding and adherence of the diet to promote long term health.

Aims/Background: The aim of this audit is the capture the nutritional status and presenting symptoms of new coeliac patients over a 12 month period. Currently there is limited Irish data on this patient group and the presentation of the disease is evolving.

Method: The data were collected over a 12 month period between January 2012 and December 2012. Data were collected retrospectively (n=7) and prospectively (n=18). Patients included were all newly diagnosed coeliac patients referred to the dietetic department (both in and out patients). Data were obtained from the patients, the health care record and laboratory system.

Results: Data were collected on 25 patients, 60% (n=15) of the patients were female. The mean age of the group was 45.2 years (median age of female 36 years versus males 49.5 years). The mean Body Mass Index (BMI) was 24.5 kg/m2 (SD +/- 4.6kg/m2). Weight loss was reported by 40% of subjects. On assessment, 80% of the group were consuming less than three portions of calcium containing foods per day. The most common symptoms pre diagnosis was diarrhoea (n=14) and abdominal pain (n=13). Twenty four percent had a family member with coeliac disease. Only six had joined the coeliac society at assessment. Seventy six percent of the patients were seen by the dietitian within one month of referral.

Conclusion: The coeliac population is similar to an Irish study carried out by Tajuddin et al., 2011, which have found a greater female predominance, with females having a lower median age at diagnosis. The majority of patients were seen within one month of referral which is in line St Vincent's University dietetic department policy. Thirty four percent of this population are classified as overweight/ obese on diagnosis; this is comparable to other studies and reflects the changing nutritional status of patients presenting with coeliac disease. The assessment of calcium intake was on diagnosis, so patients would not yet have been advised to have five portions per day, however this highlights for dietetic practice the importance of educating on adequate calcium intake. In patients where there was a delay in seeing the dietitian only 6 had joined the coeliac society. We hope to improve this by working with the gastroenterologists to jointly recommend membership on diagnosis, as well as referring onto the dietitian.

References:

Tajuddin T, Razif S, Dhar R, Thorne J, Murray FE. (2011) Clinical Presentation of Adult Coeliac Disease. Ir Med J. 104(1):20-2.

ABSTRACT 17 (13W102) POSTER PRESENTATION

Title of Paper: Evaluation Of The Use Of Fecal Calprotectin As A Diagnostic Aid For Ibd In An Irish Population

Author(s): P. K. Maheshwari , P. junagade , C. Goulding

Department(s)/Institute(s): MWRH Limerick, limerick, Ireland

Introduction: Serological Inflammatory markers can be used for assisting in the diagnoses of inflammatory bowel disease but are neither particularly sensitive nor specific

Aims/Background: Aim of this study is to investigate the role of fecal Calprotectin in the diagnosis of inflammatory bowel disease along with the serological markers ESR ,CRP and endoscopic and radiological means.

Method: Retrospective data of Fecal Calprotectin was collected from the online portal of Kings College Pathology Laboratory London , along with blood and colonoscopy reports from the iLab and Unisoft software of the Mid Western Regional Hospital Limerick respectively over period of 18 months. Statistical analysis was performed using Chi square and

Results: In the 18 months 97 patients had their faecal Calprotectin checked. Fifty-two (53.6%) of them subsequently had the diagnosis of inflammatory bowel disease made on the basis of colonoscopy, CT scan abdomen or small bowel follow through. We divided patients into 2 groups on the basis of faecal Calprotectin values. Patients in group 1 faecal Calprotectin values less than 60 (n = 27) group 2 had values above 60 to 2009 (70)Of those with normal faecal Calprotectin 21 did not have a diagnosis of IBD, whilst 6 had, of those with elevated faecal Calprotectin 23 did not have a diagnosis of IBD, whilst 47 did (Chi square test, p = 0.001).Six (22%) of group 1 had colitis while nineteen (27%) of group 2 were normal. Mean ESR in group 1 was 11.38 VS 17.65 in group 2(P=0.159 student T Test) while mean CRP in group 1 was 10.6 VS6.4 in group 2 (P=0.226 Student T test).Those patients with subsequent diagnosis of IBD (52) had a mean fecal Calprotectin of 335.89 VS non IBD patients (45) mean fecal Calprotectin value was 138 (P =0.0059 Student T test)

Conclusion: This study shows that the use of faecal Calprotectin is

a reliable indicator of IBD in the Irish populationstudied. It also shows that ESR and CRP levels do not correlate with or assist in the diagnosis of IBD in this population

ABSTRACT 18 (13W103) POSTER PRESENTATION

Title of Paper: Tolerance of Colonoscopy and questioning its utility in elderly population

Author(s): Dr Faizan Rathore,Prof. Humphrey O'Connor, Dr Naveed Sultan, Dr Declan Byrne,

Department(s)/Institute(s): Kerry General Hospital,Naas General Hospital

Introduction: This study was carried out in order to assess current practice in the Endoscopy Unit, in Kerry General Hospital against the recommended age related indicators for colonoscopies.

Aims/Background: The aim of this study was to determine the appropriateness of invasive procedure like colonoscopy in elderly population and develop an appropriate pathway for referral of elderly patients requiring colonoscopy.

Method: We retrospectively analysed the data of all colonoscopies performed at KGH between Jan 2012-Dec 2012.For classification purposes The Data was divided 4 major age groups, under 75, 76-80, 81-85, 86+. The Factors analysed were Gender, Indications, was colonoscopy diagnostic or therapeutic, Age Categories against diagnostic or therapeutic, Depth of Insertion, Complications of the Procedure and Diagnosis.

Results: A total of 1474 colonoscopies were performed. Of the total number 49.39% (n=728) males and 50.61% (n=746)were females, 85.01% (n=1253) were patients under the age of 75,9.02% (n=133) were of age 75-80, 4.07% (n=60) were of age 81-85, and 1.90% were of age 86+ (n=28), 79.9% (n=1177)of the total colonoscopies were diagnostic and 20.1% (n=297) were therapeutic. In age group <75 78.9% were diagnostic and 21.1% were therapeutic c colonoscopie,In age group 75-80 83.5% were Diagnostic and 11.7% were therapeutic, In age group 81-85 88.3% were Diagnostic and 11.7% were Therapeutic , In age group >86 89.3% were Diagnostic and 10.7% were therapeutic colonoscopies. Out of the total colonoscopies performed 45.0% were reported as normal , other diagnosis in decreasing incidence were Diverticulosis 14.24%,Hemorrhoids 7.73%,Single Colonic Polyp 3.66%, Multiple Colonic Polyps 1.36%, Diverticulosis with Hemorrhoids1.15%, Diverticulosis with colonic polyps 0.95%,Malignant Colonic tumour 0.81. Miscellaneous findings which could not be categorized as any of above made up a total of 25.03%. Complications were Not Recorded in 2% of total patients which were in age group <75. Of the total indications recorded highest was overt rectal bleeding in a total of 13.16%(n=194) and lowest being chronic constipation with abdominal pain 1.9%(n=16). No indications were recorded for 6.6%(n=97), 3.6%(n=53) of the total were screening colonoscopies, 49 on which were performed on patients <75 and the remaining between the age range 75-85. 90.2% (n=1330) of the total colonoscopies took place without any complication. Patient discomfort was highest recorded complication present in 7.6%(n=112) of the total subjects,the highest of which, was recorded in under 75 age group(98 cases) followed by 75-80 age group (11 cases),81-85 age group (2 cases) and >86 age group(1 case) . Lowest occuring complicatiom was utricaria around IV site most likely due to pethadine,recorded in 0.1% (n=1) of the total cases. Highest percentage of poor tolerance was found in 1.1% of total patients <75, 0.8% of total patients aged 75-80,1.7% of total patients in age group 81-85 and none in age group >86. 84.53% of the total colonoscopies were performed up to the caecum.

Conclusion: From the above we can determine that colonoscopy is relatively safe, and well tolerated by the elderly population compared to the younger subjects. However the incidence of therapeutic colonoscopies reduces with age, US preventive services task force recommends the screening for colorectal cancer using fecal occult blood testing sigmoidoscopy or colonoscopy in adults beginning at age 50 yrs and continuing until age 75 years, It recommends against routine screening for colorectal cancer in adult age 76-85 years ,there maybe considerations that support colorectal screening in an individual patient.It recommends against screening for colorectal cancer in adults over 85 years,it concludes that the evidence is insufficient to assess the benefits and harms of CT colonography and fecal DNA testing as screening modalities for colorectal cancer. Life expectancy at birth of total population in Ireland is 80.32 years, (Male 78.07 years ,Female 82.69 years) ,out of which healthy life years are approximated to around 65.9 years for males and 67.0 for females according to the 2010 estimate, so the controversy remains as to if elderly population should undergo screening colonoscopies if other multiple co morbidities exist? We suggest that an Multidisciplinary Team should be set up which consists of experts in fields of Geriatrics and Gastroenterology who can asses the patient on individual basis and then decide unanimously on whether to proceed with the colonoscopy or otherwise.

ABSTRACT 19 (13W105) POSTER PRESENTATION

Title of Paper: Follow up of gastric intestinal metaplasia

Author(s): Dr C Adgey, Dr B Layard, Dr C Larkin

Department(s)/Institute(s): Ulster Hospital South Eastern Trust

Introduction: Gastric intestinal metaplasia (GIM) is considered a risk factor for gastric cancer however the management and follow up for these patients is uncertain. New consensus guidelines published January 2012, state patients with extensive IM should be offered endoscopic surveillance every 3 years. This study looked to assess the outcomes for a cohort of patients with GIM followed up in a district general hospital.

Method: Patients were recruited to the study using a database of patients found to have GIM accumulated by one consultant. Retrospective chart review was undertaken for all patients in this database. Data was collected including patient's age, sex, certain assumed risk factors (smoking, alcohol intake and helicobacter pylori), relevant medications and presence of Barrett's oesophagus. The follow up pathology was then analysed looking for progression (focal IM- extensive IM- dysplasia), regression or no change

Results: There were 28 patients on the database, 43% were male. Age ranged from 34-79 (mean 62). Patients had been on the database between 6 months and 9 years (median 4 years). 24 patients had been rescoped annually (86%). Of these patients 29.2% had no change in their pathology, 50% had regressed to no IM, 8.3% regressed from extensive to focal IM and 12.5% progressed from focal to extensive IM. No patients developed gastric cancer in our follow up time.

Conclusion: Although the majority of patients did not progress (or did in fact regress) a proportion of patients did progress in the extent of GIM and therefore we support follow up surveillance of this group of patients.

ABSTRACT 20 (13W106) POSTER PRESENTATION

Title of Paper: Small bowel Crohn's disease as detected by capsule endoscopy as a predictor of response to biologic therapy – a 3 month mucosal healing assessment

Author(s): Barry Hall, Grainne Holleran, Tara Raftery, Sinead Smith, Deirdre McNamara

Department(s)/Institute(s): Department of Gastroenterology & Clinical Medicine, Tallaght Hospital & Trinity College Dublin

Introduction: Mucosal healing and deep remission have been shown to confer improved long-term outcome in patients with Crohn's disease (CD). While biologic therapies have demonstrated improved symptomatic response and their early use to achieve mucosal healing as assessed by colonoscopy may allow for modification of the natural history of CD, little is currently known of this with regard to active small bowel CD. Ileitis is increasingly diagnosed using modern diagnostic tools including MRE and wireless capsule endoscopy (WCE).

Aims/Background: To assess clinical, biochemical and mucosal response to biologic therapy in an ileitis cohort with established CD at treatment baseline and at 12 weeks using WCE.

Method: Following informed consent symptomatic patients with established CD commencing biologic therapy with active ileitis on WCE (Given SB2) were invited to participate. Baseline demographics, Harvey Brashaw Index (HBI), Work Productivity and Activity Index (WPAI) and EuroQol (EQ-5D) questionnaires, along with C-reactive protein and fecal calprotectin levels were documented. Calprotectin levels were assessed with a commercially available ELISA kit (MedLab Pathology), with a normal value being <50nmol/l. A Lewis score (LS) was used to assess the severity of ileitis (<135 inactive disease, 135-750 mild to moderate disease and >750 severe disease). At week 12 of treatment all parameters were reassessed. Mucosal healing was defined as absence of visible ulceration. Deep remission was defined as mucosal healing in association with normalization of clinical parameters. Results at baseline & week 12 were compared using two-tailed Wilcoxon analysis, a p value of <0.05 was considered significant.

Results: In all, 43 patients have been enrolled in the study, mean age 38 yrs (range 19-63) and 17 (48%) female. To date, 8 (16%) have dropped out of the study, 6 were due to a failed patency examination at week 12, one due to development of intercurrent illness and one due to patient preference. At baseline, all patients had active disease. The mean HBI was 7, mean C-reactive protein was 5 mg/l, mean calprotectin was 195 µg/g and mean WPAI and EQ5D were 3 and 60 respectively. In all, 8 (42%) had severe ileitis on WCE and the remainder had moderate disease on LS. To date, 19 (54%) have undergone a 12 week assessment. Within this cohort, 17 (89%) have ileo-colonic disease, one ileal-only disease and one colonic-only disease. In total, 11 (57%) have stricturing disease with a further 4 (20%) having fistulating disease. All patients except for one were loaded with adalimumab (160mg/80mg) and maintained on 40mg EOW. The remaining patient was commenced on infliximab. Overall there was a statistically significant symptomatic and biochemical improvement at week 12. While 13 (68%) had a decrease in LS the mean was not statistically significant from baseline. Table 1. However, 2 (10%) had minimal or inactive ileitis on follow-up capsule with a further 3 (16%) improving from severe to mild activity on LS. Of note, no patient had complete mucosal healing.

Table 1 Baseline values and 12 week response to treatment values (n=35)

Parameter (normal values) p value	Baseline Values [mean (range)]	12 Week Values [mean (range)]
HBI (<5) p<0.05	7 (0-15)	4 (0-14)
WPAI (0-10) p<0.05	3 (0-8)	2 (0-7)
EQ-5D (0-100) p<0.05	60 (40-100)	70 (40-100)
Calprotectin(<50µg/g) p<0.03	195 (30-1600)	65 (0-700)
Lewis score (<135)	552 (225-5050)	318 (0-3000)
CRP (<5mg/dl) p<0.03	5 (1-160)	2 (1-17)

Conclusion: In patients with active small bowel CD early symptomatic and biochemical response to treatment is not mirrored by mucosal healing. This could reflect a delay in mucosal healing that will eventually "catch up" with symptomatic response or that ileitis is a more resistant form of CD. Repeat assessment at one year is warranted to further assess deep remission rates in ileitis and the effect on long term outcome.

ABSTRACT 21 (13W107) POSTER PRESENTATION

Title of Paper: Prevalence And Predictors Of Colonoscopy-Related Distress In Individuals Undergoing Fit-Based Colorectal Cancer Screening: A Population-Based Study

Author(s): Linda Sharp1, Nicola Shearer2,3, Ronan Leen2,3, Colm O'Morain2,3, Deirdre McNamara2,3

Department(s)/Institute(s): 1 National Cancer Registry; 2 Department of Gastroenterology, Adelaide and Meath Hospital incorporating the National Children's Hospital; 3 Dept. of Clinical Medicine, Trinity College Dublin

Introduction: There is increasing recognition that participation in other cancer screening programmes can have an adverse psychological impact on some individuals, but little is known about psychological after-effects of colorectal cancer screening.

Aims/Background: We investigated psychological distress following diagnostic colonoscopy in those who had had a positive screening faecal immunochemical test (FIT) in a population-based screening programme.

Method: The study was nested within the second round of a colorectal cancer screening programme in Dublin. Approximately 10,000 individuals aged 50-74 years resident in the catchment area of participating general practices were invited to complete a FIT. Those who tested positive were invited to attend for colonoscopy. Two months after colonoscopy those without cancer were asked to complete a postal questionnaire which included the Impact of Event Scale (IES). Parametric and non-parametric methods were used to compare median colonoscopy-related distress scores, and percentages with significant colonoscopy-related distress (IES 9), between subgroups.

Results: 201 completed questionnaires were received. Of respondents, 47% were male, 75% were married, 29% were working and 56% had completed primary-level education only. The median colonoscopy-related distress score was 6 (inter-quartile range=2-17). 42% scored in the range for significant colonoscopy-related distress. Distress scores were significantly higher in those with only primary-level education (median scores: primary=8.5; secondary=5; tertiary=6; p=0.03) and who perceived colonoscopy as more serious (not/slightly serious=4; serious/very serious=8; p=0.01). Current depression and higher levels of health anxiety

were significantly associated with higher distress (depression: current=17; past=6; none=6; p=0.05; health anxiety: low=2; medium=7.5; high=17; p<0.01). Age, gender, social support, family history of colorectal cancer, self-rated health pre-screening, and participation in the first screening round were not associated with distress.

Conclusion: Substantial proportions of people experience psychological distress following diagnostic colonoscopy. Every screening programme involves a balance between costs and benefits. Psychological distress is an important, albeit unintended, cost of colorectal cancer screening.

ABSTRACT 22 (13W109) POSTER PRESENTATION

Title of Paper: Teenagers with IBD in Transition - are we meeting their needs?

Author(s): O'Connell L., Keegan D., Byrne K., Doherty G., Mulcahy H., Cullen G., Buckley M.

Department(s)/Institute(s): Centre for Colorectal Disease, St. Vincent's University Hospital, Elm Park, Dublin 4

Introduction: Young adults with Inflammatory Bowel Disease (IBD) often have a severe illness. In the paediatric setting they have been cared for by a multidisciplinary team (MDT) with whom they and their parents have developed a strong and reciprocal bond. Transitioning to the adult service can be daunting for all involved, and is often done on an ad hoc basis. A new clinic was established in 2012 (GC & DK) to meet with the patient, their family and paediatric team in their base hospital prior to transition. This pilot audit explores the experiences and needs of this vulnerable group.

Aims/Background: Approximately 35 teenagers with IBD had moved to our service prior to the establishment of a specific Transition Clinic. Leaving the paediatric setting can be difficult, not just for the patient, but for the MDT which has cared for them for many years. As

Method: Young adult patients who had completed the transition process and were due to attend the IBD clinic in SVUH between June and August 2013 were identified on the PAS system. This was a retrospective audit with a final sample size comprising 14 patients. An anonymous 52-item patient satisfaction survey was used. The standards used to measure our practice were the Clinical Guidelines for Transitional IBD Patients (IBD Vol 17, No 10, 2011) as well as comparison with transitional clinics in other disciplines (Ann Rheum Dis 2006).

Results: 14 patients completed this pilot audit. The majority (92%) felt well prepared for attending the adult clinic. 83% said they felt ready to 'transition'.77% stated they felt well informed about the process. All patients felt that the adult clinic was well prepared for them and 92% felt the adult clinic was aware of their history in detail. In addition, patients reported that their experience in the adult service was either equivalent (46%) or compared favourably (53%) with their paediatric experience. A number of issues were identified: 64% reported that their concerns regarding their sexual health were not addressed. 46% had been seen with their parents also present, and 46% reported being seen without their parents. 23% reported that they themselves managed their medication, while 79% managed their medication in conjunction with their parents. Also, several patients suggested that despite positive experiences in both the paediatric and adult services, the transition process itself was not well structured. It should be noted that this pilot study group comprised a mix of patients - some who had transitioned before the new clinic was established.

Conclusion: The majority of patients felt well prepared for attending the adult clinic, and felt that they were ready to transition. In addition, all reported their experience in the adult service was either superior or equivalent to that in the paediatric service. It should be noted that this was a pilot audit with a small sample size, conducted among teenagers, some of whom had recently begun to attend the adult clinic, as well as others who had transitioned earlier. Specific areas for improvement have been identified and are being implemented.

ABSTRACT 23 (13W112) POSTER PRESENTATION

Title of Paper: Generation and application of a colorectal cancer microarray library identifies a novel prognostic biomarker – adipose differentiation related protein (adipophilin)

Author(s): J Hogan 1,2, L O' Byrne 2, M O' Callaghan 2, M Kalady 3,4, J.C. Coffey 1,2,5.

Department(s)/Institute(s): Department of Surgery, University Hospital Limerick

Introduction: Substantial volumes of genetic expression data are archived within public gene expression repositories (PGER). Although the data contained is reported according to particular standards, it is not feasible to search the data using clinically relevant search terms (i.e. oncologic outcome).

Aims/Background: This study aimed to generate an archive of microarray expression data that could be searched using oncologically-relevant terminology, and then to test this facility.

Method: A UL Colorectal Cancer Archive was established based on data derived from the Gene Expression Omnibus (GEO). A software (Rover) was developed to permit clinically relevant searches using terminology such as stage and disease-free survival. As a first test, experiments were identified that compared early and late stage colorectal cancer. From these, consensus profiles were developed and adipocyte differentiation related protein identified as the top-most frequently dysregulated gene. As a second test, the cancer archive was again challenged to identify data sets annotated with outcome data. The association between ADFP and outcome was assessed using a regression-tree (CRT) based approach and via a combination of Kaplan-Meier estimates that were compared using a Log-Rank analysis.

Results: The UL Colorectal cancer archive was constructed so as to permit the novice-user to search for gene expression data associated with particular clinical parameters. Rover was a graphic user interface that permitted these searches. ADFP was identified as dysregulated across the majority of experiments comparing early and late stage colorectal cancer. CRT-analyses identified levels of ADFP above which adverse outcomes were identified. In general, increasing ADFP was independently associated with adverse disease-free outcomes in stage II and III cancer.

Conclusion: A novel archive of gene expression data was generated that (a) related to colorectal cancer and (b) could be searched using clinically-relevant terminology. Using this archive ADFP was identified as dysregulated between early and late stage colorectal cancer. Increasing ADFP expression levels were associated with adverse disease-free survival in stages II and III colorectal cancer.

ABSTRACT 24 (13W113) POSTER PRESENTATION

Title of Paper: Introducing a novel and robust technique for determining lymph node status in colorectal cancer

Author(s): J Hogan, C O'Connor, A. Aziz, M. E. O'Callaghan, C.S. Judge, C. Dunne,J.P. Burke, S.R. Walsh, M. Kalady, J. C. Coffey.

Department(s)/Institute(s): University Hospital Limerick

Introduction: Currently, techniques that determine lymph node positivity (prior to resection) have poor sensitivity and specificity. The ability to determine lymph node status, based on preoperative biopsies, would greatly assist in planning treatment in colorectal cancer. This is particularly relevant in polyp-detected cancers.

Aims/Background: This study aims to harness the potential of public gene expression repositories, to develop gene expression profiles that could accurately determine nodal status in colorectal cancer.

Method: Public gene expression repositories were screened for experiments comparing metastatic and non-metastatic colorectal cancer. A customized graphic user interface was developed to extract genes dysregulated across the majority of identified studies (i.e. consensus profiles or "CP"). The utility of CP was tested by determining if classifiers could be derived that determined nodal positivity or negativity. Consensus profile-derived classifiers were tested on separate Affymetrix and Illumina–based experiments and collated outputs compiled in summary-receiver operator curve characteristic format with area under the curve (AUC) reflecting accuracy. The association between classification and oncologic outcome was determined using an additional, independent data set. Final validation was conducted using the Ingenuity© network-linkage environment.

Results: Four consensus profiles were generated from which classifiers were derived that accurately determined node positive and negative status (pooled AUC were 0.79 ± 0.04 and 0.8 ± 0.03 for nodal positivity and negativity respectively). Overall AUC ranged from 0.73 to 0.86 demonstrating high accuracy across consensus profile type, classification technique and array platform used. As CP enabled classification of nodal status, survival outcomes could be compared for those predicted node negative or positive. Patterns of disease-free and overall survival were identical to those observed for standard histopathologic nodal status. Genes contained within consensus profiles were strongly linked to the metastatic process and included (amongst others) FYN, WNT5A, COL8A1, BMP and smad family members.

Conclusion: Microarray expression data available in public gene expression repositories can be harnessed to generate consensus profiles. The latter are a source of classifiers that have prognostic and predictive properties.

ABSTRACT 25 (13W115) POSTER PRESENTATION

Title of Paper: Expression of serum angiogenic factors in patients with sporadic small bowel angiodysplasia

Author(s): Grainne Holleran, Sinead Smith, Deirdre McNamara

Department(s)/Institute(s): Department of Gastroenterology and Clinical Medicine, Tallaght Hospital and Trinity College DUblin

Introduction: Angiodysplasias account for over 50% of small bowel causes of obscure gastrointestinal bleeding. Little is known about their pathophysiology, and as a result, the development of specific treatments is limited. Abnormal serum levels of certain angiogenic factors have been suggested previously in small cohorts of patients with sporadic colonic, and genetic - Hereditary Haemorrhagic Telangiectasia (HHT), forms of GI angiodysplasia. Angiogenic factors may represent targets for new therapies and act as useful diagnostic and prognostic biomarkers for sporadic small bowel disease.

Aims/Background: To assess putative angiogenic factor levels in sporadic small bowel angiodysplasia compared with controls.

Method: Following ethical approval and informed consent, serum samples were collected and stored at -80oC for batch analysis, from patients with a definite diagnosis of sporadic small bowel angiodysplasia (P2) on capsule endoscopy, and from healthy controls, in which GI bleeding had been out-ruled by a negative faecal immunochemical test. Patients with features consistent with, or known HHT were excluded. Serum levels of angiopoietin-2 (Ang-2), soluble endoglin (sEnd), vascular endothelial growth factor (VEGF), and platelet derived growth factor (PDGF) were measured using commercially available enzyme-linked immunosorbent assay (ELISA) kits (R&D Systems). Samples were prepared in duplicate according to the manufacturer's guidelines and absorbance was read at a wavelength of 450nm. All results were expressed as a mean and compared between patients and controls, a p value of <0.05 was considered significant.

Results: In all, serum samples were analysed from 30 patients, 53% (n=16) female and 26 controls, 54% (n=14) female, with mean ages of 68.1 years (34-90) and 65.5 years (46-74) respectively. Levels of Ang-2 were significantly higher in the angiodysplasia group with a mean of 4883pg/ml (842-11767) vs. a mean of 2536pg/ml (792-6243) in controls p<0.001 (Figure 1). Interestingly, there were no significant differences in levels of sEnd, VEGF or PDGF between the patient and control groups (Table 1).

Table 1. Levels of angiogenic factors in patients and controls

Angio-genic factor	Angio-dysplasia mean	Angio-dysplasia range	Control mean	Control range	P value
Ang-2 pg/ml	4883	842-11767	2536	792-6243	<0.001
Endoglin ng/ml	3.69	2.12-6.84	4.65	1.96-9.0	0.69
VEGF pg/ml	355.9	45-929	289.6	54-1130	0.32
PDGF pg/ml	4229	929-39978	3171	955-6208	0.44

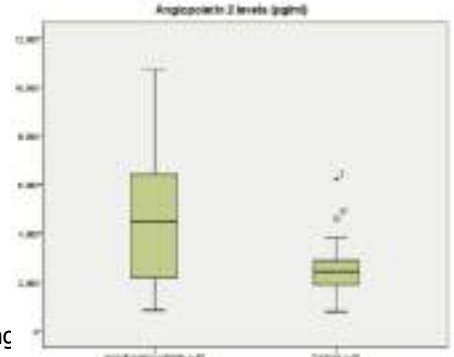

Figure 1. Serum Ang-2 levels in patients and controls

Conclusion: Serum Ang
patients with sporadic small bowel angiodysplasia and may represent a useful diagnostic and prognostic biomarker. No significant association was found with levels of sEnd, VEGF or PDGF, as suggested in previous studies. Further studies looking at additional factors in the Ang-2 signalling pathway may provide valuable information on its specific involvement in the development of sporadic small bowel angiodysplasia.

ABSTRACT 26 (13W116) POSTER PRESENTATION

Title of Paper: TNF-a dependent Angiopoeitin mediated angiogenesis in sporadic small bowel angiodysplasia; novel pathophysiology and potential clinical marker

Author(s): Grainne Holleran, Sinead Smith, Paul Crotty, Deirdre McNamara

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

Introduction: Angiodysplasias account for over 50% of small bowel causes of obscure gastrointestinal bleeding. Lesions are known to bleed recurrently and the condition carries an overall mortality of 2%. Angiodysplasias are thought to develop as a result of an imbalance in the angiogenic cascade, although the exact mechanism remains elusive. Previous research we have undertaken has associated elevated serum angiopoietin-2 (Ang-2) levels with angiodysplasia. In vitro studies have shown that the angiopoietins Ang-1 and Ang-2 are ligands of the endothelial receptor tyrosine kinase Tie-2. Ang-1 regulates endothelial cell survival and blood vessel maturation and plays a key role in maintaining vascular integrity. Ang-2 is a functional antagonist of Ang-1. Ang-2 is stored in Weibel-Palade bodies and is rapidly released in response to coagulation and inflammation. Inflammation and angiogenesis are associated with several pathological disorders and previous data suggests a TNF-a dependent dual functional roles of Tie2 in inflammatory angiogenesis

Aims/Background: To explore the interaction between angiopoietins and potential interplay with TNF-a mediated angiogenesis in small bowel angiodysplasia.

Method: Following informed consent, serum samples were collected and stored at -80oC for batch analysis from patients with a definite diagnosis of sporadic small bowel angiodysplasia (P2) on capsule endoscopy, and from healthy controls in which GI bleeding had been out-ruled by a negative faecal immunochemical test. Patients with features consistent with, or known HHT were excluded. Serum levels of Ang-1, Ang-2 and TNF-a were measured using commercially available enzyme-linked immunosorbent assay (ELISA) kits (R&D Systems). Samples were prepared in duplicate according to the manufacturer's guidelines and absorbance was read at a wavelength of 450nm. All results were expressed as a mean and compared between patients and controls, and the mean of the ratio of ang2/ang1 levels for each group was calculated. A p value of <0.05 was considered significant.

Results: A total of 80 serum samples were analysed for each factor, including 40 patients (48% male, average age 71 years) and 40 controls (43% male, average age 70 years). As expected and in keeping with our previous work levels of Ang-2 were significantly higher in patients (mean 4600pg/ml) than in controls (mean 2973pg/ml) p<0.001. In addition levels of Ang-1 were significantly lower in the patient group (mean 13071pg/ml) vs. controls (mean 21169pg/ml) p<0.004 (table 1). We also found that levels of TNF-a were significantly lower in the patient group (mean 6.7pg/ml) vs. controls (mean 12.2pg/ml) p<0.003. The mean of the ratio of Ang2/Ang1 levels was found to be significantly higher in patients (1.05) vs. controls (0.29) p<0.05.

Angiogenic factor	Patient mean	Patient range	Control mean	Control range	P value
Ang-1	13071	615-43833	21169	2253-56010	<0.004
Ang-2	4600	842-11767	2973	792-7995	<0.001
TNF	6.7	1.97-16.94	12.2	1.73-42	<0.003
Mean ratio Ang-2/Ang-1	1.05	0.06-9.26	0.29	0.06-1.74	0.049

Table 1.

Conclusion: Ours is the first study to have identified a link between angiopoietin 1 and 2 ratios and angiodysplasia in patients. The TNF-a findings are also novel and would strongly suggest a role for inflammatory mediated angiogenesis in this condition.

ABSTRACT 27 (13W118) POSTER PRESENTATION

Title of Paper: Trainee experience of open cholecystectomy in the laparoscopic era.

Author(s): S McCain, C Jones, MA Taylor, G Morris-Stiff

Department(s)/Institute(s): Mater Hospital Belfast

Introduction: The laparoscopic approach to gallbladder surgery has almost completely replaced conventional open cholecystectomy as the gold standard for symptomatic cholelithiasis. There is still a role for an open approach but this is generally reserved for complex cases with unclear anatomy.

Aims/Background: This study aimed to evaluate the experience and competencies of higher surgical trainees in Northern Ireland in performing open cholecystectomies

Method: An email survey of all higher surgical trainees in Northern Ireland was performed. All trainees were accessed through the Northern Ireland Medical and Dental Training Agency (NIMDTA). Each trainee provided their year of training, along with details of how many laparoscopic cholecystectomies (LC's) and open cholecystectomies (OC's) they had assisted with, performed with assistance or performed independently. Trainees' confidence to perform 12 different steps of an OC was also assessed.

Results: 76.5% (n=26) of all higher surgical trainees in Northern Ireland responded. There was a wide variety of experience and this was often comparative to their level of training. 19 trainees had performed over 40 LC's under supervision, while 8 had performed over 40 LC's independently. There was much less exposure to OC's in comparison to LC's. 1 trainee had assisted at over 40 OC's while only 10 trainees had performed more than 10 OC's under supervision and no one had performed more than 10 OC's independently. All trainees felt that through attending theatre lists and rotating through HPB, their ability to perform OC would improve

Conclusion: Whilst it is of paramount importance to competently perform a laparoscopic cholecystectomy by the completion of higher surgical training, the core skills of performing an open cholecystectomy in a complex situation need to be maintained. Training therefore needs to address the needs of the trainees through rotation through an HPB unit, and simulation.

ABSTRACT 28 (13W119) POSTER PRESENTATION

Title of Paper: Incidental pancreatic pathology on computed tomography of abdomen – a comparison between a district general hospital and a regional HPB unit

Author(s): S McCain, O Doyle, C Jones, A Karran, MA Taylor, G Morris-Stiff

Department(s)/Institute(s): Mater Hospital Belfast Northern Ireland, Prince Charles Hospital Merthyr Wales

Introduction: Several studies have documented the prevalence of incidental pancreatic pathology based on the findings of cross-sectional imaging studies but to-date these have all been from tertiary referral units.

Aims/Background: This study aimed to assess and compare the prevalence of pancreatic pathology based on computed tomography (CT) in a defined population within a general hospital (GH) and regional HPB setting.

Method: Patients undergoing abdominal CTs were identified from the radiology database, in both the district general hospital and the regional HPB unit. Reports were reviewed to determine the presence of pancreatic pathology. Both request forms and patient notes were reviewed to determine cases in which the pancreatic findings were incidental. Indications for CT, demographic features and final diagnoses were also noted.

Results: During a 12-month period 3000 abdominal CT's were performed in the general hospital, and 1583 in the regional HPB unit. Incidental pancreatic pathology was identified in 0.3% (n=9) cases in the GH, while 0.76% (n=12) of patients in the HPB unit had an incidental finding of pancreatic pathology. Radiological findings in the GH group included: cystic lesions (n=4); solid lesions (n=4); and chronic pancreatitis (n=1). Radiological findings in the HPB group included: cystic lesions (n=2); solid lesions (n=4); and chronic pancreatitis (n=6).

Conclusion: Incidental pancreatic pathology is not a particularly common CT finding, however within the setting of a regional HPB unit there is evidence of increased detection of incidental pancreatic pathology, especially chronic pancreatitis.

ABSTRACT 29 (13W120) POSTER PRESENTATION

Title of Paper: Is hypertension adequately recognised and appropriately treated in liver transplant recipients in a tertiary referral centre?

Author(s): Schmidt-Martin D, McCormick PA.

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

Introduction: Cardiovascular disease is the third leading cause of death in patients who have received a liver transplant. The immunosuppressants used in transplant patients are associated with increased risk of hypertension. Previous studies have demonstrated a prevalence of hypertension of 30-65% among liver transplant recipients.

Aims/Background: To audit the management of hypertension in a liver transplant cohort and identify factors which might predict hypertension early in the post transplant period.

Method: We performed a retrospective cohort study of 23 patients post orthoptic liver transplantation attending the national liver transplant centre. We reviewed that charts and noted all outpatient blood pressure readings from the time of transplant. All readings above 140 mmHg were regarded as suggestive of hypertension and the clinical notes were reviewed to identify whether appropriate action was taken. We mapped blood pressure measurements over time and calculated the treatment effect of either hospital or primary care management of patient hypertension.

Results: 23 patients were studied over a mean of five years post OLT (range 1 – 13). 78% had hypertension. Of 427 independent measurements 210 (in 23 patients) were suggestive of underlying hypertension. A note was made in the medical notes of the abnormal reading on 17 occasions (8%) in 5 patients. This was acted on by either ordering a 24 hour bp monitor (1 patient) or commencing anti hypertensive treatment on four occasions in 3 of the five noted to be hypertensive. The introduction of an antihypertensive agent by primary care was identified in a further five patients. Of the 18 patients identified by the study as hypertensive, treatment had been commenced in 8 (44%) with a mean improvement in blood pressure from 167.75 mmHg to 142.875 mmHg a mean improvement of 25 mmHg. Unfortunately, of the 8 patients treated, 6 (75%) remained hypertensive at follow up without further modification of treatment). We examined the patterns of blood pressure change to identify patterns and identified that all patients on long term steroid therapy were hypertensive (n=8). Prednisolone during the induction of immunosuppression is associated with hypertension and its likely discontinuation is often cited as a reason for not treating hypertension. Interestingly, we found that hypertension while on steroids was highly predictive of long term hypertension with 92% of such patients subsequently developing hypertension after steroids had been discontinued.

Conclusion: 78% of a post transplant cohort had blood pressure readings highly suggestive of hypertension. This is under recognised and under treated by both primary and tertiary care. Furthermore although the treatments commenced are appropriate, target blood pressures are not achieved in 755 of cases. Finally, hypertension on steroids during the induction of immunosuppression is highly suggestive of hypertension in the long term and should not deter the introduction of appropriate anti hypertensives.

ABSTRACT 30 (13W121) POSTER PRESENTATION

Title of Paper: The utilisation of PET-CT in the assessment of colorectal liver metastases

Author(s): C Jones, S McCain, S Badger, McKie L, T Diamond, MA Taylor, T Lynch

Department(s)/Institute(s): Mater Hospital Belfast

Introduction: PET-CT can be used for staging in colorectal cancer and can potentially avoid unnecessary laparotomies. This is particularly important when considering a patients suitability for potential liver resection.

Aims/Background: This study aimed to determine the influence of PET-CT in the assessment of the extent of metastatic disease and its management.

Method: All patients over a 2 year period with colorectal cancer were included. PET-CT reports were retrospectively reviewed, along with pathology reports where appropriate. Patient demographics, indication for PET-CT, and PET-CT findings were recorded. The influence of PET-CT on clinical management was subsequently determined. The overall cohort was divided into 3 groups; Group 1 were those with negative PET-CT, Group 2 had a positive PET-CT but

no surgery, and Group 3 had a positive PET-CT and surgical intervention.

Results: 93 patients met the inclusion criteria, out of 2180 patients from January 2006 to December 2007 inclusive. In the overall cohort, PET-CT was performed due to clinical suspicion in 11.8% of patients (n=11), 10.7% (n=10) had rising tumour marker (CEA), and 72 patients (77.4%) had previous abnormal radiological imaging. Group 1 consisted of 36 patients; group 2 had 42 patients; while group 3 consisted of 15 patients. In Group 1, 9 patients with potential liver metastases on CT, PET-CT was subsequently negative. In Group 2, 11 patients with potentially resectable disease on staging CT, were upstaged due to PET-CT findings, seven of which had previously unknown extra-hepatic disease. In Group 3, only one had unresectable disease at laparotomy, despite the PET-CT.

Conclusion: PET-CT clearly demonstrated additional benefits in the staging of colorectal liver metastases through avoiding laparotomies in patients with previously undiagnosed extra-hepatic disease.

ABSTRACT 31 (13W122) POSTER PRESENTATION

Title of Paper: NR4A2 Orphan Nuclear Receptor in Stage II Colon Cancer

Author(s): HM Mohan, M Cotter, K Sheahan, D Crean, E Ryan, AW Baird, EP Murphy, DC Winter

Department(s)/Institute(s): St. Vincent's University Hospital, University College Dublin

Introduction: Nuclear receptors are critically important in tumour biology. This study evaluates a group of orphan nuclear receptors in colorectal cancer- the NR4A orphan nuclear receptors. Although classically transcription factors, non-genomic actions have been described, and their nuclear:cytoplasmic distribution is important functionally as cytoplasmic NR4A receptors can interact with mitochondrial proteins to promote or inhibit apoptosis. In bladder cancer, cytoplasmic mislocalisation of NR4A2 has been shown to occur and is associated with outcome. Unravelling the role of NR4A receptors in colorectal cancer may enable discovery of novel therapeutic targets.

Aims/Background: This study aimed to evaluate whether changes in cytoplasmic:nuclear localisation of NR4A2 occured in Stage II colon cancer, and whether may this may be useful as a biomarker to predict those with early disease more likely to have a poor prognosis.

Method: Colon cancer cell lines (Caco-2, T84, LS174T) were treated with a variety of stimuli important in the tumour microenvironment (hypoxia, prostaglandin E2, adenosine and proinflammatory cytokines). Expression of NR4A receptors was analysed by RT-PCR. Immunohistochemistry was performed on a tissue microarray of stage II colorectal cancer with tumour and adjacent normal colonic tissue. Staining was assessed by two assesors(1 surgery, 1 pathology)

Results: There is increased expression of all three NR4A receptors in colon cancer cell lines in response to stimuli important in the tumour microenvironment including prostaglandin E2, adenosine and hypoxia. In addition, on examining the tissue microarray, there is increased cytoplasmic staining for NR4A2, and an altered nuclear-cytoplasmic ratio with relatively more cytoplasmic NR4A2 in tumour compared to matched normal tissue. ($p<0.001$) However, this was not associated with a difference in outcomes.

Conclusion: NR4A2 is upregulated in conditions simulating the tumour microenvironment, with marked cytoplasmic mislocation in Stage II disease. However, it is not a useful biomarker in Stage II colon cancer.

ABSTRACT 32 (13W124) POSTER PRESENTATION

Title of Paper: Vortex formation time in the assessment of patients with newly diagnosed Hereditary Haemochromatosis

Author(s): Byrne D1 , Walsh J 1 , Almuntaser I1, Ellis L 2, King G1, Murphy RT2, McKiernan S1, Norris S 1

Department(s)/Institute(s): Department of Cardiology1 and the Department of Gastroenterology2 St James Hospital, Dublin 8 Ireland.

Introduction: Vortex formation time (VFT) is an index of the optimal conditions for vortex formation. In Hereditary Haemochromatosis (HH), subtle inefficient propagation of blood flow through the left ventricle (LV) may result from myocardial iron deposition with subsequent impaired LV filling and suboptimal vortex formation. We assessed echocardiographic-derived vortex formation time (VFT) in control subjects and patients with newly diagnosed HH.

Aims/Background: To explore the relationship between Vortex Formation Time as a measure of diastolic function and iron overload in patients with newly diagnosed HH compared to a control group

Method: Transthoracic echocardiography was performed in 20 normal subjects (mean age 49.19± 2.5) and in 20 patients who have early HH (mean age 50.66± 2.4) with average ferritin levels (953.8mcg/L ± 114.5). Conventional parameters and tissue Doppler (TD) indices were measured. VFTa was obtained using the formula: $4 \times (1\ \beta)/\pi \times \alpha^3 \times$ LVEF, where β is the fraction of total transmitral diastolic stroke volume contributed by atrial contraction (assessed by time velocity integral of the mitral E- and A-waves) and α is the biplane end-diastolic volume (EDV)1/3 divided by mitral annular diameter during early diastole.

Results: The VFT was increased in HH subjects (3.49 ± 0.21) compared to controls (2.55± 0.21) ($P=0.0037$). There was no difference in age, gender, body surface area ($P=0.89$). The early diastolic myocardial velocities were decreased in HH (13.39cm/s ± 0.68) compared to controls (15.87cm/s± 0.67) ($P=0.0139$). Significant correlation was observed between VFT and early diastolic myocardial velocities ($R=-0.48$ & $P=0.0012$).

Conclusion: VFT is a dimensionless index, incorporating LV diastolic parameters and may provide a useful parameter for the ongoing assessment of HH patients following venesection.

ABSTRACT 33 (13W125) POSTER PRESENTATION

Title of Paper: Rolling out FODMAP diet - symptom improvement in tertiary referral and self referral population.

Author(s): Ferguson T, O'Keeffe J, Ni Shuilleabhain A, Stack WA, Macken K, Jackson LM

Department(s)/Institute(s): Bon Secours Hospital, Cork

Introduction: The low FODMAP diet has been shown to be a management strategy in patients with functional GI disease. FODMAP is an acronym for Fermentable, Oligo - , Di - and Mono-

saccharides and Polyols) short chained carbohydrates that are fermentable in the large bowel. Recent studies have confirmed that FODMAP exclusion can lead to an improvement in gut symptoms in selected IBS population.

Aims/Background: The aim of this study is to investigate the outcomes of all patients that attended the dietetic department in the Bon Secours Hospital for instruction on low FODMAP from May 2011 to October 2012.

Method: 54 patients (43F:11M) received low FODMAP advice over a 17 month period. They were self referred, GP referred or self referred. Individual advice was delivered by 2 dietitians trained on the delivery of the low FODMAP diet. Patients completed a questionnaire scoring severity of symptoms at baseline and after 8 weeks of FODMAP elimination. Patients who failed to attend follow up had the questionnaire carried out over the phone. 50/54 patients instructed on the low FODMAP diet completed the follow up questionnaire.

Results: After 8 weeks FODMAP elimination a total of 39/45 patients (87%) reported an overall improvement in abdominal symptoms and 35/46 (76%) reported an overall improvement in abdominal pain. There was no significant difference in outcomes between tertiary referral, GP, or self referral patients. 56% advised that the diet was easy or no problem to follow, and 76% would definitely recommend the diet to other IBS patients. 58% reported to have followed the diet all the time.

Conclusion: Restricting dietary FODMAP's has been shown to improve symptoms in patients with IBS. Our study confirms the usefulness of this dietary intervention in practice. Further follow up will demonstrate if benefits achieved will be sustained long term for this patient group.

ABSTRACT 34 (13W126) POSTER PRESENTATION

Title of Paper: How reliable is the internet? Evaluation of Youtube as a source of information for Endoscopic Ultrasound

Author(s): Muhammad Farman,Ching Leung,Gavin Harewwod

Department(s)/Institute(s): Gastroenterology/Beaumont Hospital

Introduction: With growing availability of medical information in the public domain, it is becoming increasingly important to ensure the high quality of this material. Youtube is one of the most frequently accessed portals by patients to further their clinical knowledge. With its broad popularity, it likely influences patient's behaviour and attitudes.

Aims/Background: The aim of this study was to objectively evaluate the quality of information available on Youtube for Endoscopic Ultrasound.

Method: The first 100 Youtube video clips under the search term 'Endoscopic Ultrasound' (EUS) were identified on 17/8/2013. These clips were individually rated for clinical accuracy (scale of 1 [least accurate] to 3 [most accurate]) by a single independent observer who was a senior Gastroenterology trainee with good knowledge of EUS with supervision by an experienced consultant endosonographer. The source of material (individuals, academic medical institutions, and others), number of views per week and duration of video clip were recorded.

Results: Of the 100 EUS video clips 12 were duplicates leaving 88 for analysis. The majority of video clips 58% (51/88) were produced by an academic medical institution while 28% were produced by individuals (25/88) and 14% (12/88) by other sources. Mean video duration was 4.2 minutes. The mean number of views/week was 15 with higher mean views (20/wk) for clips from academic institutions vs those produced by individuals (10.5/wk p=0.2). Most videos (76%) scored a high level of accuracy (score of 3); video clips produced by an academic medical institution were more likely to have high accuracy scores (88% vs 56% by individuals, p = 0.001).

Conclusion: Our findings indicate that overall quality of Youtube information for EUS is good with most demonstrating high levels of clinical accuracy. The most accurate clips are produced by academic institutions and are viewed more frequently by the public. Internet portals such as Youtube represent a valuable opportunity for gastroenterologists to disseminate high quality information to inform and educate patients.

ABSTRACT 35 (13W127) POSTER PRESENTATION

Title of Paper: Haemostatic powder for upper gastrointestinal bleeding: early experiences of a novel therapy in Ireland.

Author(s): Hall PSJ, Mainie I.

Department(s)/Institute(s): Belfast City Hospital

Introduction: Upper gastrointestinal (GI) bleeding has an estimated incidence of 48-160 per 100 000 adults per year with mortality ranging from 10-14%.[1] Despite a trend towards a reduction in mortality, 5-10% of patients still experience a recurrence of bleeding despite standard therapy with adrenaline injection, thermocoagulation and mechanical clips.[2] Current haemostatic therapies can be difficult to apply effectively in areas such as the posterior duodenum and proximal lesser curvature of the stomach. Bleeding sites can be diffuse and difficult to control with localised therapy.

Aims/Background: Haemospray (Cook Medical) is a novel haemostatic powder which is delivered endoscopically for the treatment of acute upper GI bleeding. Highly adsorptive, it acts via the formation of a mechanical barrier over a bleeding site and concentrates coagulation

Method: This case series reports on our initial experience with Haemospray in a hospital in Northern Ireland:

- A 76 year old male with a post-sphinceterotomy bleed in intensive care following endoscopic retrograde cholangiopancreatography (ERCP) for complicated choledocholithiaisis.
- A 60 year old gentleman with alcoholic cirrhosis and Barretts oesophagus with major bleeding from 3 sites following endoscopic mucosal resection (EMR) of the oesophagus.
- Bleeding following the EMR of a large hyperplastic gastric polyp in a 56 year old lady.
- A 77 year old Jehovah's witness presenting with bleeding related to a malignant tumour overgrowth around an indwelling oesophageal stent.
- An 83 year old lady presenting with melaena after ERCP, sphincterotomy and stent insertion for choledocholithiasis.

Conclusion: We have demonstrated the use of Haemospray in a variety of difficult cases including post-ERCP, post EMR and in a case of bleeding from an oesophageal malignancy. We would support its use where the application of traditional therapies is not possible or

unsuccessful. Further studies and cost-benefit analysis will be required to find where Haemospray belongs in the algorithm for treating acute upper GI bleeding.

References:
1. Barkun, A.N., et al., *International consensus recommendations on the management of patients with nonvariceal upper gastrointestinal bleeding.* Ann Intern Med, 2010. **152**(2): p. 101-13.
2. Sung, J.J., et al., *Early clinical experience of the safety and effectiveness of Hemospray in achieving hemostasis in patients with acute peptic ulcer bleeding.* Endoscopy, 2011. **43**(4): p. 291-5.
3. Leblanc, S., et al., *Early experience with a novel hemostatic powder used to treat upper GI bleeding related to malignancies or after therapeutic interventions (with videos).* Gastrointest Endosc, 2013. **78**(1): p. 169-75.

ABSTRACT 36 (13W128) POSTER PRESENTATION

Title of Paper: Changes in sedation practices for ERCP over time; experience of a single tertiary centre

Author(s): Orla Delaney, Carthage Moran, Maeve Lucey, Seamus O'Mahony, Orla Crosbie

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

Introduction: Endoscopic retrograde cholangiopancreatography (ERCP) is a complex gastrointestinal procedure that has been practised for over 30 years. The technique involves imaging of the biliary tree and pancreatic duct following endoscopy and is used to aid the diagnosis of obstruction, for example by gallstones or cholangiocarcinoma. ERCP can be an uncomfortable procedure; sedation and analgesia improve the efficiency of the procedure, quality of the results, and comfort of the patient . However, sedation is also responsible for the majority of complications related to diagnostic endoscopy. We investigated changes in sedation for ERCP in a single tertiary centre between the years 2007 and 2012. Unit policy changed with emphasis on more patients receiving co-administration of an opiate in addition to midazolam.

Aims/Background: 1. To investigate a change in sedation practice over time.

Method: Departmental electronic endoscopy reporting tool was used to assess ERCPs performed in the years 2007 (131 procedures) and 2012(153 procedures). Patient age, gender, sedation agents and dosage, complications, indication for procedure and findings were recorded and into Microsoft Excel. SPSS was used for statistical analysis Student t-test, graphs and frequency statistics).

Results: Sedation practice changed significantly with time.

	2007	2012	
Mdazolam	8.2(CI 7.7-8.6)	4.9(CI 4.7-5.2)	*p<.001
Mean dose (mg)	85%	26%	*p<.001
Patients receiving >5mg	7%	96%	*p<.001
Patients receiving opiod	75		
Pethidine mean dose(microg)		72	
Fentanyl mean dose (microg)			

Conclusion: Sedation practices changed dramatically in five years with reduction in both the mean dose of midazolam administered and proportion of patients receiving a dose of greater than 5mg. This was facilitated in part by an increase in the use of co-administered opiate (from 7% to 96% of cases).

ABSTRACT 37 (13W129) POSTER PRESENTATION

Title of Paper: An audit of management of upper gastrointestinal bleeding at Cork University Hospital

Author(s): Yousif K, Deasy C, Crosbie O, Zulqernain A

Department(s)/Institute(s): Departments of Gastroenterology and Emergency Medicine in Cork University Hospital.

Introduction: Upper gastrointestinal bleeding (UGIB) is a common and major gastrointestinal emergency with considerable morbidity and mortality. The National Institute for Health and Clinical Excellence (NICE) guidelines for the management of UGIB recommends Gastroscopy within 24 hours, the use of Terlipressin for variceal bleeding, Proton Pump Inhibitor only in confirmed non-variceal bleeding, and to use the Glasgow Blatchford Score (GBS) and Rockall scores pre and post-endoscopy respectively, for risk analysis, and for prognosis.

Aims/Background: To audit and evaluate the management of patients presenting with upper GI bleeding to the Emergency Department of Cork University Hospital, and compare the management with the recently published NICE guidelines.

Method: This was designed as a retrospective study over the last six months. There were 70 patients who presented to the Emergency Department with hematemesis, melena, and hematochezia were included in the study. The data was collected to include the pre-endoscopy assessment using GBS and pre-endoscopy Rockall score, and post-endoscopy assessment using the Rockall.

Results: The mortality rate in this cohort was 12.8% (one third of this group never underwent a gastroscopy as they were deemed palliative). Of the 70 patients, 58.6% were males with a median age of 65.5 years. The mean GBS was 6.61(SD 4.8), the mean pre-endoscopy Rockall score was 2.5 (SD 2.0), and the mean post-endoscopy Rockall score was 3.9 (SD 2.6). 39 patients (55.7%) had gastroscopy during their admission, of which 84.6% had a GBS of ≥4. Of the total endoscopy procedures performed, only 61.5% were performed within the first 24 hours. Despite the recommendations of NICE guidelines, 87% received IV PPI therapy pre-endoscopy, 28.5% received a blood transfusion and only 10% received Terlipressin. Of the OGDs performed; Oesophageal varices 36%, Oesophagitis 13%, Duodenal ulcers 10%, Oesophageal ulcers 7.7%, Gastritis 7.7%, and Duodenitis 7.7%.

Conclusion: The audit highlights shortcomings in the availability of acute endoscopy. Adherence to published NICE mandates a change in the delivery of acute endoscopy service.

ABSTRACT 38 (13W130) POSTER PRESENTATION

Title of Paper: Rising Incidence and Increasing Severity of Very Early Onset Ibd in Ireland

Author(s): R Wylde1,2, A Carey1,3, M.Hamzawi1, S Quinn1, A Broderick 1, B Bourke1,3, S Hussey1,3

Department(s)/Institute(s): 1.National Centre for Paediatric Gastroenterology (NCPG), OLCHC, Crumlin, Dublin 2.Leiden University Medical Centre, The Netherlands

Introduction: Inflammatory bowel disease (IBD) in Irish children is on the rise. Very early onset IBD (VEO-IBD), those diagnosed under the age of 10, is rare and can be severe in its presentation.

Aims/Background: Limited literature on VEO- IBD exists. The aim of the current study is to examine the epidemiology, phenotype and outcomes of VEO-IBD from 2000 to 2012 using a national cohort of Irish children.

Method: A retrospective review from the medical records of all children diagnosed with VEO-IBD (age at diagnosis <10yrs) attending the NCPG from January 2000 to December 2012 was undertaken. Patient demographics, diagnostic work-up, phenotype, initial and subsequent treatment and long term outcomes were recorded. Follow up review was conducted at 1,2,5,10 years and maximum clinical follow up. Cases were phenotyped according to the Paris Classification (Levine et al., 2011). Changes in the incidence rates were calculated using the Poisson regression.

Results: One hundred and fifty eight patients (50% male) with VEO-IBD were identified; 78(49%) Crohns Disease (CD), 63(40%) Ulcerative Colitis (UC) and 17(11%) IBD-undefined (IBD-U). Median age of onset was 7.5 (IQR:3.42). From 2000-2012, the overall incidence of VEO-IBD has increased significantly (p=0.026) due to a rise in UC. Pancolonic UC has increased 4-fold since 2000 (p=0.018) and the incidence of severe UC disease activity has risen significantly (p=0.01). Notably, the incidence of upper gastrointestinal CD increased significantly between the years 2000-2005 and 2006-2012 (p=0.003). Males had a higher risk of more upper GI disease than females (p=0.02) and greater risk of extensive disease location (L3 +/- L4) (p=0.03). At one year follow up, 95(64%) patients were in remission, 53 (36%)had been commenced on immunomodulators and 3(2%) on biologics. At maximum follow up, 20 (13%) had undergone surgery (12 UC, 8 CD).

Conclusion: The increasing incidence and severity of VEO-IBD, especially UC, is significant but remains unexplained. The factors causing the difference in disease between gender is also yet unknown. Future prospective longitudinal studies are needed to fully elucidate the factors underlying VEO-IBD in Irish children.

ABSTRACT 39 (13W131) POSTER PRESENTATION

Title of Paper: High Rates of H. pylori Resistance to Clarithromycin and Metronidazole in an Irish Cohort. Is it Time to Switch First Line therapy?

Author(s): Sinead Smith1, Rana Bakhtyar Haider1, Grainne Holleran1, Barry Hall1, Andy Lawson2, Colm O'Morain3, Deirdre McNamara1.

Department(s)/Institute(s): 1Dept of Gastroenterology & Clinical Medicine, Tallaght Hospital & TCD; 2Gastrointestinal Infections Reference Unit, Public Health England; 3Dept of Gastroenterology, Charlemont Clinic

Introduction: Eradication of Helicobacter pylori is recommended in all symptomatic patients. Empirical triple therapy with a proton pump inhibitor, and a dual antibiotic combination with amoxicillin and either metronidazole or clarithromycin, remains the first line treatment. In recent years, treatment success rates have fallen significantly below the 80 % recommended by the Maastricht IV Consensus guidelines. This is in line with a rapid increase in antibiotic resistance, in particular to clarithromycin, with second line and sequential treatments with levofloxacin, tetracycline and rifabutin often required. The European Helicobacter Study Group now recommends that clarithromycin should be abolished from standard anti-H. pylori regimens once resistance rates reach 15 % and have advised local surveillance and monitoring of antibiotic resistance to guide clinicians and improve eradication rates.

Aims/Background: To determine the prevalence of H. pylori antibiotic resistance in an Irish cohort of patients attending for routine endoscopy in two centres.

Method: Following ethical approval prospective recruitment of any patient aged over 18 years, undergoing routine gastroscopy, without any known contraindication to standard gastric biopsy was undertaken. Suitable subjects were invited to participate in the study, and informed consent was obtained. In addition to any necessary diagnostic samples, two further antral biopsies were taken at endoscopy, and H. pylori infection was detected by the rapid urease Campylobacter-like organism (CLO) test. Biopsies from H. pylori-positive patients based on their CLO test were cultured onto Columbia agar plates containing 10 % laked horse blood. Antibiotic susceptibility testing was performed using E-test strips (Biomerieux) and isolates were deemed sensitive or resistant using minimum inhibitory concentration cut-off guidelines outlined by the European Committee on Antimicrobial Susceptibility Testing (clarithromycin >0.5 mg/L; metronidazole >8 mg/L; amoxicillin >0.12 mg/L; levofloxacin >1 mg/L, tetracycline >1 mg/L; rifampicin >1 mg/L).

Results: To date, 133 subjects have been recruited from centre one. The average age was 57 years and 57 % of the subjects were male. H. pylori was present in 19.5 % (n=26). The H. pylori infected group were slightly but significantly younger (average age 51 ± 18 versus 57 ± 15 years; p = 0.04). A total of 34 biopsy samples have been plated for culture, 26 and 8 from centres 1 and 2 respectively. Of these, 74 % (n=25) were culture positive, 6 % (n=2) were culture negative and 20 % (n=7) had overgrowth of contaminating bacteria, prohibiting susceptibility testing. Antimicrobial susceptibility testing on pure H. pylori isolates indicated that the resistance rates for metronidazole and clarithromycin were significant at 60 % (n=15) and 12 % (n=3) respectively. Isolates from 8 % of patients (n=2) were resistant to both clarithromycin and metronidazole. None of the strains tested were resistant to levofloxacin, amoxicillin, rifabutin or tetracycline.

Conclusion: Resistance levels of H. pylori to metronidazole and clarithromycin in our Irish cohort is high. Clarithromycin resistance is approaching the cut-off level for withdrawal from regular use in first line triple therapy regimens. Resistance to metronidazole has almost doubled compared to a study carried out at our centre in 2007/2008 (O'Connor A. et al., 2010 Eur J Gastroenterol Hepatol). On-going resistance surveillance is necessary to assist clinicians in their choice of future eradication therapies.

ABSTRACT 40 (13W134) POSTER PRESENTATION

Title of Paper: The distribution of lymphatic vessels within the small intestinal and colonic mesenteries - an immunohistochemical analysis.

Author(s): Kevin Culligan MRCSI.,1 Rishabh Sehgal MRCSI., 1 Daniel Mulligan BSc.,1 Colum Dunne PhD.,1 Stewart Walsh FRCSEd.,1 Fabio Quondamatteo MD.,2 Peter Dockery PhD.,2 J. Calvin Coffey FRCSI.1

Department(s)/Institute(s): 1.Department of Surgery, Centre for Interventions in Infection, Inflammation and Immunity (4i), Graduate Entry Medical School, University Hospitals Group Limerick,

TRUST in HUMIRA -

10 YEARS OF EFFICACY DATA FOR RA IN LABEL[1]

9 INDICATIONS - THE MOST OF ANY SELF-ADMINISTERED BIOLOGIC[1]

MORE THAN

85 COUNTRIES[2]

15 YEARS OF CLINICAL TRIAL EXPERIENCE, BEGINNING WITH RHEUMATOID ARTHRITIS (RA)[3]

71 CLINICAL TRIALS IN THE LARGEST PUBLISHED ANTI-TUMOR NECROSIS FACTOR (TNF) CROSS-INDICATION SAFETY DATABASE[3]

Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe and Humira 40mg/0.8ml solution for injection for paediatric use Refer to Summary of Product Characteristics for full information. Presentation: Each 0.8ml single dose pre-filled pen, pre-filled syringe or vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA): Humira in combination with methotrexate is indicated for the treatment of moderate to severe, active RA in adult patients when the response to disease-modifying anti-rheumatic drugs (DMARDs) including methotrexate has been inadequate. Humira is also indicated for the treatment of severe, active and progressive RA 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. Polyarticular juvenile idiopathic arthritis (JIA): Humira in combination with methotrexate is indicated for the treatment of active JIA, in children and adolescents aged 2 to 17 years who have had an inadequate response to one or more DMARDs. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Psoriatic arthritis (PsA): Humira is indicated for the treatment of active and progressive PsA 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 AS who have had an inadequate response to conventional therapy. Axial spondyloarthritis (SpA) without radiographic evidence of AS: 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. Crohn's disease (CD): Humira is indicated for treatment of moderately to severely active CD, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or who are intolerant to or have medical contraindications for such therapies. Paediatric Crohn's Disease: Humira is indicated for the treatment of severely active Crohn's disease in paediatric patients (6 to 17 years) 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. Psoriasis: Plaque 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 ciclosporin, methotrexate or PUVA. Ulcerative colitis (UC): Humira is indicated for treatment of moderately to severe 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. **Dosage and administration:** Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of conditions for which Humira is indicated. Patients treated with Humira should be given the special alert card. After proper training in injection technique, patients may self-inject with Humira if their physician determines that it is appropriate and with medical follow-up as necessary. During treatment with Humira, other concomitant therapies (e.g. corticosteroids and/or non-pharmacological agents) should be optimised. RA, PsA, AS or SpA: Non-radiographic: 40mg administered every other week as a single dose via subcutaneous injection. RA: In monotherapy some patients who experience a decrease in their response to Humira may benefit from an increase in dose intensity to 40mg every week. There may be a need for dose intercalation, for instance before surgery or if a serious infection occurs. Available data suggest that re-introduction of Humira after discontinuation for 70 days or longer resulted in the same magnitudes of clinical response and similar safety profile as before dose interruption. For RA, JIA, PsA and AS, available data suggest that the clinical response usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within this time period. JIA: Age 2 to 12 years: 24mg/m² body surface area to a maximum single dose of 40mg administered every other week via subcutaneous injection. The volume for injection is based on the patients' height and weight (see Dm/PG for Height and Weight dosing chart). A 40mg paediatric vial is available for patients who need to administer less than the full 40mg dose. Age 13 to 17 years: 40mg administered every other week via subcutaneous injection regardless of body surface area. CD: The recommended Humira induction dose regimen for adult patients with moderate to severe CD is 80mg at Week 0 followed by 40mg at Week 2. In cases where a more rapid response is desired, the regimen 160mg at Week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days), 80mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 40mg every other week as subcutaneous injection. Some patients who experience declined response may benefit from an increase in dosing frequency to 40mg Humira every week. Some patients who have not responded by Week 4 may benefit from continued therapy through Week 12. Continued therapy should be carefully reconsidered in a patient not responding within the time period. Paediatric CD: patients ≥40kg: recommended inductor dose regimen of 40mg at Week 0 followed by 20mg at Week 2 (a 80 mg dose. In cases of need for a more rapid response to therapy, the regimen 80mg at Week 0 (dose can be administered as two injections in one day), 40mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 20mg every other week as SC injection. Some patients who experience declined response may benefit from 20mg every week. patients ≤40kg: double the dose regimen for these patients ≤40kg Crohn's disease therapy should be carefully reconsidered in a patient not responding by week 12. Psoriasis: The recommended dose of Humira for adult patients is an initial dose of 80mg administered subcutaneously, followed by 40mg administered every other week starting one week after the initial dose. Continued therapy beyond 16 weeks should be carefully reconsidered in a patient not responding within this time period. UC: The recommended Humira induction dose regimen for adult patients with moderately to severely UC is 160mg at week 0 (dose can be administered as four injections in one day or as two injections per day for two consecutive days) and 80mg at week 2. After induction treatment, the recommended dose is 40mg every other week via subcutaneous injection. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Some patients who experience decrease in their response may benefit from an increase in dosing frequency to 40mg Humira every week. Available data suggest that clinical response is usually achieved within 2-8 weeks of treatment. Continued therapy is not recommended in patients not responding within this time period. **Contraindications:** Active tuberculosis or other severe infections such as sepsis, and opportunistic infections; moderate to severe heart failure (NYHA class III/IV) and hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings:** Infections: Patients taking TNF-antagonists are more susceptible to serious infections. Impaired lung function may increase the risk for developing infections. Patients must therefore be monitored closely for infections, including tuberculosis, before, during and for 4 months after treatment with Humira. Treatment with Humira should not be initiated in patients with active, chronic or localised infections until infections are controlled. In patients who have been exposed to tuberculosis and patients who have travelled in areas of high risk of tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis, the risk and benefits of treatment with Humira should be considered prior to initiating therapy (see Opportunistic Infections). Patients who develop a new infection while undergoing treatment with Humira should be monitored closely and undergo a complete diagnostic evaluation. Administration of Humira should be discontinued if a patient develops a new serious infection or sepsis, and appropriate anti-microbial or antifungal therapy should be initiated until the infection is controlled. Physicians should exercise caution when considering the use of Humira in patients with a history of recurring infection or with underlying conditions which may predispose to infections, including the use of concomitant immunosuppressive medications. Serious Infections: Serious infections, including sepsis, due to bacterial, mycobacterial, invasive fungal, parasitic, viral, or other opportunistic infections such as listeriosis, legionellosis and pneumocystis have been reported in patients receiving Humira. Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septicaemia. Hospitalisation or fatal outcomes associated with infections have been reported. Tuberculosis: Tuberculosis, including reactivation and new onset of tuberculosis, has been reported in patients receiving Humira. Reports included cases of pulmonary and extra-pulmonary (i.e. disseminated). Before initiation of therapy with Humira, all patients must be evaluated for both active or inactive ('latent') tuberculosis infection. Appropriate screening tests, should be performed in all patients. Local recommendations may apply. If active tuberculosis is diagnosed, Humira therapy must not be initiated. If latent tuberculosis is suspected, a physician with expertise in the treatment of tuberculosis should be consulted and the benefit/risk balance of therapy with Humira should be considered. If inactive ('latent') tuberculosis is diagnosed, appropriate treatment must be started with anti-tuberculosis prophylaxis treatment before the initiation of Humira, and in accordance with local recommendations. In patients who have several or significant risk factors for tuberculosis despite a negative test for latent tuberculosis infection, treatment should also be considered before the initiation of Humira and in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Some patients who have previously received treatment for latent or active tuberculosis have subsequently developed tuberculosis while being treated with Humira. Other opportunistic infections. Opportunistic infections, including invasive fungal infections, have been observed in patients receiving Humira. These infections have not consistently been recognised in cases taking TNF-antagonists and this resulted in delays in appropriate treatment, and infection resulting in fatal outcomes. For patients who develop the signs and symptoms such as fever, malaise, weight loss, sweats, cough, dyspnoea, and/or pulmonary infiltrates or other serious systemic illness with or without concomitant shock, an invasive fungal infection should be suspected and administration of Humira should be promptly discontinued. Diagnosis and administration of empiric antifungal therapy in these patients should be made in consultation with a physician with appropriate expertise. Hepatitis B Reactivation. Reactivation of hepatitis B (HBV) has occurred in patients receiving a TNF-antagonist including Humira, who are chronic carriers of this virus (i.e. surface antigen positive), with some fatal outcomes. Patients should be tested for HBV infection before initiating treatment. Patients that test positive should have a consultation with a physician. In patients who develop HBV reactivation, Humira should be stopped and effective antiviral therapy with appropriate supportive treatment should be initiated. Carriers of HBV who do not require treatment or who develop HBV while on therapy may be candidates for vaccination. Vaccinations. Live vaccines should not be given concurrently. Children exposed to adalimumab in utero may be at increased risk of infection for up to 5 months after the last dose of adalimumab during pregnancy. Administration of live vaccines in these infants during this time period is not recommended. Concomitant therapy. In clinical studies, concomitant use of methotrexate, corticosteroids, salicylates, NSAIDs, and analgesics did not alter the clinically apparent safety profile of Humira. Immunosuppression. Humira was administered to 257 patients aged 65 and older and no overall differences in safety or effectiveness were observed between these subjects and younger subjects. Autoimmunity. Treatment may result in the formation of autoantibodies. Haematologic reactions. Humira has been associated, in rare cases, with

– An unmatched legacy.

MORE THAN

670,000

PATIENTS CURRENTLY TREATED WORLDWIDE[2]

MORE THAN

23,000

PATIENTS IN GLOBAL STUDIES[3]

HUMIRA adalimumab | 10 YEARS

new onset or exacerbation of clinical symptoms and/or radiographic evidence of central nervous system demyelinating disease including multiple sclerosis and optic neuritis, and peripheral demyelinating disease, including Guillain-Barré syndrome. Caution should be exercised when considering Humira in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. **Allergic reactions:** Post-marketing serious allergic reactions including anaphylaxis have been reported following Humira administration. If an anaphylactic reaction or other serious allergic reaction occurs, administration of Humira should be discontinued immediately and appropriate therapy initiated. **Malignancies and lymphoproliferative disorders:** In clinical trials, more cases of malignancies including lymphoma and leukaemias have been observed among patients receiving a TNF-antagonist compared with control patients. These data cannot exclude a possible risk of malignancy in patients receiving chronic and adolescents treated with TNF-antagonists. Furthermore, there is an increased background lymphoma risk in RA patients. Rare post-marketing cases of hepatosplenic T-cell lymphoma have been identified in patients treated with adalimumab. Some of these cases have occurred in young adult patients on concomitant treatment with azathioprine or 6-mercaptopurine used for inflammatory bowel disease. The potential risk with the combination of azathioprine or 6-mercaptopurine and Humira should be carefully considered. A risk for the development of hepatosplenic T-cell lymphoma in patients treated with Humira cannot be excluded. Caution should be exercised in considering Humira treatment of patients with a history of malignancy. All patients, and in particular patients with a medical history of extensive immunosuppressant therapy or psoriasis patients with a history of PUVA treatment should be assessed for the presence of non-melanoma skin cancer prior to and during treatment with Humira. Caution should also be exercised when using TNF-antagonists in COPD patients, as well as in patients with increased risk of malignancies due to heavy smoking. With current data it is not known if initiation of treatment influences the risk for developing dysplasia or colon cancer. All patients with UC who are at increased risk for dysplasia or colon cancer (e.g. patients with long-standing UC or primary sclerosing cholangitis), or who had a prior history of dysplasia or colon carcinoma, should be screened for dysplasia at regular intervals before therapy and throughout their disease course. This evaluation should include colonoscopy and biopsies per local recommendations. **Haematologic reactions:** Pancytopenia including aplastic anaemia has rarely been reported with TNF-blocking agents. Adverse events of the haematologic system, including cytopaenia (eg. thrombocytopaenia, neutropaenia) have been reported with Humira. Patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias. Vaccinations: Patients on Humira may receive concurrent vaccinations, except for live vaccines. It is recommended that all patients, if possible, be brought up to date with all immunisations in agreement with current immunisation guidelines prior to initiating Humira therapy. **Congestive heart failure:** Humira should be used with caution in patients with mild heart failure (NYHA class III) and discontinued in patients who develop new or worsening symptoms of congestive heart failure. **Autoimmune process:** Humira may result in the formation of autoimmune antibodies. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Humira and is positive for antibodies against double-stranded DNA, further treatment with Humira should not be given. **Surgery:** There is limited safety experience of surgical procedures in patients treated with Humira. The long half life of Humira should be taken into consideration when a surgical procedure is planned, and the patient should be monitored for infections. **Small bowel obstruction:** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture that may require surgical treatment. Available data suggest that Humira does not worsen or cause strictures. **Elderly population:** The frequency of serious infections among Humira treated subjects over 65 years of age was higher than those under 65 years of age. Some of these had a fatal outcome. Particular attention regarding the risk for infection should be paid when treating the elderly. **Interactions:** Combination of adalimumab with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Pregnancy and lactation:** Administration of adalimumab is not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. Administration of live vaccines to infants exposed to adalimumab in utero is not recommended for 5 months following the mother's last adalimumab injection during pregnancy. Women must not breast-feed for at least five months after the last Humira treatment. **Driving and machinery:** Humira may have a minor influence on the ability to drive and use machines. **Side Effects:** From clinical data arises marked ↑↑ which indicates spontaneous reporting data. Very common ≥ 1/10. Respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), localised infections (including neutropaenia and agranulocytosis, anaemia, ↑lipids increased, headache, oesophageal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rashes, mucocutaneous rash, non-infectious skin reaction (including injection site reactions)), musculoskeletal pain, systemic infections (including fungal infections, joint infections, benign neoplasm, skin cancer (excluding melanoma and squamous cell carcinoma), and squamous cell carcinoma), bacteraemia, tuberculosis, opportunistic infections (including disseminated histoplasmosis, candidiasis and tuberculosis), intestinal infections (including gastroenteritis viral, otitis and soft tissue infections (including cellulitis, erysipelas, necrotising fasciitis and herpes zoster), eye infections, oral infections (including herpes simplex, oral herpes and tooth infections), reproductive tract infections (including vulvovaginal mycotic infection), urinary tract infections (including pyelonephritis), fungal infections, joint infections, benign neoplasm, skin cancer (excluding basal cell carcinoma and squamous cell carcinoma), thrombocytopaenia, lymphocytosis, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphataemia, dehydration, mood alterations (including depression), anxiety, insomnia, paraesthesias (including hypoaesthesia), migraine, intracranial hypertension, visual impairment, conjunctivitis, blepharitis, eye swelling, vertigo, tachycardia, hypertension, flushing, hypertension, cough, asthma, dyspnoea, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, sclerosing and inflammation of pancreas (including pancreatitis), hepatitis, urticaria, bruising (including purpura), stomatitis (including eczema), onychoclasis, hyperhidrosis, musculospasm (including blood creatine phosphokinase increased), myasthenia, renal impairment, chest pain, oedema, pyrexia, coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), abnormal body fat position (including decreased DNA antibody), blood sodium abnormal (hyponatraemia) increased, impaired healing. Uncommon ≥ 1/1000 to < 1/100. Opportunistic infections and tuberculosis (including candidiasis of mucosae, histoplasmosis and mycobacterium avium complex infection), neurological infections (including viral meningitis), eye infections, bacterial infections, diverticulitis[1], pancytopenia, solid organ neoplasm (excluding breast cancer, lung neoplasm and thyroid neoplasm), melanoma, idiopathic thrombocytopaenic purpura, sarcoidosis[1], cerebrovascular accident[1], tremor, neuropathy, diplopia, deafness, tinnitus, myocardial infarction[1], arrhythmia, congestive heart failure, pulmonary embolism[1], chronic obstructive pulmonary disease, interstitial lung disease, pneumonitis, pleural effusion[1], pancreatitis, dyspepsia, face oedema, cholecystitis and cholelithiasis, bilirubin increased, necrotic enzymes, night sweats, scar, rhabdomyolysis, systemic lupus erythematosus, ecchymosis, erectile dysfunction, intervention, vascular arterial occlusion, aortic aneurysm, thrombophlebitis. Rare ≥ 1/10,000 to < 1/1,000: Leukaemia[1], anaphylaxis[1], demyelinating disorders (eg. optic neuritis, Guillain-Barré syndrome)[1], pancytopaenia, multiple sclerosis, cardiac arrest, pulmonary fibrosis[1], bowel perforation[1], reactivation of hepatitis B[1], autoimmune hepatitis[1], erythema multiforme[1], cutaneous vasculitis[1], Stevens-Johnson syndrome[1], angioedema[1], Lupus-like syndrome[1]. Very rare < 1/10,000: Liver failure[1], not known: Hepatosplenic T-cell lymphoma[1], Merkel Cell Carcinoma[1] **Prescriber's should consult the summary of product characteristics for further information on side effects. Overdose:** No dose-limiting toxicity was observed during clinical trials. The highest dose level evaluated has been multiple intravenous doses of 10 mg/kg approximately 15 times the recommended dose. **Legal Category:** POM **Marketing Authorisation Numbers/Presentations:** Vial: EU/1/03/256/001; 1 pack contains 2 cartons each containing 1 single use vial and empty sterile injector syringe, needle and vial adapter. Pre-filled syringe: EU/1/03/256/002 each carton contains 2 single use pre-filled syringes in a blister. Pre-filled Pen: EU/1/03/256/003 each carton contains 2 single use pre-filled pens in a blister. **Further information is available from AbbVie Limited, Block B, Lilley Valley Office Campus, Osarrylale, Co. Dublin. Date of revision of PI:** February 2015 PI/HUM/UK. **References:** 1. HUMIRA [summary of product characteristics]. AbbVie Limited. Available on www.medicines.ie 2. Data on file. Abbvie Inc. 2012. 3. Burmester GR, Feldmann R, Cardiel MH, et al. Adalimumab: long-term safety in 23 458 patients from global clinical trials in rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, psoriatic arthritis, psoriasis and Crohn's disease [published online ahead of print May 5, 2010]. Ann Rheum Dis. doi:10.1136/ard.nde.2011.201244.

IRE/HUM/1300/0XE Date of Preparation: August 2013

abbvie

Limerick, Ireland. 2.Anatomy

Introduction: Inadequate mesocolic resection is associated with adverse oncologic outcome for colon cancer. This is most probably secondary to poor insight into the mesocolic anatomy leading to inaccurate planar dissection of the mesocolic lymphatic package. Surprisingly, mesenteric lymphangiology has not been fully characterised to date. Recently, a reappraisal of the mesenteric anatomy and histology of the colon has been undertaken therefore providing an opportunity to accurately determine the distribution of mesocolic lymphatic architecture.

Aims/Background: To characterise the distribution of the lymphatic vessels (LV) within the mesenteric organ (i.e. small intestinal and colonic mesentery) and Toldt`s fascia.

Method: Mesenteric samples were harvested from 12 human cadavers. Samples were taken from the small bowel mesentery, ascending, transverse, descending mesocolon and from both apposed and non-apposed mesosigmoid. Samples were, fixed and sectioned appropriately followed by immunohistochemical staining using the monoclonal antibody D2-40 (podoplanin), haematoxylin and eosin, and Masson`s Trichrome.

Results: The distribution of LV were similar across the small intestinal mesentery and the entire mesocolon sampled. Small LV (<20µm) were identifiable within the submesothelial connective tissue monolayer (SCTM), located immediately below the peritoneal surface. Within the body of the mesocolon, LV were evident within the connective tissue septations that arose from the SCTM. Within this connective tissue lattice, LV were observed to accompany their corresponding blood vessels. LV were evident in the layer of Toldt`s fascia, interposed between the mesocolon and underlying retroperitoneum in one-third of samples.

Conclusion: This is the first study to describe lymphatic vessels at such proximity to the peritoneal surface. Lymphatic vessels also occurred throughout the mesenteric connective tissue lattice, as well as within Toldt's fascia. These finding has fundamental implications for oncological resections. The presence of LV within Toldt's fascia requires a reappraisal of the exact plane utilised for colonic mobilisation.

ABSTRACT 41 (13W135) POSTER PRESENTATION

Title of Paper: Eosinophilic Oesophagitis: Men find this hard to swallow?

Author(s): Vikrant Parihar,Antoine Murray,Clare Kennedy, Paul Crotty, Barbara Ryan

Department(s)/Institute(s): Departments of Gastroenterology and Histopathology;Adelaide and Meath Hospital

Introduction: Eosinophilic oesophagitis (EO) has been increasingly recognised and diagnosed over the past decade. It is characterised by an eosinophil-predominant inflammatory infiltrate on oesophageal biopsy, with a level of >15 eosinophils per high power field required to make a diagnosis. The symptoms include dysphagia and slow eating and the endoscopic features range from a normal appearing mucosa to so-called 'trachealisation', longitudinal ridging, white appearing micro-abscesses and strictures.

Aims/Background: The aim of this on-going retrospective study is to assess the clinical presentation, endoscopic findings, demographic profile and response to treatment of patients diagnosed with EO at our institution.

Method: The histopathology database at our institution from 2011-2012 was interrogated and this identified 59 adult patients where at least one biopsy from either the oesophagus or OGJ cited a raised eosinophil count per high power field. A retrospective review of these patients' charts was then completed. This study is ongoing and to date over 50% of the charts have been available for review, the remainder are awaited.

Results: 30 charts (51%) have been reviewed to date. Out of these, only 17(56%) were definitively labelled as having EO. In the remaining 13 (44%) of patients, the raised eosinophil count was not sufficient to meet the diagnostic criteria for EO and was thought to reflect reflux change. Of the 17 confirmed patients so far, the median age was 41 years and 14 (82%) were males. The most common symptom was dysphagia (47%) followed by reflux symptoms which were unresponsive to PPI therapy (23%). The remaining patients presented with food bolus impaction (11%) and chest pain (6%). Only 7/17 cases (41%) of confirmed histological EO had typical endoscopic features, with the remainder having a macroscopically normal oesophagus. All the patients were treated with high dose PPI's and in addition 10 patients received topically ingested steroids. 8(47%) patients had repeat oesophageal biopsies taken after a period of treatment. Of these, 6 (75%) had persistent eosinophilic infiltrate and only 2(25%) demonstrated normalisation of the mucosa.

Conclusion: EO is a condition which predominantly affects young and middle aged males. The oesophagus appeared macroscopically normal in 60% of cases, so oesophageal biopsy is crucial in patients presenting with dysphagia and no other identifiable cause at endoscopy. Our results suggest that normalisation of the eosinophilic infiltrate occurs in only a minority of patients with EO following treatment, although there may have been a selection bias in patients undergoing repeat endoscopy and biopsy.

ABSTRACT 42 (13W136) POSTER PRESENTATION

Title of Paper: Hepatoma surveillance in viral hepatitis cohort in a University Teaching Hospital: Are we targeting the correct patients? A retrospective audit.

Author(s): K Hartery, V Mallaett, A Coffey, D Pritchard, FE Murray,

Department(s)/Institute(s): Department of Hepatology, Beaumont Hospital RCSI, Dublin 9.

Introduction: Hepatoma is a common and serious complication of advanced and viral liver disease. Survival rate is dismal unless diagnosed early. AASLD guidelines recommend HCC surveillance for high-risk patients in the form of 6-monthly liver ultrasound. The extent of utilization in clinical practice is low.

Aims/Background: A retrospective audit of the appropriateness of liver ultrasound requests for hepatoma surveillance in accordance with AASLD guidelines.

Method: A written log of all ultrasound ordered for HCC surveillance in viral hepatology department was kept from September 2010 to July 2011. Patients demographic (including age, gender, and ethnicity), liver biopsy results, and FP levels recorded from electronic PIPE system. Ultrasound findings and interval between scans was recorded with follow-up period of 2 years from McKiession Radiology system. Patient's attendance same was also recorded. FHx of HCC was not routinely documented in patients chart.

Results: Data for a total of 284 patients was recorded, with median age of 43 and interquartile range of 36 and 55. 179 were male. 187 were chronic Hepatitis C, 95 were chronic Hepatitis B, and 2 were co-infected with chronic Hep C/Hep B. With regard to ethnicity, 28 Africans, 32 Asians, 27 Eastern Europeans, and 197 were Irish. 115 patients had been previous biopsy of whom 58 had No fibrosis. 34 had Mild Fibrosis, 10 had Bridging Fibrosis, 7 had Bridging Fibrosis with Nodule Formation, and 6 were Cirrhotic. 34 patients were cirrhotic on ultrasound. The average value for ?FP was 6.87. Eleven patients had values greater 20. Of the 284 ultrasounds ordered 36 patients (12.6%) did not attend their appointments. According to AASLD guidelines, 67 of 284 (23.6%) scans ordered were appropriate. If patients who had mild fibrosis, bridging fibrosis, and bridging fibrosis with nodule formation were included a further 12 patients were deemed appropriate (total of 27.8%) The average interval between scans in this group was 9.9 months with a range of 3-26 months.

Conclusion: 6-monthly liver ultrasound has also been shown to increase quality-adjusted life-years in patients who developed hepatoma and subsequently received resection or liver transplant. It is important however that this cost effective measure is applied to the appropriate population.

ABSTRACT 43 (13W137) POSTER PRESENTATION

Title of Paper: Audit of SeHCAT test to investigate suspected bile acid malabsorption, in a tertiary referral hospital.

Author(s): Tighe D, Sheehy N, McKiernan S

Department(s)/Institute(s): St James's Hospital

Introduction: Bile acid malabsorption (BAM) can be a debilitating chronic condition, causing chronic diarrhoea. Patients most at risks, include those with inflammation of their ileum, as in Crohn's disease, those with previous ileal resections, cholecystectomy, or immune deficiency. A certain percentage may also be diagnosed as having, idiopathic bile salt malabsorption (IBAM). SeHCAT is a taurine-conjugated bile acid analogue which was synthesized for use as a radiopharmaceutical to investigate the in vivo enterohepatic circulation of bile salts. SeHCAT has been shown to be absorbed from the gut and excreted into the bile at the same rate as cholic acid, one of the major natural bile acids in humans. Treatment of BAM is in the form of bile acid sequestration, such as cholestyramine.

Aims/Background: The purpose of this audit was to review results of SeHCAT test performed at our centre, and to identify which patients would benefit from this useful test in the future.

Method: The SeHCAT test was performed in 24 patients, from 19/07/12 to 18/09/2013. A standard protocol was used. A 75 Se SeHCAT capsule of 0.37MBq was taken by each patient and each patient was then scanned 3 hours later, to establish a baseline level of 75 Se in the body. After 7 days patients were re-scanned and the remaining 75 Se is expressed as a percentage of the baseline. Information of patient's demographics and background was obtained from examination of patients electronic patient records.

Results: In 62.5% of patients BAM was abnormal, with a SeHCAT retention rate of less than 15%. Taking into account borderline cases (retention rate 15-20%), this figure rose to 70.8%. Of these 6(35.2%) were severe (<5% retention), 6(35.2%) moderate (5-10% retention), 3(17.6%) mild (10-15% retention) and 2(11.7%) borderline (15-20% retention). 75% of the referrals were women, with an average age of 58 years. With regard to the distribution of positive SeHCAT tests according to underlying aetiology, there were 2 patients(11.7%), who fell into BAM Type 1 (ileal disease/resection). 5 patients (29.4%) were deemed to be idiopathic, BAM Type 2 (IBAM). Two patients with IBAM were first degree relatives. 10(58.8%) patients were BAM Type 3(secondary to other causes). These included 5 patients with prior cholecystectomy and 5 patients with underlying immune deficiency. 3 patients with multiple myeloma and receiving treatment with Lenalidomide, had a positive SeHCAT result, suggesting a direct association.

Conclusion: This audit helps confirm that SeHCAT is a useful test for identifying bile salt malabsorption. It will allows us to better risk stratify and identify which patients will benefit from this test, and allow diagnosis at an earlier stage.

ABSTRACT 44 (13W138) POSTER PRESENTATION

Title of Paper: Hickman line infections in Home Parenteral Nutrition Patients – the Belfast Experience

Author(s): Murray, E ; Campbell, R.; Smyth, R.; Rafferty, G; Turner,GB.

Department(s)/Institute(s): Nutrition Support Team, Royal Victoria Hospital, Belfast

Introduction: Catheter related Blood Stream infections are a common cause of recurrent admissions and morbidity for Home Parenteral Nutrition (HPN) patients.

Aims/Background: To identify episodes of Catheter Related Blood Stream Infection (CRBSI) in patients on home Parenteral Nutrition attending the Belfast Hospitals Trust.

Method: All patients on home parenteral nutrition/electrolytes between June 2012 and June 2013 were identified from Nutrition Support Team records. Electronic records for all laboratory, radiology, medical and nursing disciplines were retrospectively reviewed for each patient. Episodes of sepsis with positive Hickman line or line tip cultures were identified and records of organisms cultured and antibiotics prescribed were collated.

Results: Over the audit period, 34 HPN patients were identified, with an average duration of administration being 1529 days (range 167 to 4756 days). 79 % of patients self-managed Hickman lines. There were 102 confirmed episodes of CRBSI in HPN patients; which corresponds to 1.97 per 1000 catheter days. 38% patients had no infections; nine patients had six or more infections (accounting for 80 of the CRBSI episodes). The most common organisms identified were Coagulase Negative Staphylococcus; Gram negative organisms and Candida. Seventy per cent of lines were removed. Five out of six patients with a jejuno-colic anastomosis had infections; compared to 12/28 patients with an end jejunostomy/ileostomy. There were 7 patients who stopped administering home parenteral nutrition within the time frame; 4 patients died – 2 due to sepsis.

Conclusion: Home parenteral nutrition remains a safe treatment option for patients with intestinal failure. Our HPN infection rate is comparable to other tertiary units for intestinal failure. A small cohort of patients are responsible for the majority of infections.

ABSTRACT 45 (13W140) POSTER PRESENTATION

Title of Paper: Variability in Gastroenterologists' Fees in Private

Practice: A National Audit

Author(s): Muhommed Farman, Fintan O'Toole, Calvin Tsoi, Gavin Harewood, Frank Murray, Stephen Patchett

Department(s)/Institute(s): Beaumont Hospital

Introduction: There is growing evidence to demonstrate significant regional variation in pricing for medical services both nationally and internationally. Among the public, increasing the transparency of medical costs for patients is gaining popularity. A recent survey by the National Consumer Agency detected significant price differences charged by pharmacies for the same prescription; the average percentage difference in price was 56% (ranging from 37% to 199%).

Aims/Background: The aim of this study was to describe the variation in fees charged by consultant gastroenterologists for private consultations nationally.

Method: All consultant gastroenterologists in private practice in Ireland were identified from the Irish Medical Directory. The physicians' offices were contacted by phone to ascertain the cost of an initial consultation. The physician's affiliation with an academic medical centre and geographic location were also recorded. All costs were expressed as multiples of the overall mean cost of an initial consultation. The coefficient of variation (Standard Deviation / mean) was calculated to describe the variation in consultant charges.

Results: In total, cost information was obtained from 42 gastroenterologist offices, 10 in north Dublin, 15 in south Dublin, 10 in Cork/Galway and 7 from elsewhere. There was some geographic variation in the mean cost of initial consultation, 1.06 (north Dublin city) vs 1.05 (south Dublin city) vs 0.94 (Cork/Galway) vs 0.88 (elsewhere), with the only significant difference being between costs of Dublin and elsewhere in pairwise analysis, $p = 0.001$. Overall, there was minimal variation in fees nationally, coefficient of Variation = 14% (CV < 20% is considered low variation). There was no significant difference in costs between academic and non-academic gastroenterologists in any of the four regions.

Conclusion: As expected, consultant gastroenterologist fees are higher in Dublin compared to elsewhere by approximately 15% which compares favourably with price differences observed among pharmacies. There is low variation in fees charged among gastroenterologists nationally.

ABSTRACT 46 (13W141) POSTER PRESENTATION

Title of Paper: Comparison of participation rates between males and females in faecal immunochemical test colorectal cancer screening: A review and meta-analysis

Author(s): Clarke N, Osbourne A, Kearney P, Sharp L.

Department(s)/Institute(s): National Cancer Registry Ireland, Deparment of Epidemiology and Public Health UCC, Centre for Men's Health IT Carlow

Introduction: Colorectal cancer is the third most common cancer in men and the second in women worldwide. CRC can be prevented through screening and treated effectively, or cured, if caught early. There is higher incidence (20.3 vs. 14.6 per 100,000) and mortality (9.6 vs. 7.0 per 100,000) in men worldwide. In Ireland new cases are expected to grow substantially. Screening includes invasive (colonoscopy) and non-invasive testing (Faecal immunochemical test (FIT). Recommendations are prompting screening programmes to move towards FIT as the initial screening modality. Some studies and screening programmes have reported lower uptake among males.

Aims/Background: This systematic and meta-analysis review aimed to determine if uptake of FIT-based CRC screening is lower among men than women.

Method: We searched PubMed and Embase for English peer-reviewed papers published during 2000-2012, from randomised controlled trials (RCTs), cohort studies and population-based screening programmes using FIT screening. For inclusion, studies had to report numbers invited and screened by gender. 246 potentially eligible papers were identified. Two reviewers independently screened titles and abstracts, obtained and reviewed full-text articles, and performed data abstraction. A meta-analysis using a random effects model was performed with male uptake of FIT as the outcome of interest.

Results: Nine studies met the eligibility criteria, (3 Italian, 2 Dutch, Australia, USA, Republic of Korea and Spain). Of these, 4 studies were RCTs, 3 were population-based screening programmes and 2 were cohort studies. Invitation strategies varied from GP/ non-GP recommended invitations, invitation or pre-invitation letters and invitations with or without kits. Combined uptake in male and females ranged from 19.6% to 72.5%. Of the 9 studies, 7 had significantly lower uptake among males; two showed no significant difference. When combined in a meta-analysis, uptake was significantly lower in men (OR 0.88, [0.84, 0.91] $p<0.0001$], $I2=97\%$).

Conclusion: While FIT tests have been shown to improve participation rates, uptake is still significantly lower among men. Further investigation is required into the acceptability of FIT screening among men, while national screening programmes should plan and design programmes with a greater focus on gender equity in uptake.

ABSTRACT 47 (13W143) POSTER PRESENTATION

Title of Paper: Impact of high definition colonoscopy on polyp detection in a single centre

Author(s): M. Walshe; M. Boyle; G. Bennett; B. Kelleher; P. MacMathuna; S. Stewart; J. Leyden

Department(s)/Institute(s): GI Unit, Mater Misericordiae University Hospital

Introduction: The adenoma/polyp detection rate is one of the recognised key performance indicators for colonoscopy. In recent years high definition (HD) colonoscopy has become more widely available. However to date, studies have not shown a significant improvement in polyp detection rates with high definition colonoscopy compared to standard colonoscopy.

Aims/Background: To assess the impact of HD colonoscopy on polyp detection rates among five consultant endoscopists in a single endoscopy unit.

Method: We performed a retrospective review of the computerised endoscopy database. Colonoscopy polyp detection rates for each of the five endoscopists were analysed over two separate nine month periods (two years apart); the first using only standard definition monitors and second using only high definition monitors. Narrow band imaging (NBI) was available during both periods. Only single-

endoscopist procedures were included. Patient demographics, classification (inpatient or outpatient) and bowel preparation quality were also analysed. Categorical data were analysed using Fishers exact test and continuous data using the Mann Whitney U test.

Results: From January to September 2011 the five endoscopists performed 531 single-endoscopist colonoscopies – 49% male, 14% inpatients, median age 59(range 17 to 96). Polyps were detected in 157 (30%) of the procedures. 646 colonoscopies were performed over the corresponding nine month period in 2013 – 47% male, 6% inpatients, median age 56 (range 17-91). Polyps were detected in 166 procedures (26%) in 2013. Poor bowel preparation was reported in 54 (10%) of procedures in 2011 and 61 (9%) of procedures in 2013. The differences in patient age and classification (inpatient or outpatient) were statistically significant, however the overall polyp detection rates were similar for the two groups.

Conclusion: There was no statistically significant difference in reported polyp detection rates with HD colonoscopy. The bowel preparation quality and polyp detection rates were in line with the Conjoint Board (RCPI and RCSI) key performance indicators.

ABSTRACT 48 (13W145) POSTER PRESENTATION

Title of Paper: National HCV Treatment Outcomes of the DAA triple therapy cohort – first report of ICORN registry

Author(s): A O'Leary, E Gray, on behalf of ICORN

Department(s)/Institute(s): Irish Hepatitis C Outcomes and Research network (ICORN)

Introduction: The Irish Hepatitis C Outcomes and Research network (ICORN) Treatment Registry is the first prospective outcomes database in Ireland. It is designed to prospectively collect and collate real world clinical and economic outcomes for patients treated with triple therapy for Genotype 1 HCV infection. Triple therapy regimens include the addition of a direct acting antiviral agent (DAA), either telaprevir or boceprevir, to the dual therapy backbone of pegylated interferon (PEG-IFN) and ribavirin (RBV). A total of seven hospitals are involved across hepatology, gastroenterology and infectious disease disciplines.

Aims/Background: The aim of this review is to report the preliminary data from the registry with particular reference to patient demographics, HCV genotype, and the profile of DAA use.

Method: The national ICORN HCV registry is a web-based tool hosted on an electronic platform developed by the Dublin Centre for Clinical Research in conjunction with the ICORN network. Patients are consented for inclusion in the registry and data is manually collected at each site to facilitate collation. Data is downloaded from the registry in report format and systematically undergoes quality control procedures. Data analysis to date is descriptive.

Results: A total of n=142 patients are registered to date (October 2013) in 5 hospitals. The cohort is predominantly male (63.4%), the average age is 46.5 (range 20-72) and the majority are Irish born (70%). 60% (n=73/122) are treatment naive and 40% (49/122) are cirrhotic. Genotype 1, 1a and 1b account for 38%, 34% and 29%, respectively, of the n=116 patients whose status is known. Data capture is on-going through quarterly site visits. Treatment commenced in June 2012 and to date, telaprevir patients account for 63% of the cohort, with 33% for boceprevir. Outcomes in terms of SVR rates and tolerability will be presented.

Conclusion: Observational data generated from the registry to date will enable an in-depth assessment of the effectiveness and tolerability of these high cost therapeutic regimens in patients treated in the Irish setting. A resource utilisation study has commenced and will allow true treatment costs to be calculated.

ABSTRACT 49 (13W146) POSTER PRESENTATION

Title of Paper: Endoscopic Retrograde cholangio_pancreatography practice in a Dublin tertiary centre(Mater Hospital)

Author(s): Dr Ion Cretu, Dr Vincent Wall, Prof Padraig MacMathuna, Dr Jan Leyden, Dr Bari Kelleher, Dr Steve Stewart, Dr Gayle Bennett

Department(s)/Institute(s): GI unti, Mater Hospital

Introduction: ERCP is an important tool for the management of pancreato- billiary disease. As the Mater hospital is a tertiary centre, we felt we don't get enough feed back on the patients referred from peripheral hospital. This clinical audit is our current practise review ahead of JAG accreditation

Aims/Background: To compare the current practice of ERCP in the Mater Hospital against set standards by Joint Advisory Group on Gastrointestinal Endoscopy(JAG) and to capture eventual pitfalls with the aim to implement changes and reaudit

Method: Patients who had ERCP in January-June 2012 were identified on the EndoRad endoscopy reporting system. The data were collected retrospectively from the endoscopy report/discharge letters/laboratory and radiological results, using a data collecting sheet. The outcome of the procedure of the patients from peripheral hospital were collected by requesting discharge letters from the medical records department of the particular hospital. In addition information was prospectively collected on ERCP's performed in 2013 by contacting the refering team or the patients within 2 weeks of the procedure.

Results: There were a total of 256 ERCP's performed in the Mater Hospital in January-June 2012 and 198 ERCP's performed in the Mater Hospital in January-April 2013. Sedation was with Midazolam + Fentanyl +- Pethidine. 8 patients had general anaesthetic. There were no complications related to the use of sedation.Choledocholithiasis was the most common indication in 64%,malignant strictures in 23%,benign stricture in 5.5%, bile duct injury in 5.5%. Cannulation rate was 90.2, completion rate was 83.8%. Overall complication rate was 4.25%. Pancreatitis occured in 2.52%, Bleeding in 0.59%, perforation in 0.59%, infection in 0.5%, lithotripsy basket stuck requring emergency surgery in 0.25%. There were 51 unsuccesfull cannulation of which 13(25.5%) were reattempted succesfully.PTC was peformed in 23 cases((45%), 6(11.7%) went for surgery and the rest returned to the refering hospitals(data not available). Precut was performed in 3.9%. Brushings were diagnostic in 50% of cases.

Conclusion: The current practice is in keeping with the current standards. The cannulation/completion and complication rate were within the standards set by the JAG

ABSTRACT 50 (13W147) POSTER PRESENTATION

Title of Paper: Assessment and Treatment of Hazardous Alcohol

Drinkers in Ireland: A Survey of Irish Gastroenterologists

Author(s): Audrey Dillon; Stephen Stewart

Department(s)/Institute(s): Liver Centre, Mater Misericordiae University Hospital, Dublin 7

Introduction: Alcohol related morbidity and mortality in Ireland is rising, with evidence of increasing hospital admissions, alcohol related cancer and liver disease. The rates of alcohol related harm among younger age groups has increased dramatically. The Royal College of Physicians of Ireland (RCPI) convened a policy group on alcohol which made a number of public health recommendations as well as specific, evidence-based recommendations on medical care including screening and interventions.

Aims/Background: There is very little known about what services are available to, and used by Irish clinicians dealing with patients who may be hazardous drinkers. The aim of this study was to identify the current management of hazardous drinkers.

Method: A short survey was designed to identify the types of interventions and services currently in use by clinicians treating hazardous drinkers. The survey covered the screening tools used to identify hazardous drinkers as well as the treatments used, including pharmacotherapy and access to referral services. An online survey tool, www.surveymonkey.com, was used, and the link was sent by email to all members of the Irish Society of Gastroenterology. A reminder email was sent 1 month later. 65 (of 298) members responded.

Results: 45 (69%) of the respondents were consultants in gastroenterology / general medicine, 14 (22%) were gastroenterology registrars/SpRs and 3 (5%) were surgeons. Most respondents used clinical judgement (57%) as the main tool of assessment or screening in those patients suspected of hazardous drinkers. 31% used the CAGE tool, 4% used the AUDIT tool and 8% used no formal tool. 26 (40%) respondents offered the patient a repeat clinic visit with themselves, and 42 (64%) delivered a formal brief intervention. 25 (38%) referred patients to an alcohol nurse specialist, 31 (48%) referred patients to local non-statutory services like Alcoholic Anonymous and 15 (23%) referred patients to psychiatry. Only 3 (5%) were able to refer patients directly to psychological services. 55 (85%) did not prescribe any pharmacotherapy for hazardous drinkers, of those that did, acamprosate was used most. 52 (80%) did not have access to outpatient alcohol detoxification services.

Conclusion: These results show that there is a significant deficit in alcohol treatment services in Ireland with less than half of the respondents having access to an alcohol nurse specialist and 80% having no access to outpatient detoxification services. While there is room for improvement in the use of pharmacotherapy to treat alcohol addiction, there is also a pressing need for the development of psychological services to treat alcohol dependence in Ireland.

ABSTRACT 51 (13W148) POSTER PRESENTATION

Title of Paper: Coeliac-like duodenal pathology in orthotopic liver transplant (OLT) patients on mycophenolate therapy (MPA)

Author(s): MB Cotter1, A AbuShanab2, R Merriman2, PA.McCormick2, K Sheahan 1*

Department(s)/Institute(s): (1)Department of Histopathology, St. Vincent's University Hospital & UCD, Dublin 4, Ireland. (2) Department of Hepatology, St. Vincent's University Hospital, Dublin 4, Ireland.

Aims/Background: Diarrhoea following OLT is a significant clinical problem associated with MPA therapy. Although its pattern of inducing injury in the lower gastrointestinal tract is well known, the injury pattern in the duodenum is less extensively documented. We aimed t

Method: Retrospective cohort database of all duodenal biopsies in patients who had OLT were analyzed in a single centre over a 19 year period. Clinical characteristics were studied which included indication of OLT and duodenal biopsy, immunosuppressant use, anti-tTG IgA serology and outcomes. Histological specimens were reviewed by two pathologists and compared with coeliac cases and normal controls.

Results: Of the 667 OLT patients that underwent upper GI endoscopy, 127 patients had duodenal biopsies taken, amounting to a total of 152 biopsies performed. 87.5% (n: 133/152) of these were histologically normal. Sixteen patients showed abnormal histology and among those 7 patients (43.8%) were on MPA therapy at the time of biopsy. Symptoms in this cohort included diarrhoea (71.4%), weight loss (60%), nausea and vomiting (28.6%) and abdominal pain (14.3%) and occurred at a median of 2.8 years (range 49 - 3905 days) after initiation of MPA therapy. MPA-associated duodenal changes included shortened villi, an increase in intraepithelial lymphocytes (IELs), an increase in endocrine cell counts and an increase in apoptotic counts. In comparison, age-matched patients with confirmed coeliac disease showed similar histological features however, with no increased apoptosis.

Conclusion: Diarrhoea following OLT in patients on MPA therapy is a significant entity& is associated with duodenal pathological changes in a significant % of cases. Pathologists & gastroenterologists should be aware of the features of MPA-associated duodenal injury, including coeliac-like changes, & be alert when there is an increase in apoptotic counts.

ABSTRACT 52 (13W149) POSTER PRESENTATION

Title of Paper: Audit of the implementation of the hepatocellular carcinoma surveillance programme in cirrhotic patients: A single-centre experience

Author(s): Grace Chan, Jun Liong Chin, Jane Cox, Hannah Smyth, Angelina Farrelly, Muhammad Jalil Md Ateeq, Suzanne Norris.

Department(s)/Institute(s): Hepatology Centre, St James's Hospital, Dublin 8

Introduction: Hepatocellular carcinoma (HCC) arises on a background of cirrhosis in up to 90% of cases . HCC screening of cirrhotic patients should therefore facilitate early detection and treatment. In Ireland, screening for HCC typically involves liver ultrasound to detect focal liver lesions and alphafetoprotein (AFP) measurements every 6 months.

Aims/Background: To evaluate the implementation and effectiveness of a HCC surveillance programme in a hospital setting. Also, to identify factors that may contribute to programme compliance.

Method: Cirrhotic patients diagnosed from 2000 to 2012 were identified from our records of outpatient attendance, inpatient and day case admissions. Data was retrieved from electronic patient records. Diagnosis of cirrhosis was supported by histology and/or imaging criteria. Acceptable HCC surveillance interval for both AFP

measurement and liver ultrasound was approximately every 6 monthly from diagnosis of cirrhosis. Statistical analysis was carried out using IBM SPSS Statistics V.20.

Results: Of 413 cirrhotic patients attending SJH services, 44.6% (n=184) had 6-monthly AFP measurements and 42.4% (n=175) had 6-monthly liver imaging. Only 33.7% (n=139) of patients underwent both AFP and liver imaging at 6-monthly interval. Of those who underwent appropriate surveillance, only 2.9% (n=4) were subsequently diagnosed with HCC as the majority of patients diagnosed with HCC did not undergo appropriate HCC surveillance (84.6%; 22/26), p=0.042. Mean age did not did not differ significantly between those who underwent appropriate HCC surveillance (53.4±11.6years) compared to those who did not (55.2±12.5years), p=0.151. Gender was also not significantly different in the two groups. MELD was also not significantly different in those undergoing appropriate surveillance, with a mean MELD of 12.8±9.0 compared to 14.5±8.9 in those who did not (p=0.055). Patients with NASH cirrhosis (88.9%, 8/9) attended appropriate surveillance more frequently than other aetiologies (32.4%, 131/404), p<0.005. 65.2% (122/187) of patients who attended hepatology outpatients regularly had 6-monthly AFP measurements and 63.1% (118/187) had 6-monthly liver imaging. They were more likely to undergo both AFP measurements and liver imaging (54.0%; 101/187) compared to those who did not attend hepatology outpatients regularly (16.8%, 38/226), p<0.001.

Conclusion: Compliance with HCC surveillance in our hospital was poor, particularly in those not attending hepatology services. This audit identifies the clear need for an education programme to increase awareness of HCC surveillance in cirrhotic patients. Further research is required to identify the other factors contributing to poor compliance with HCC surveillance. An automated ultrasound surveillance programme has since been implemented in our centre to allow for more timely recall of cirrhotic patients. However, the value and cost effectiveness of such a programme will need to be evaluated further given the poor HCC identification rate within a structured programme.

ABSTRACT 53 (13W150) POSTER PRESENTATION

Title of Paper: Identifying Risk Factors for the Development of Hepatocellular Carcinoma in Patients with Cirrhosis

Author(s): Grace Chan, Jun Liong Chin, Hannah Smyth, Angelina Farrelly, Jane Cox, Muhammad Jalil Md Ateeq, Suzanne Norris

Department(s)/Institute(s): Hepatology Centre, St James's Hospital, Dublin 8

Introduction: Hepatocellular carcinoma (HCC) is a recognised complication of cirrhosis. HCC surveillance in Ireland typically involves alpha-fetoprotein (AFP) measurements and liver ultrasound every six months. Although many expert consensus groups (EASL, AASLD) advocate HCC surveillance in cirrhotic patients, the effectiveness of HCC surveillance in improving survival is not established. Further patient risk stratification may identify a subgroup of patients for whom HCC surveillance is cost effective.

Aims/Background: To investigate specific risk factors for developing HCC in our cohort of patients with cirrhosis.

Method: Cirrhotic patients diagnosed from 2000 to 2012 were identified from our records of outpatient attendance records, inpatient and day case admissions using EPR. Diagnosis of cirrhosis was supported by histology and/or imaging criteria. Risk factors for the development of HCC were assessed by univariate analysis.

Results: Of 413 cirrhotic patients identified, more than two thirds were male (n=286; 69.2%). 26/413(6.3%) patients developed HCC. A significantly higher percentage of males developed HCC, 8.4% (24/286) of males compared to 1.6% (2/127) of females (p=0.008). The mean age (60.6±11.5 vs 54.2±12.2years, p=0.010) and AFP concentration (376.7±909.3 vs 6.4±48.1ng/mL, p<0.0001) were significantly higher in cirrhotic patients who developed HCC compared to those who did not. Of those diagnosed with HCC, 19.2%(5/26) had normal AFP levels. Aetiology of cirrhosis contributed significantly to HCC diagnosis, with 16.4%(12/73) of those with viral hepatitis developing HCC compared to 4.1%(14/340) of those with other aetiologies (p<0.001). However, the MELD score was not significantly different in patients with or without HCC (13.1±8.4 vs 14.0±9.0, p=0.631)(table 1). The majority of patients with HCC were male (24/26; 91.6%), aged > 50years (21/26; 80.8%) and had viral hepatitis (12/26; 46.2%). Two thirds (65.4%; 17/26) of HCC were detected as a single focal liver lesion, while (34.6%; 9/26) of HCC were multifocal. The mean tumour size, defined as the widest diameter of the largest liver lesion, was 3.4cm±1.8cm. Of the treatment modalities for HCC, 80.8% of patients received one of more of the following: transarterial chemoembolisation, 53.8% (14/26); radiofrequency ablation, 7.7% (2/26); sorafenib, 19.2% (5/26); surgical resection, 11.5% (3/26); and only 7.7% (2/26) of patients received orthotopic liver transplantation. Due to advance HCC stage and/or poor liver function, 19.2% (5/26) of patients received symptomatic treatment alone.

	HCC (n=26)	Non-HCC (n=387)	P value
Age	60.6±11.5	54.2±12.2	0.010
Gender			
Male	24 (8.4%)	262 (91.6%)	0.008
Female	2 (1.6%)	125 (98.4%)	
Aetiology			
Viral	12 (16.4%)	61 (83.6%)	<0.0001
Non-viral	14 (4.1%)	326 (95.9%)	
AFP	376.7±909.3	6.4±48.1	<0.0001
MELD	13.1±8.4	14.0±9.0	0.631

Table 1. Comparing risk factors for the development of hepatocellular carcinoma

Conclusion: These local data support the international evidence that male gender, older age, higher AFP and viral hepatitis were significantly associated with the development of HCC in our cirrhotic cohort.

ABSTRACT 54 (13W152) POSTER PRESENTATION

Title of Paper: "Jackhammer Oesophagus"- A new clinical entity identified by High Resolution Manometry

Author(s): L Barry1, G Mohamed2, M Buckley2 & T Murphy3

Department(s)/Institute(s): 1. GI Function Laboratory, Mercy University Hospital, Cork. 2 Centre for Gastroenterology, Mercy University Hospital, Cork. 3 Department of Oesophago-Gastric Surgery

Introduction: High Resolution Manometry (HRM) with oesophageal pressure topography (EPT) and the Chicago Classification of oesophageal motility disorders allows oesophageal spastic disorders

to be grouped into 3 distinct manometric and clinical entities: (1) spastic achalasia (2) distal oesophageal spasm and (3) Jackhammer oesophagus (JO). The peristaltic amplitude of the oesophagus as measured by conventional manometry has been replaced by the distal contractile integral (DCI) as the summary measure of the distal oesophageal contraction in HRM and EPT. This study reports the clinical features and manometric findings of Jackhammer oesophagus via HRM and EPT in our center.

Method: HRM and EPT data of 75 consecutive patients were reviewed over an 8 month period. Jackhammer oesophagus was defined according to the most recent Chicago Classification as at least one contraction with a (DCI) of >8000mmHg*sec*cm. Other Chicago Classification parameters were also recorded.

Results: 6 patients (8%)(1 female) met the Chicago Classification criteria for Jackhammer Oesophagus. The most common presenting symptom was dysphagia (50%); other symptoms included chest pain (33.3%) and Globus (16.6%). The mean DCI recorded in these patients was 8425.5mmHg*sec*cm, mean maximum DCI was 13045.5mmHg*sec*cm. 50% of patients had impaired relaxation of the oesphagogastric junction as demonstrated by an elevated Integrated Relaxation Pressure (IRP) (>15mmHg). Distal Latency (DL) and Contractile Front Velocity (CFV) parameters fell within normal ranges (Table 1)

HRiM parameters	Jackhammer Oesophagus patients MUH(n=6)	Normal ranges[1]
DCI mean (mmHg*cm*sec)	8425 (6991-10793)	<5000
DCI max (mmHg*cm*sec)	13045 (9264-23028)	
IRP (mmHg)	13.5 (9-17)	<15
CFV (cm/s)	3.66 (3-5)	<9
DL (sec)	5.73 (4.6-6.3)	>4.5

Table 1. Comparison of HRiM among MUH patients with Jackhammer Oesophagus and normal standardized ranges (*1.Neurogastroenterol Motil (2012)24 (Suppl.1)57-65*

Conclusion: To our knowledge, this is the first report of Jackhammer Oesophagus in an Irish setting. JO is a relatively uncommon oesophageal motility disorder occuring in 8% of patients referred for HRM. Impaired relaxation of the oesophagogastric junction appears to occur frequently in association with JO.

ABSTRACT 55 (13W153) POSTER PRESENTATION

Title of Paper: EUS-guided drainage of Pancreatic Pseudocysts: Experience from a Single Tertiary Referral Centre

Author(s): V Parihar*, D Nally§, P Cronin§, N Breslin*, K Conlon§, P Ridgway§, BM Ryan*

Department(s)/Institute(s): Departments of Gastroenterology* and Surgery§, AMNCH, Tallaght

Introduction: A pancreatic pseudocyst is a collection of pancreatic enzymes encased by reactive granulation tissue, occurring in or around the pancreas as a consequence of inflammatory pancreatitis or ductal leakage. Up to 40% of the Pseudocysts resolve without intervention (1). Intervention is recommended for patients with Pseudocysts who are symptomatic or those with an infected pseudocyst. The drainage options for pseudocyst include surgical cyst gastrostomy (open or laparoscopic), percutaneous drainage or endoscopic ultrasound (EUS) guided endoscopic drainage. Arguments in favour of the latter intervention include its less invasive nature with resultant possible lower morbidity and shorter hospital stay (2).

Aims/Background: The aim of this study was to evaluate the experience of EUS-guided pseudocyst drainage over a 9 year period in our institution.

Method: A retrospective and structured review of charts of identified patients who underwent endoscopic drainage of pancreatic pseudocyst was performed. The study is on-going and further patients will be identified. Baseline demographics and disease particulars were recorded. Discharge summaries and radiology reports confirmed those for inclusion in this review. The primary endpoint of this study was the technical success of the procedure, with secondary outcomes being complication and reintervention rates. Technical success was defined as the ability to drain pseudocyst by placement of transmural stent, while radiological resolution was a cyst less than 2cm on post-procedure imaging. With respect to complications, bleeding refers to bleeding during or after procedure requiring transfusion or requiring endoscopy; perforation is characterised by peritoneal or mediastinal signs & pneumperitoneum or pneumomediastinum on x-ray or CT; super infection denotes new onset pyrexia, positive blood culture, or fluid cultures at second procedure and stent migration requires stent retrieval from within the cyst lumen.

Results: To date, 17 patients (10 male, 7 female) have been identified who underwent EUS-guided drainage over a 9 year period with a mean follow up of 20 months. The mean age at the time of drainage was 48 years. The aetiology of the pseudocyst was gallstones and alcohol in 49% and 31% of cases respectively. The procedure was technically successful in 16 (94%) of patients. Follow-up radiology was available for 14/16 patients, of which 11(79%) had cysts less than 2cm in diameter. The mortality rate for this procedure was 0%. 7 (44%) patients experienced a complication: 4(25%) developed super-infection, all of whom responded to antibiotics; 1 (6.25%) had stent migration; 1 (6.25%) had abdominal pain post procedure with CT abdomen showing pneumperitoneum which was managed conservatively and 1 (6.25%) developed both pneumomediastinum and superinfection. Superinfection rates were higher in patients on PPI therapy, although this did not reach statistical significance. In total, 10 /16 patients (62%) required further intervention: 5/16 patients (31%) required further intervention through another modaliity: 1 percutaneous and 4 surgical cystgastrostomy for infection, failure of the cyst to resolve or both. 5 (31%) patients had further EUS –guided procedures to drain septated or multiple cysts or for stent blockage. Pseudocyst size was significantly larger in those who required re-intervention compared to those who had a single successful procedure (p=0.015).

Conclusion: EUS guided drainage of pancreatic pseudocysts was technically successful in almost all cases. The mortality was 0% but 44% of patients experienced a complication. Re-intervention rates were high, particularly in those with large cysts. PPI therapy may be associated with increased infection rates.

References:

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ABSTRACT 56 (13W156) POSTER PRESENTATION

Title of Paper: ITPA polymorphisms as predictors of ribavirin-induced haemolyticanaemia in Hepatitis C treated patients.

Author(s): Yousif K, Moran C, Kenny-Walsh E, Crosbie O, Fanning LJ

Department(s)/Institute(s): Department of Hepatology, Cork University Hospital and Medical Virology, Department of Internal Medicine, University College Cork

Introduction: Hepatitis C virus infection (HCV) is one of the major causes of liver cirrhosis and hepatocellular carcinoma. The standard of care treatment still includes both Peg-interferon (pegIFN) and Ribavirin (RBV), with the recent addition of direct acting antiviral drugs to this regime. Ribavirin is a guanosine nucleoside analogue with proven anti-viral activity. Anemia is a significant side-effect of ribavirin based anti-HCV therapy. RBV is the primary causative agent for the haemolysis. InosineTriphosphatase (ITPAse) is an enzyme that metabolizes RBV. Functional variants of ITPase (1) rs1127354 and (2) rs7270101 have been found to protect against RBV-induced hemolytic anemia to varying degrees. ITPase deficiency is associated with higher levels of ITPA concentration which protects against Ribavirin-induced depletion.

Aims/Background: To examine the ITPase gene single nucleotide polymorphisms (SNPs) rs1127354 and rs7270101 and the association with anaemia in HCV treated patients. Anemia was indicated if there was a 3g/ml decrease in haemoglobulin levels from the pre-treatment level.

Method: Fifty patients with chronic HCV treated with pegIFN and RBV were included, 30 males, 29 patients with genotype 1 and 21 patients with genotype 3. The decrease in Hb at week 8 was compared to baseline. Statistical analysis was performed using the chi-square test for categorical data. SNPs for rs1127354 and rs7270101 were molecularly determined. The alleles for rs1127354 are CC, CA and AA and for rs7270101 are AA, AC and CC coding for the wild type, heterozygosity and homozygosity phenotypes, respectively. The predicted levels of ITPase deficiency vary according to the haplotypes from 100% ITPase activity (wild type both alleles), to <5% ITPase levels (rs1127354 homozygosity and rs7270101 wild type).

Results: 29 patients (58%) developed anemia. 29 patients (58%) had SNP associated with normal ITPase (100%) activity, 10 patients (20%) with mild ITPase deficiency (60%) and 11 patients (22%) with moderate ITPase deficiency (30%). The incidence of Hb drop of >3 g/dL was 66% in patients with normal or mild deficiency of ITPase activity compared to 27% in patients with moderate ITPase deficiency, P= 0.019. 10 patients (20%) were managed with Erythropoietin (EPO) alone, 2 patients (4%) had only dose reduction of Ribavirin and 2 were managed with both EPO and Ribavirin dose reduction. None had blood transfusion. The overall study SVR rate is 51% (25 patients); 20 patients (52.6%) with normal ITPA levels or mild deficiency, and 5 patients (45%) with moderate ITPAse deficiency which is not statistically significant, p= 0.675.

Conclusion: Moderate ITPase deficiency was associated with protection against anemia at week 8 in comparison to patients with normal ITPase and mild ITPase deficiency. There is no association between SVR and ITPA variants. This finding may be helpful in planning future treatments for patients with HCV and the likely requirement for drug dose adjustment and support required to maintain Hb levels.

ABSTRACT 57 (13W157) POSTER PRESENTATION

Title of Paper: Coeliac Serology Testing In Irish Children - A Substitute For Biopsy?

Author(s): JS Kutty1, M McDermott2, M O'Sullivan2, S Quinn1, A Broderick1,3, B Bourke1,3, S Hussey1,3

Department(s)/Institute(s): 1National Centre for Paediatric Gastroenterology & 2Department of Pathology, OLCHC,Crumlin, Dublin 12, Ireland, 3School of Medicine and Medical Science, University College Dublin, Dublin, Ireland

Introduction: Small intestinal biopsy remains the reference standard for diagnosing coeliac disease (CD) in children. Recent international guidelines suggest that for select patients, biopsy may not be necessary.

Aims/Background: The aims of this study were to: (a) correlate coeliac serology with histology findings in Irish children with a high pre test probability of the disease. (b) determine if proposed changes to the CD diagnostic algorithm hold true in an Irish paediatric coh

Method: A retrospective chart review of all cases of suspected CD that underwent endoscopy at the National Centre for Paediatric Gastroenterology, Our Lady's Children's Hospital from January 2004 to December 2011 was undertaken. Data retrieved included endoscopic and histologic findings, co-morbidities and serology results (where available).

Results: 596 patients (57% female) underwent endoscopy for suspected CD. Serology data were available for 544 (91%) patients. CD was confirmed on histology in 304 (51%) children. tTG (tissue transglutaminase) was positive in 405 (79%) patients, of whom 288 (71%) also had a positive biopsy. 7 patients (5%) with negative tTG had a positive biopsy. Of the available 195 positive EMA (endomysial antibody) results, 184 (94%) had a positive tTG as well. 110 of 117 children with tTG values > 20mg/ml plus a + EmA had CD on histology. 3 of 105 (2.8%) patients with tTG>100 mg/ml had a normal histology. The sensitivity, specificity, positive predictive value and negative predictive value of tTG levels ranging from 2-99 were 96% (CI 92-98), 53% (CI 46-59), 59% (CI 53-64.8) and 95% (CI 90-98) respectively. The corresponding values for tTG levels >100 were 94% (CI 87-97), 98% (CI 93-99), 97% (CI 92-99) and 95% (CI 90-98).

Conclusion: Intestinal biopsy remains the reference standard for CD diagnosis. High titre serology correlates well but not perfectly with histology findings. Diagnostic accuracy rather than screening convenience is essential before prescribing a life-long gluten free diet.

ABSTRACT 58 (13W158) POSTER PRESENTATION

Title of Paper: Post transplant lymphoproliferative disease is more common in patients transplanted for primary sclerosing cholangitis

Author(s): N. Ullah, A. Abu Shanab, D. Schmidt, E. Elrayah, M. Iqbal, D. Houlihan, A. McCormick

Department(s)/Institute(s): Liver Transplant Unit, St. Vincent's University Hospital, Dublin

Introduction: Post transplant lymphoproliferative disease (PTLD) is a well recognized complication of therapeutic immunosuppression in transplant recipients. It represents a spectrum of abnormalities

ranging from a benign infectious mononucleosis like illness to malignant lymphoma. It is associated with high mortality.

Aims/Background: To determine incidence and outcomes of PTLD in liver transplant recipients.

Method: A retrospective study was performed by collecting data on liver transplant patients in a single institution from 1993 to 2013. Data was analysed to identify PTLD patients and determine their demographic details, the reason for original transplant, presenting symptoms, immunosuppression regimens, Epstein Bar Virus (EBV) status, and patient survival.

Results: From a total of 710 liver transplants recipients, 19 (2.68%) were diagnosed with PTLD. There were more males (n=16, 84.2%) than females (n=3, 15.8%), with a median age of 54 years (range 22-65) at the time of liver transplant. Median time from transplant to diagnosis of PTLD was 76 months (range 19-173). The primary indication for transplant was: PSC (n=7), AIH (n=3), PBC (n=2), ALD (n=2), ALD/HCC (n=1), ALD/HCV/HCC (n=1), HCV/HCC (n=1), HBV (n=1), POD (n=1). The majority of patients presented with gastrointestinal symptoms (n=12). The most common imaging abnormality was lymphadenopathy (n=8), followed by retroperitoneal mass (n=3), mesenteric mass (n=3), bowel (n=2), liver (n=2), and brain (n=2) involvement. The most commonly used immunosuppressant was tacrolimus (n=15), followed by mycophenolate (n=11), azathioprine (n=9), and cyclosporine (n=5). At least 14 patients have taken more than one immunosuppressant at some point till diagnosis of PTLD. 2 patients had both detectable EBV PCR and positive EBV histology while an additional 3 patients had positive EBV histology. 16 patients were treated with chemotherapy - among these 2 had surgery and 1 had radiotherapy. Mortality from PTLD was 57.9% with median of 6 months from diagnosis to death (range 0-39).

Conclusion: Our incidence of PTLD is comparable to published literature. Notably PTLD was diagnosed in 10.4% of PSC transplants. Male gender and PSC appear to be risk factor for PTLD.

ABSTRACT 59 (13W159) POSTER PRESENTATION

Title of Paper: The use of MR Enterography in changing management of patients in a District General Hospital.

Author(s): Somerville J, Ferguson C, Hall P, Morrison G.

Department(s)/Institute(s): Altnagelvin Area Hospital, Western Trust.

Introduction: MR Enterography is a well established tool for small bowel imaging without radiation exposure. It is routinely available in Altnagelvin and is regularly used by the gastroenterology team in the assessment of IBD patients.

Aims/Background: To compile data on the indications for the MR Enterography studies performed in Altnagelvin from May 2009 to May 2013 and to ascertain if changes in clinical management occurred following results.

Method: MR Enterography reports performed within the study period were obtained from NIPACs and related clinical data compiled from Patient Centre.

Results: A total of 101 MR Enterographies (46.5% male) in patients ranging in age from 13 years to 75 years were eligible for study. 69 scans were requested for assessment of known Crohn's disease, 16 for investigation of possible Crohn's disease, 8 for small bowel imaging in patients with known colitis, 4 to clarify small bowel abnormalities on previous imaging, 2 to investigate small bowel obstruction and 1 to further investigate a possible GI motility disorder.

On the basis of the MRE results, 44 patients had changes to their medical therapy. 43 of these 44 patients were patients with Crohn's disease who had escalation to their medical therapy. A further 8 patients received continued funding for biologics.

18 patients were referred for consideration of further procedures -12 were referred for surgery, 3 for balloon dilatation of small bowel strictures and 3 for further investigation with capsule endoscopy.

31 patients had no change in management, but of these, 12 had a normal MRE allowing exclusion of small bowel pathology.

Conclusion: MR enterography is a safe and useful tool in excluding, diagnosing and directing management of a variety of small bowel pathologies. There appears to be a particular role for identifying patients who require escalation of management in Crohn's disease.

ABSTRACT 60 (13W160) POSTER PRESENTATION

Title of Paper: Impact of speciality ward reconfiguration on inpatient upper GI endoscopy wait times and overall length of stay in the a single institution

Author(s): Marie P. Boyle, Jan E. Leyden

Department(s)/Institute(s): Department of Gastroenterology, Mater Misericordiae University Hospital

Introduction: Improving efficiencies in the delivery of inpatient care, with a reduction in average length of stay, is a key focus of the Health Service Executive in Ireland. Speciality ward reconfiguration is one initiative which has been adopted in our institution to try to achieve more efficient inpatient care.

Aims/Background: Audit of the impact of speciality ward reconfiguration on inpatient upper GI endoscopy (OGD) wait times and length of stay (LOS) in our institution.

Method: Retrospective audit of patients admitted through the Emergency Department who underwent an OGD during their inpatient stay - 100 consecutive inpatient OGDs before and 100 consecutive inpatient OGDs after the introduction of speciality ward reconfiguration. Data on patient demographics, time to endoscopy and LOS were retrieved from the hospital's electronic patient record database. Categorical data were analysed using Fishers exact test and continuous data using the Mann Whitney U test.

Results:
Both groups were comparable in terms of age and sex, ($p >= 0.05$). Differences in median time to OGD and median LOS were statistically significant.

Conclusion: Speciality ward reconfiguration lead to a reduction in the waiting time for an inpatient OGD and a reduction in the median length of hospital admission. These results suggest that speciality ward reconfiguration will facilitate more efficient delivery of inpatient care.

	Pre-Speciality Ward reconfiguration (n=100)	Post-Speciality Ward reconfiguration (n=100)	
Median Age and Range	69.5years (Range 26-89)	66 years (Range 17-88)	*p>0.05*
Sex	Male 49: Female 51	Male 53: Female 47	*p=1*
Median time to OGD	5 days (Range 0-70)	3 days(Range 0-69)	*p<0.05*
Median LOS	11 days (Range 1-192)	8 days (Range 1-85)	*P<0.05*

ABSTRACT 61 (13W161) POSTER PRESENTATION

Title of Paper: Clinical audit on the use of thromboprophylaxis in patients admitted with active inflammatory bowel disease

Author(s): N. Ullah, I. R. Malik, D. O'Hare, J. Elliott, N. Mahmud

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

Introduction: Baseline risk of venous thromboembolism (VTE) in patients admitted to hospital with medical disorder is around 15%. Inflammatory bowel disease (IBD) is a recognized risk factor for VTE and is associated with a roughly three fold increase in the risk of VTE. There is now substantive evidence that in medical patients, the use of low molecular weight heparin (LMWH) reduces the risk of symptomatic VTE by over 50%. VTE prophylaxis is an important safety intervention and is recommended in patients with active IBD to reduce the burden of VTE.

Aims/Background: To measure adherence to guidelines in relation to the use of VTE prophylaxis in patients admitted to hospital with active IBD.

Method: Retrospective analysis of medical records of patients admitted with active IBD between january to december 2012 was carried out at St. James's Hospital. Demograhic details including age, sex, diagnosis, use of LMWH (enoxaparin or tinzaparin), lenght of stay (LOS) and VTE events were recorded.

Results: A total of 62 patients with 75 recorded admissions to hospital with active IBD in the one year period were included in the study. 37 patients had Crohn's disease and 25 Ulcerative colitis. 60 admissions were acute presentations and 15 elective. Mean age of patients was 40.94 years (range 18-84). Male to female ratio was 22:40. Average LOS was 11.68 days (range 3-62). One case of venous thrombosis related to presentation was diagnosed among inpatients. Prophylactic LMWH was administered within 24 hours of admission in 70 out of 75 admissions, including the patient diagnosed with venous thrombosis.

Conclusion: Our audit demonstrated adherence to thromboprophylaxis guidelines in 93.33% of patients admitted to hospital with active inflammatory bowel disease and we aim to continue the current good practice.

ABSTRACT 62 (13W162) POSTER PRESENTATION

Title of Paper: Success and safety profile of stent placement under direct endoscopic visualisation for decompression of obstructing colorectal cancer

Author(s): Orla Craig, Numan Khan, Ciara McGrath, Brian Hayes, Mohd Syafiq Ismail, Brian Christopher, John Keohane, Subhasish Sengupta

Department(s)/Institute(s): Our Lady of Lourdes, Drogheda, Co. Louth

Introduction: Self-expandable metal stent (SEMS) placement is a minimally invasive option for achieving acute colonic decompression in obstructed colorectal cancer. It is an accepted procedure for the palliative management of colorectal cancer in patients with inoperable disease and can be used as a bridging procedure to relieve obstruction pending elective surgery in those with resectable tumours. It is usually done with fluoroscopic guidance but can be done under direct endoscopic visualization when the colonic lumen in not completely occluded by the obstructing tumour mass. Due to limited access to fluoroscopy at our institution, colonic stents to relieve obstruction or impending obstruction are placed under direct endoscopic visualization. A therapeutic endoscope (with a 3.8mm channel) is used to partially penetrate the stricture and allow easy introduction of a guide wire.

Aims/Background: The aim of our study was to assess the feasibility and safety of colonic stent placement under direct endoscopic visualization.

Method: We retrospectively collected data on all patients who underwent SEMS placement to relieve obstructing colon cancer in our GI endoscopy unit between July 2011 and July 2013 through chart review. Patient demographics, location of stent, stent length, technical and clinical success, complications, need for repeat procedure and survival were recorded.

Results: 11 SEMS placements were carried out on 9 patients (4 men, 5 women, mean age 76) under direct visualization during the time period. One stent was placed at the splenic flexure, the remaining were in the sigmoid or at the recto-sigmoid junction. All were technically and clinically successful in relieving obstruction. There were no cases of stent migration or perforation. Median hospital stay post procedure was 2 days. Mean survival was 251 days. 3 patients were still alive at the time of study completion. Stents were replaced in 2 patients, 37 days and 637 days after the initial procedure.

Conclusion: SEMS placement under direct endoscopic visualization is technically and clinically successful for achieving acute colonic decompression in colorectal cancer. There were no serious outcomes in our patient cohort.

ABSTRACT 63 (13W163) POSTER PRESENTATION

Title of Paper: Nutritional Screening and Management in Stroke: An audit of the multidisciplinary approach to acute stroke admissions (Plus Poster)

Author(s): McGoran J, Barber A, Todd S

Department(s)/Institute(s): Altnagelvin Hospital

Introduction: National guidelines in stroke and stroke rehabilitation advise prompt nutritional screening and management for acutely admitted patients in order to ensure adequate feeding in a patient group at high risk of malnutrition.

Aims/Background: Nutritional screening and management in hospital is a topical issue which is constantly under scrutiny. The involvement of doctors in this process can often be lacking and the potential benefit overlooked. This report aims to assess the standard of nutrit

Spring Meeting 2013 (Big)

Dr Garret Cullen

Professor Kieran Moriarty

Method: Clinical notes for patients admitted to Altnagelvin Hospital with acute stroke, between May and July 2013 were assessed for nutritional screening and management by the admitting team (MUST and weights, medical assessment, swallow screening) and audited based on NICE guidelines.

Results: Of 42 patients audited, 29 received pre MUST assessment on admission, six requiring MUST assessment and five proceeding to this in a timely manner. Twenty-four patients were weighed on admission or had an estimate/recall weight. Sixteen patients had appropriate hydration assessment. Swallowing difficulties were raised by the admitting doctor for twelve patients, of which eight had speech and language assessments within 72 hours. Overall 21 patients had speech and language review within 72 hours of admission. Thirty-five patients had adequate feeding established within 24 hours of admission.

Conclusion: The results are encouraging but we feel improvements can be made. Furthermore, the presence of the doctor as part of the team that identifies and addresses nutritional difficulties could lead to much improved clinical management. We plan to improve our practice with the following actions: Provide formal water swallow assessment training to nursing staff and refresher training to doctors during induction, along with training on how to identify patients with swallowing and nutritional difficulties; Urge doctors to highlight the need for nutritional assessment on the admission plan; Identify and address barriers to healthcare professionals in carrying out these tasks; Keep an accurate record of feeding charts for undernourished patients, reviewed these daily and take appropriate action to ensure adequate nutritional intake; Expedite transfer of all acute stroke patients to a Stroke Ward.

ABSTRACT 64 (13W164) POSTER PRESENTATION

Title of Paper: Types of Achalasia in an Irish Population using High Resolution Manometry (HRM)

Author(s): G. Mohamed, L. Barry, M. Buckley

Department(s)/Institute(s): Gastroenterology Department, Mercy University Hospital

Introduction: Oesophageal manometry was traditionally the gold standard for diagnosis of oesophageal disorders .High resolution manometry and oesophageal pressure topography have revolutionized the interpretation of oesophageal motility disorders. Achalasia, one of the most important oesophageal disorders is subclassified into three clinical subtypes based upon the visible contractile activity and pressurization patterns by using HRM.

Aims/Background: To subclassify types of achalasia in an Irish population using HRM .

Method: The HRM data for 75 patients undergoing between February 2013 and September 2013 were reviewed .All cases of achalasia were defined according to the Chicago classification into three subtypes (type I// II / III)[1].

Results: 22.66 % (n=17) were found to have achalasia. 15 patients (88% of total positive) met the HRM criteria for type II (66% female/ mean age 55.4 years). One patient (male /36 years) had type III and one patient (male/24 years) had type I achalasia.

Conclusion: HRM subclassifies achalasia. 88% of Irish patients have type II achalasia. Subclassification has an important role in determining the optimal treatment and prognosis for patients with achalasia[2] .

References:
1.Pandofino JE, Kwiatek MA, Nealis T ,et al.Achalasia: a new clinically relevant classification by HRM.Gastroenterology 2008;135:1526-1533. 2.Wout O.Rohof . Gastroenterology 2013;144(4):718-725

ABSTRACT 65 (13W165) POSTER PRESENTATION

Title of Paper: Intern Practical Skills: A comparison of Confidence Levels between Medical and Surgical Interns.

Author(s): Keane F., Geraghty T., Joyce K., Waters P.S., Khan W., Khan I., Barry K., Waldron R., Byrne D.

Department(s)/Institute(s): Department of Surgery, Mayo General Hospital.

Introduction: The National Intern Training Programme was approved by the Irish Medical Council in May 2011, and outlines the professional competence requirements for newly appointed doctors during their intern year. This includes an array of practical skills interns should be capable of performing on completion of internship.

Aims/Background: The objective of this study is to assess interns' confidence levels at performing clinical skills at intervals. We further aimed to compare medical and surgical intern confidence levels after one month and three months of gastrointestinal internship.

Method: Interns from both medical and surgical teams were asked to rate their confidence levels from 1 to 5, at three time intervals 1) Day one of internship, 2) After one month of internship, 3) After 3 months of internship, for the following six clinical tasks, as outlined by the NITP above; Venepunture; Cannulation; NG Tube Insertion; Performing Blood Cultures; Male Catheterisation; Performing Arterial Blood Gas Analysis. Interns partaking in the study completed a survey, where they prospectively rated their confidence levels at performing the above clinical tasks.

Results: • Medical and Surgical interns showed equal confidence levels after one month and three months, in both venepuncture and cannulation. •

Conclusion: There is a discrepancy of confidence ratings between surgical and medical gastrointestinal interns, which requires attention in intern teaching programmes.
Surgical interns displayed greater confidence levels at performing NG Tube insertion, with a median of 3 compared with median confidence among medical interns of 2/5 after three months. • Medical interns showed significantly greater confidence at perform

ABSTRACT 66 (13W168) POSTER PRESENTATION

Title of Paper: Incidence of Severe Diarrhoea in Patients with Malignant Melanoma on Ipilimumab: A Single-Centre Experience in the West of Ireland

Author(s): Hong YY, Teo MY, Kiat C, Donnellan P, McLoughlin RM

Department(s)/Institute(s): Department of Gastroenterology, Department of Medical Oncology, University Hospital Galway

Introduction: Ipilimumab is an anti- Cytotoxic T Lymphocyte Antigen 4 (anti-CTLA4) monoclonal antibody that targets immune checkpoints. Efficacy has been demonstrated with advanced malignant melanoma with possibility of long-term survival. However, rates of immune-mediated toxicities are high and Ipilimumab-induced gastrointestinal toxicities can be challenging to manage.

Published clinical trials data suggested all grade diarrhoea in the range of 27% and grade 3/4 diarrhoea (severe diarrhoea requiring hospital admission) in the range of 5%.

Aims/Background: Due to hyper-selective nature of clinical trials participants and potential pharmacogenomic variation amongst different populations, we sought to examine the incidence of grade 3/4 diarrhoea in patients treated with Ipilimumab in the west of Ireland in a

Method: Patients with diagnosis of advanced malignant melanoma treated with Ipilimumab were identified from oncology pharmacy database between 06/2010 and 06/2013. Patients' clinical details were extracted from electronic chart and discharge letters review. Diarrhoea severity was graded according to NCI CTCAE v4 (National Cancer Institute Common Terminology Criteria for Adverse Events version 4). Fisher's exact and t-test were used for statistical analysis.

Results: There are a total of 24 patients with advanced malignant melanoma receiving Ipilimumab between 06/2010 and 06/2013 in University Hospital Galway of which 58% of them are male. Median age was 62 years (range: 21-76). 7 (29%) patients received Ipilimumab as first line treatment, 10 (42%) have liver metastasis, while 7 (29%) have lung metastasis. Of these, only 3 (13%) had radiographic documentation of response to Ipilimumab. The incidence of severe diarrhoea was 21% (5/24), all of which required hospitalisation. Out of the 5 patients, 80% were female, 40% received the treatment as first line medication, and 0% achieved treatment response. Exploratory analysis showed there is no significant correlation between age, gender, or site of metastasis, and the development of grade 3/4 diarrhoea.

Conclusion: The incidence of severe diarrhoea after receiving Ipilimumab in the cohort of this single centre is 21%, which is much higher comparing published data (in the range of 5%). No statistically significant factors predisposing to severe diarrhoea identified, possibly due to relatively small sample size. Development of grade 3/4 diarrhoea did not translate into higher response rate. A larger cohort, which involves the collaboration between few tertiary hospitals is needed for further study.

ABSTRACT 67 (13W169) POSTER PRESENTATION

Title of Paper: Therapeutic Phlebotomy Does Not Affect Liver Stiffness Levels in Patients with Hereditary Haemochromatosis

Author(s): NA Mohd Noordin(1), C Kiat(2), M Azhar(1), J Lee(2)

Department(s)/Institute(s): (1) National University of Ireland, Galway, (2) Department of Gastroenterology and Hepatology, University Hospital Galway

Introduction: Transient Elastography (Fibroscan) determines the degree of fibrosis non-invasively in patients with liver disease.

Aims/Background: This study aims to evaluate liver stiffness levels in patients with hereditary Haemochromatosis (HH), and specifically the influence of therapeutic phlebotomy on liver stiffness levels.

Method: This was a single-centre cohort study of HH patients (C282Y/C282Y and C282Y/H63D) attending the Haemochromatosis clinic at University Hospital Galway. This study included patients who were undergoing phlebotomy (either for iron depletion or maintenance) and have had liver stiffness measured by Fibroscan. In 20 patients, repeat stiffness levels were measured after a period of phlebotomy. Patients' serum ferritin levels were measured periodically as part of usual clinical care. Spearman's correlation was used to analyse the correlations between liver stiffness nod serum ferritin, and paired samples T-test to evaluate the changes in stiffness levels after phlebotomy.

Results: Liver stiffness measurements were performed in 238 patients. Mean serum ferritin when liver stiffness were measured was 486.96ng/ml (+/-748.17ng/ml). The correlation between initial liver stiffness and serum ferritin was weak (r=0.256) but statistically significant (p<0.001). 20 patients had repeated liver stiffness measurement after a mean of 16.79kPa (+/-10.59) and a mean of iron 2815.59mg (+/-1925.17) removed (250mg iron per 500ml blood). There was no significant change in liver stiffness levels after phlebotomy (6.23kPa [before] vs 6.21kPa [after], P=0.965) despite a significant decrease in serum ferritin levels (520.40ng/ml [before] vs 80.25ng/ml [after], P=0.017)

Conclusion: There is a weak but significant correlation between serum ferritin and liver stiffness, as measured byFibroscan. phlebotomy is the mainstay treatment for iron overload in HH patients but this study does not show significant change in liver stiffness (a surrogate marker for liver fibrosis) after phlebotomy despite reduction in serum ferritin.

ABSTRACT 68 (13W170) POSTER PRESENTATION

Title of Paper: Review of an Outpatient Infliximab Service - Altnagelvin Hospital

Author(s): C Braniff, C Ferguson

Department(s)/Institute(s): Altnagelvin Hospital, Derry

Introduction: There is a growing population of patient's recieving Infliximab therapy for inflammatory bowel disease. The provision of Infliximab is regulated by national guidelines. In 2012 Altnagelvin Hospital conducted a review of its outpatient Infliximab service.

Method: In Altnagelvin Hospital outpatients receive Infliximab therapy in the day case unit. Records are maintained for every patient. Information was gathered from the day case unit notes and the medical notes. NICE guidelines were used as an audit tool. Day case staff were interviewed regarding the service. Any complications of therapy were investigated.

Results: 42 patients received Infliximab therapy over the 12 month period. 40 of the 42 patients had Crohn's Disease. 2 patients had Ulcerative Colitis. The majority of patients had chest x-rays and viral titres performed before commencing Infliximab. However there was no documentation about recommending vaccinations. All patients had an indication for Infliximab therapy that met with NICE guidelines. 40 of the 42 patients had been reviewed in clinic within the previous year. 4 patients had stopped Infliximab due to infusion reactions. 2 patients had proceeded to require abdominal surgery. 1 patient had developed shingles.11 patients were taking steroids with each Infliximab infusion.

Conclusion: The provision of Infliximab in Altnagelvin Hospital adheres to NICE guidelines. Infliximab therapy is commenced in the appropriate patients and the patients are monitored closely. There was a higher than expected number of infusion reactions. Patients should be counselled on receiving appropriate vaccinations. The review process has highlighted best practice in the provision of an infliximab service.

ABSTRACT 69 (13W172) POSTER PRESENTATION

Title of Paper: Endoscopic Pyloric Suturing to Facilitate Weight

Loss: A pilot study

Author(s): Barry McMahon, Stephen Bligh, Peter Nowlan, Christoph Blau, Christy Cummins, John Healy, Jim Coleman, Deirdre McNamara

Department(s)/Institute(s): TAGG, Department of Clinical Medicine, Trinity College Dublin; Bioresources Unit, Trinity College, University of Dublin, Dublin, Ireland; Trinitas Ventures, Citywest Business Campus, Dublin 24, Ireland

Introduction: Obesity continues to increase in epidemic proportions despite efforts to bring it under control and is commonly associated with many serious medical disorders, including heart disease, diabetes, hypertension, osteoarthritis, sleep apnoea, and an increased incidence of various types of cancer. Approximately 300,000 adults in the United States die each year because of obesity-related causes. The primary treatment objective is weight reduction. Even moderate weight loss produces health benefits and has been associated with marked reductions in the risk for medical disorders. For this study it was rationalised that restriction of the pylorus would result in weight loss as it is known that patients with partial gastric outlet obstruction have delayed gastric emptying, a sensation of early and prolonged satiety, and decreased caloric consumption.

Aims/Background: To decrease gastric emptying and cause early and prolonged satiety by endoscopically narrowing the gastric pylorus in a porcine model

Method: An endoscopic riveting device, which can be used to place sutures at flexible gastroscopy, was used in this study. The riveting device was guided into place under endoscopic vision and consisted of a hollow needle that penetrated the target area in the pylorus. Attached to this needle was a rivet to which a 316LVM Biocompatible Stainless Steel suture was attached. Once the rivet was deployed, the needle retracted automatically and the delivery catheter was removed from the working channel of the gastroscope leaving behind a suture loop which was firmly attached to the rivet. A second rivet was placed through the full thickness of the pyloric gastro intestinal tissue with the riveting device, after capturing the suturing loop protruding from the first rivet to create a cinch.

Results: For the initial prototype development, ex-vivo bench top experiments were carried out to narrow the pylorus in 6 pig stomachs. All rivets were safely deployed (figures 1a and 1b), fixed and embedded in the wall of pylorus without complication. There was no evidence of leakage from stomach wall at site of suture implants. To date one in-vivo endoscopic pilot study has been carried out on a porcine model under general anaesthetic. This pig stomach was successfully implanted with 2 rivets and one suture, resulting in a narrowing of the pylorus which did not widen under peristalsis (figure 2).

Conclusion: For this pilot study the implants were demonstrated to be held securely in place with no evidence of perforation of the pyloric wall on sacrifice of the animal. Long term porcine survival studies post implantation of a pyloric narrowing implant are now being planned, with the aim of monitoring the food intake post procedure to determine the extent of weight change. Figure 1 a and 1 b Endoscopic Rivet & Suture Proto-type. Figure 2. Pyloric Cinch

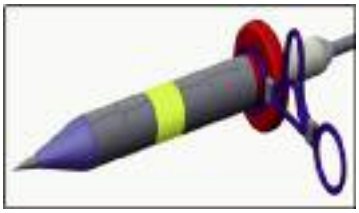


Figure 1 a and 1 b Endoscopic Rivet & Suture Proto-type

Figure 2. Pyloric Cinch

ABSTRACT 70 (13W173

Title of Paper: Laparoscopic J pouch: Evaluation of a surgical technique- 1cm incisions for restorative Ilio-anal pouch anastomosis (IPAA) stage I.

Author(s): NM Fearon, M O'Sullivan, C Browne, MC Whelan, D Collins, P Neary

Department(s)/Institute(s): Dept of Colorectal Surgery, AMNCH

Introduction: The colorectal unit at AMNCH is a specialist referral unit for the surgical management of inflammatory bowel disease.

Aims/Background: This study is a retrospective review of patients who underwent laparoscopic J pouch surgery between 2008 and 2013.

Method: We evaluated surgical technique, post-operative complications and functional outcomes (Gastrointestinal Quality of Life Index and Wexner Scoring System) over the study period.

Results: Twenty-three patients were identified. The majority were male (n=15) and most had a diagnosis of ulcerative colitis (n=20). Using a standardised surgical technique with specimen extraction via the ileostomy site, the largest incision was 1cm. The median length of stay was 6.5 days (3-11 days). There were no immediate complications, 25% of patients had an early complication and 15% had a late complication. No patients required re-operation. The median frequency of daytime bowel motions was 5.5 (1-12) and nocturnal bowel motions was 1.5. Half of the patients gave a Wexner score of 0 indicating no faecal incontinence, while two patients had a score of 5/20.

Conclusion: Using a standardised surgical technique, laparoscopic IPAA may be performed with minimal incision lengths, and promising functional outcomes.

ABSTRACT 71 (13W174) POSTER PRESENTATION

Title of Paper: Transanal endoscopic microsurgical resection of

complex rectal polyps obviates the need for abdominal surgery- results from the AMNCH TEMS registry.

Author(s): Fitzgerald LL, M O'Sullivan, MC Whelan, D Collins, D Kavanagh, P Neary

Department(s)/Institute(s): Tallaght Hospital

Introduction: Complex rectal polyps require complete removal to avoid transformation into adenocarcinoma. Effective excision of rectal polyps is generally feasible via a transanal approach however higher rectal polyps are not generally suitable for excision using standard approaches. Transanal endoscopic microsurgery (TEMS) allows for removal of high rectal lesions.

Aims/Background: This study analyses outcomes for TEMS resection of rectal polyps at our institution with a focus on the management of high rectal lesions

Method: A retrospective analysis of the prospectively maintained TEMS database was performed. Outcomes including histological diagnosis, evidence of adenocarcinoma, post-operative complications and requirement for a repeat procedure were evaluated. In addition, a subgroup analysis of high rectal polyps was performed.

Results: Of the 252 patients who underwent a TEMS procedure during the study period (1998-2013), 170 were male and the median age was 65 years (range 24-89). The majority of lesions were tubulovillous adenomas with low grade dysplasia however 32 patients had evidence of adenocarcinoma. Overall 22 patients required a repeat procedure. One hundred and fifteen patients had a lesion above 8cm from the anal verge, this included 64 patients with a lesion above 10cm. The median length of stay after TEMS was 4 days (range 1-27). Complications arose in 15% of patients but were mostly related to post-operative bleeding and urinary retention.

Conclusion: TEMS allows for safe and effective removal of both low and high rectal lesions with good post-operative outcomes.

ABSTRACT 72 (13W175) POSTER PRESENTATION

Title of Paper: Transanal minimally invasive microsurgery (TAMIS): An initial single institute experience

Author(s): NM Fearon, M O'Sullivan, MC Whelan, D Collins, P Neary

Department(s)/Institute(s): Dept of Colorectal Surgery, AMNCH

Introduction: The colorectal unit at Tallaght hospital is the national referral centre for transanal endoscopic microsurgery (TEMS) for the management of rectal dysplastic polyps. Recently, we trialled the disposable transanal minimally invasive microsurgery (TAMIS) Gelpoint system.

Aims/Background: This study aims to report the results of this pilot study.

Method: A retrospective review of a prospectively maintained database was carried out. Patient demographics, tumour characteristics and postoperative outcomes were analysed over a one year period from April 2012-April 2013.

Results: Ten patients underwent TAMIS during the study period. Histology of the excised specimens included tubulovillous adenoma with low grade dysplasia (3), tubulovillous adenoma with high grade dysplasia (2), adenocarcinoma (2), villous adenoma (1) and tubular adenoma (2). One patient had a positive margin with a focus of high grade dysplasia and underwent re-excision. One case was completed as a transanal debulking procedure. Mean operating time was forty minutes and the average distance from the anal verge was 8cm. Median length of stay was two days. There were three minor complications in the study group- rectal bleeding (2) and peri-anal pain (1). All complications were treated conservatively.

Conclusion: Our initial experience with TAMIS has yielded positive results suggesting it may be a useful treatment option for selected rectal lesions. In addition it may be viable alternative for transanal resection in centres lacking TEMS equipment.

ABSTRACT 73 (13W176) POSTER PRESENTATION

Title of Paper: Inadvertent Peg Tube Re-Insertions: The Experience Of A Single Referral Centre Over An Eight Year Period.

Author(s): M. Zeeshan, MS Ismail, A. Leonard, D. Mulholland, S. Sengupta, J Keohane.

Department(s)/Institute(s): Department of Gastroenterology, Our Lady of Lourdes Hospital, Drogheda

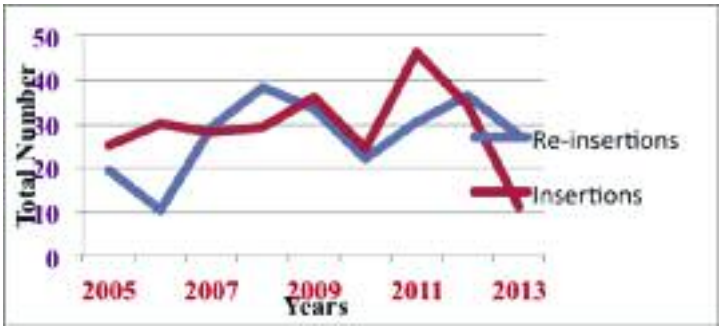
Introduction: Percutaneous endoscopic gastrostomy (PEG) tubes are an accepted method of long term enteral nutrition. Since its introduction by Gauderer in 19801 its use has increased exponentially, and so has the morbidity and mortality associated with it2. Like any other medical advancements it should be utilised in appropriately selected patients.

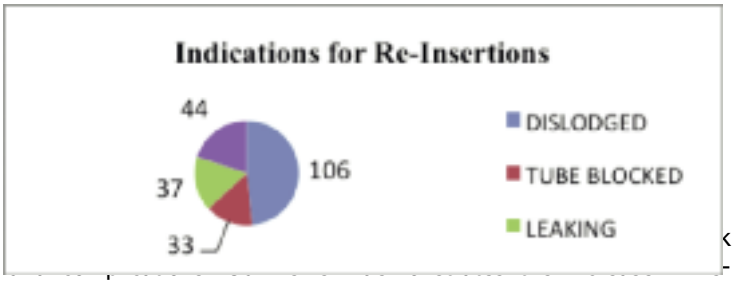
Aims/Background: To evaluate rates of PEG placement and re-insertion in a single centre from 2005 to 2013.

Method: This was a retrospective review of all PEG placements and re-insertions in a single referral centre between 2005 and Sept 2013. Data was collected from the HIPE database, endoscopy database, patients records and Emergency Department records. Data was collected for the indications, complications and number of re-insertions of PEG tubes

Results: A total 275 patients had PEG tubes were inserted between 2005 to 2013. The mean patient age was 68yrs (12-100). There were 39 (42%) females and 54 (58%) males. 93 (33.8%) patients had a total of 220 PEG re-insertions with a range of between 1 and 18 times. There was a trend towards increasing number of re-insertions during the time period (Figure 1). The indication for PEG re-insertion is demonstrated in Figure 2. 49 (53%) of the patients were from nursing homes.

Figure 1





insertion PEG tubes with many patients having multiple re-insertions. Multiple re-insertions of PEGs following inadvertent removals are associated with obvious clinical, financial and ethical issues, especially in nursing home patients. Institutions should develop guidelines with involvement of multidisciplinary team to select appropriate patients in the first instance and educate staff on the maintenance of PEG tubes. Ultimately the outcome that matters is not just the quantity of life but the quality of it.

References

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ABSTRACT 74 (13W177) POSTER PRESENTATION

Title of Paper: The safety and tolerability of Telaprevir and Boceprevir based triple therapy for Hepatitis C genotype 1 in an Irish patient cohort

Author(s): El-Sherif O, Quinn C, Hynes B, McGrath M, Irish H, McKiernan S, Norris S

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

Introduction: The addition of a protease inhibitor to Pegylated Interferon-γ and Ribavirin for hepatitis C genotype 1 infection has resulted in a significant increase in the rates of sustained virological response, and shorter therapy for many patients. However, triple therapy is associated with more adverse events. In patients with advanced fibrosis, a significantly higher rate of serious adverse events has been observed in real life cohorts compared to phase 3 trials.

Aims/Background: We report the safety and tolerability analysis of triple therapy in a cohort treatment experienced and treatment naïve patients, with a high proportion of cirrhotics.

Method: The data (charts and electronic patient records) from all patients who commenced triple therapy for hepatitis C genotype 1 between May 2011 and December 2012 in our unit was reviewed. Patients who received at least one dose of a protease inhibitor were included in this analysis. Fibrosis was assessed by liver biopsy or Fibroscan® within the 18 months predating treatment.

Results: 60 patients met inclusion criteria. 22/60 (37%) had compensated cirrhosis. Rash was noted in 12/60 (20%) patients (Grade 1 – 13%, Grade 2 – 5%, Grade 3 – 2%). Anal pruritis was reported by 23% of patients. Anaemia (Haemoglobin < 10g/dl) and severe anaemia (Haemoglobin < 8.5g/dl) were observed in 60% and 23.3% of patients respectively. Severe neutropenia (Neutrophil count < 0.5x109/L) developed in 10% of patients. Treatment discontinuation rates for non-response and viral breakthrough were 8.3% and 6.7% respectively. Side-effects resulted in treatment discontinuation in 7/60 patients: depression (2%), hepatic decompensation (3%), grade 3 rash (2%), severe abdominal pain (2%), and severe sepsis (2%). There were no discontinuations due to thrombocytopenia. Safety and Tolerability of Triple Therapy for HCV Table.

Table 1 – Safety and Tolerability of Triple Therapy for HCV

	Telaprevir (n=40)	**Boceprevir (n=20)**
Female – n. (%)	13 (33)	3 (15)
Age – median	49	37
BMI > 30 – n. (%)	7 (18)	5 (25)
Cirrhosis – n (%)	14 (35)	8 (40)
IL28 non CC – n (%)	27 (68)	12 (60)
Treatment History		
Naïve – n (%)	20 (50)	14 (70)
Relapser – n (%)	17 (42.5)	1 (5)
Non-Responder – n (%)	3 (7.5)	5 (25)
Lowest Haemoglobin		
> 10 (g/dL)	17 (42.5)	7 (35)
8.5 – 10 (g/dL)	11 (27.5)	10 (50)
< 8.5 (g/dL)	12 (30)	3 (15)
Rash		
Grade 1	4 (10)	4 (20)
Grade 2	3 (7.5)	0 (0)
Grade 3	1 (2.5)	0 (0)

Conclusion: Triple therapy was safe and tolerable in our patient cohort. There were fewer than expected treatment discontinuations because of side effects. Anaemia was the most troublesome side effect, but was manageable with Ribavirin dose reductions and Erythropoietin. The majority of serious adverse events occurred in the cirrhotic group.

ABSTRACT 75 (13W178) POSTER PRESENTATION

Title of Paper: Late viral breakthrough and late relapse in the triple therapy era: a cautionary tale

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

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

Introduction: Despite the improved virological response observed with the addition of a protease inhibitor (PI) to Peginterferon and Ribavirin treatment in chronic hepatitis C virus (HCV) genotype 1 infection, some patients experience viral breakthrough while on therapy. Most of the reported cases of viral breakthrough develop in the first few weeks after the completion of the PI phase of therapy. The durability of a sustained virological response (SVR) post treatment is also unclear. Follow up data on viral relapse after achieving SVR is lacking, with no published case reports of late relapse post SVR. Additionally, the improved SVR rate is informing a change in practice to shorten duration of treatment as new protease inhibitors are brought to market.

Aims/Background: We report two cases of late virological breakthrough with Telaprevir based triple therapy and one late relapse post SVR with Boceprevir with Boceprevir based therapy.
Method: Patient A was a 64 year old female, IL28B CT, treatment naïve patient with genotype 1b infection and cirrhotic. Patient B was a 40 year old male, IL28B CT, previous non-responder with genotype

1 infection and cirrhotic. Patients A and B received 48 weeks of Peginterferon and Ribavirin with Telaprevir for the first 12 weeks. Patient C was a 46 year old male, IL28 CT, treatment naïve patient with genotype 1a infection and stage 1/6 fibrosis. He received a 4 week lead in of Peginterferon and Ribavirin followed by 24 weeks of triple therapy with Boceprevir.

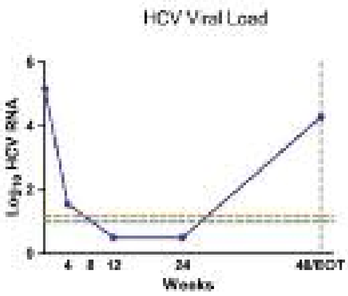
Results: Viral loads on treatment are outlined in table 1 and 2. Patient A had virological breakthrough at the end of treatment (week 48) having been negative at week 12 and 24. Patient B was PCR negative at week 12 and had virological breakthrough at week 24. Patient C achieved SVR but became PCR positive 48 weeks after completing treatment, with a rebound in ALT.
Late Viral Breakthrough and Relapse Tables and Graphs

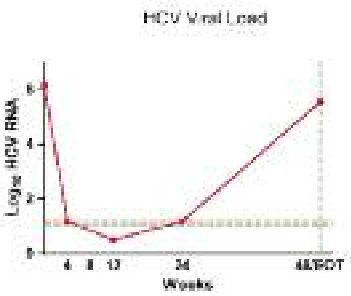
Table 1

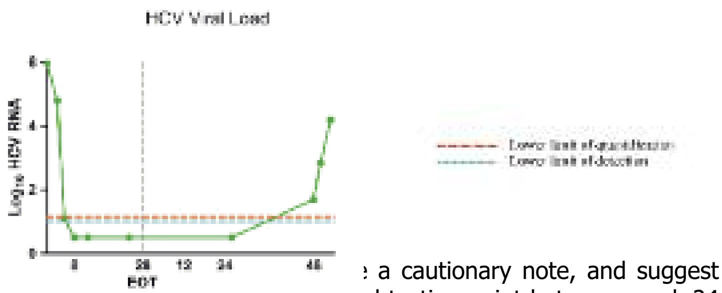
	Patient A		Patient B	
	Viral Load (iu/mL)	ALT (iu/L)	Viral Load (iu/mL)	ALT (iu/L)
Baseline	[illegible]	68	[illegible]	49
Week 4	37	28	< 15	17
Week 12	Not detected	47	Not detected	16
Week 24	Not detected	28	< 15	17
Week 48	19400	73	[illegible]	51

Table 2

	Patient C	
	Viral Load (iu/mL)	ALT (iu/L)
Baseline	74290	53
Week 4	< 15	29
Week 8	Not detected	18
Week 12	Not detected	27
Week 24	Not detected	16
24 weeks post tx	Not detected	18
48 weeks post tx	[illegible]	42







[illegible] a cautionary note, and suggest the need for an additional viral load testing point between week 24 and week 48 of treatment, especially in patients with cirrhosis. Early identification of viral breakthrough is important in minimising unnecessary treatment related morbidity and cost. Furthermore, patients who achieve SVR with 24 weeks of therapy should continue to have 6 monthly ALT monitoring + HCV PCR until the durability of SVR with triple therapy is established.

ABSTRACT 76 (13W180) POSTER PRESENTATION

Title of Paper: Bone mineral density in women with chronic Hepatitis C infection in Cork University Hospital.

Author(s): Thevaraajan Jayaraman, Susan Corbett, Elizabeth Kenny-Walsh, Orla Crosbie.

Department(s)/Institute(s): Department of Hepatology, Cork University Hospital

Introduction: It is suggested that persons with chronic hepatitis C infection are at higher risk of developing osteoporosis.

Aims/Background: To study the bone mineral density and rates of osteoporosis in our cohort of women with chronic hepatitis C infection.

Method: From the departmental database, we identified a cohort of Irish women who were exposed to Hepatitis C virus genotype 1B via contaminated anti D administered in 1977. Patients were separated into two groups: 1) chronically infected with Hepatitis C (PCR+); 2) spontaneously cleared the virus with positive antibodies (PCR-). Reports of the latest dual energy x-ray absorptiometry (DEXA) performed were retrieved from each patient's medical records. Standard statistical methods were applied

Results: A total of 101 patients were identified of which 52 are PCR+ and 49 are PCR-. Mean age of PCR+ and PCR- are 63 (54-77) years and 63 (54-75) years respectively (p=0.861). DEXA scan measurements at the spine showed that PCR+ has lower BMD (1.026±0.115 g/cm² vs. 1.074±0.136 g/cm², p = 0.058), T-score (-1.29±0.97 vs. -0.88±1.13, p =0.052) and Z-score (-0.102±1.03 vs 0.439±1.01, p =0.009). Measurements at the left femur also showed that PCR+ has lower BMD (0.913±0.120 g/cm² vs. 0.934±0.135 g/cm², p =0.408), T-score (-0.73±1.00 vs. -0.55±1.13, p =0.412) and Z-score (0.188±0.93 vs. 0.481±0.95, p =0.126). Based on spinal T-scores, the rate of osteoporosis in PCR+ is 9.6% compared to 4.1% in the PCR- (p=0.253). Based on left femoral T-scores, the rate of osteoporosis is 1.9% in PCR+ and 2.1% in PCR- (p=0.785). 10 out of 52 patient in the PCR+ group are known to have established liver cirrhosis compared to none in the PCR- group. Comparing measurements at the spine between the cirrhosis and non-cirrhosis groups within the PCR+ group showed that the cirrhosis group has higher BMD (1.034±0.120 g/cm² vs. 1.024±0.115 g/cm², p =0.813), T-scores (-1.22±1.01 vs. -1.31±0.97, p =0.801) and Z-scores (0±1.17 vs. -0.126±1.01, p =0.732). At the left femur, the pattern is reversed; the cirrhosis group has lower BMD (0.896±0.088 g/cm² vs. 0.917±0.127 g/cm², p =0.627), T-scores (-0.88±0.74 vs. -0.69±1.06, p =0.601) and Z-scores 0.09±0.79 vs. 0.78±0.97, p =0.714). The rate of osteoporosis at the spine in the cirrhosis group is 10% compared to 9.5% in the non-cirrhosis group (p= 0.914). Comparing left femur T-scores, none in the cirrhosis group have osteoporosis, compared to 2.4% in the non-cirrhosis group(p=0.786).

Conclusion: There is no significant difference in rates of osteoporosis between PCR+ and PCR- patients; and between the cirrhosis and non-cirrhosis groups within the PCR+ group. PCR+ patients have significantly lower spinal Z-scores compared to PCR- patients. Further studies need to be performed prospectively with a larger sample size adjusting for confounding factors such as presence of co-morbidities, use of steroids and anti-viral therapy.

ABSTRACT 77 (13W181) POSTER PRESENTATION

Title of Paper: INCIDENCE OF CHEMOTHERAPY INDUCED

DIARRHOEA IN COLORECTAL CANCER PATIENTS: A RETROSPECTIVE ANALYSIS

Author(s): C.S. Lee1, B. Nolan1, D. Fennelly1, G. Cullen1, H. Mulcahy1, G.A. Doherty1, E.J. Ryan2

Department(s)/Institute(s): 1Centre for Colorectal Disease, St. Vincent's University Hospital, Dublin, Ireland. 2School of Medicine and Medical Sciences, University College Dublin, Dublin, Ireland.

Introduction: Chemotherapy induced diarrhoea (CID) is a common and extremely debilitating side effect of many chemotherapeutic regimens. Not only does CID negatively impact on cancer patients' quality of life it also causes delays in treatment or dose reduction; with more severe CID requiring hospitalization. This poses a significant burden; both clinically and economically, in oncology care. However there is an increasing body of evidence to suggest that the development of certain chemotherapy toxicities were associated with improved survival in colorectal cancer.

Aims/Background: Our objective was to ascertain the extent of CID at our centre in a retrospective analysis, additionally if there are certain risk factors and the effect of CID on overall survival.

Method: We performed a retrospective chart review. We included all patients with Stage II or III colorectal cancer (CRC) who received adjuvant chemotherapy at our centre during the period 2006-2009. Tumour location, pathological stage, chemotherapy regimen and the number of cycles received, hospitalisations, drug reductions and incidence of CID and other toxicities were noted. All patients were followed up to study completion or death.

Results: During the study period 105 patients (61 males) underwent curative surgery for CRC and subsequent adjuvant chemotherapy. Average age of diagnosis was 62.5 years (Range= 30.5 to 83.8) and 75.2% of CRC were left sided lesions. 57 patients (54.26%) had positive nodes on pathological staging. These patients received adjuvant chemotherapy totaling 807 cycles with a completion rate of 85.7 %. 126 events of CID were reported in 57 patients; giving a CID incidence rate of 54.2%. 16 patients (15.2%) experienced severe CID during adjuvant chemotherapy; resulting in delay of treatment cycle (n= 10), dose reduction or alteration (n= 12), hospitalization (n=3) and early termination of chemotherapy (n=2). Females have a significantly higher risk of developing CID (68.1% v 44.2%, p=0.018) and use of oxaliplatin and fluorouracil (5FU) have a higher rate of CID compared with 5FU alone (62.8% v 35.8%, p=0.03). Patients who develop CID during treatment have a significantly higher overall survival (OS) at 3 years compared with patients without CID (92.9% vs 81.25%, p=0.047). However OS at 5 years were similar in both groups (75.4% v 75.4%, p=N.S.)

Conclusion: Adjuvant chemotherapy frequently results in CID. A significant proportion of these patients suffer severe symptoms that limit chemotherapy treatment and negatively impact on quality of life. The development of CID was associated with better outcome at 3 years in our study, but this finding requires additional study. Future work in our center will prospectively further assess our findings and evaluate factors that may influence enterotoxicity and CID.

ABSTRACT 78 (13W182) POSTER PRESENTATION

Title of Paper: Comparison of Risk Scoring Systems as Predictors of Post-Operative Mortality in Benign Major Colorectal Surgery

Author(s): De Marchi J, Gormley C, Joyce WP

Department(s)/Institute(s): Galway Clinic, Royal College of Surgeons in Ireland

Introduction: Physiological and operative severity scoring in surgery has undergone significant changes since the original development of the POSSUM predictor of mortality. The POSSUM model, developed in 1991[1], has largely been replaced by more accurate variants as the original model was found to overestimate the mortality in lower risk operative cases and underestimate the mortality in the elderly patient population[2]. This led to the development of the recalibrated 'Portsmouth' POSSUM (P-POSSUM) model still frequently used today[2]. Specialty specific models began to appear at the start of the millennium, including the ColoRectal POSSUM (CR-POSSUM) model, and have generally been found to be better predictors of mortality compared to their non-specialty specific counterpart[3]. Validation of these risk prediction models has been extensive, however, manuscripts specifically relating to benign colorectal surgery have been somewhat limited.

Aims/Background: To compare the performance of the POSSUM, P-POSSUM, and CR-POSSUM models in the prediction of operative mortality for benign colorectal surgery from a single surgeon unit.

Method: A total of 94 patients who underwent resection for the treatment of benign colorectal cancer at a single institution from 2004 were included. The study was conducted retrospectively on all consecutive patients requiring elective and emergency colorectal surgery for benign disease. Models were compared by examining observed to expected (O:E) ratios.

Results: Overall 30 day mortality among the patient population was 4.26% (N=4). The risk prediction models had a predicted mortality as follows: POSSUM 3.36% (O:E ratio 0.78, not significant at p = 0.75), CR-POSSUM 3.43% (O:E ratio 0.80, p = 0.77), and P-POSSUM 3.15% (O:E ratio 0.74, p = 0.69).

Conclusion: All three models accurately predicted mortality in our patient population with no statistically significant difference seen between observed and expected outcomes. This paper further adds to the existing body of evidence for use of these prediction models in the pre-operative risk assessment of Irish patients undergoing major colorectal surgery. Specifically, it adds to the relatively under evaluated population of benign colorectal disease. Larger sample numbers would add to the power of this audit and enable minute clinically significant differences to be detected within subgroup analysis; such as extremes of age, elevated ASA and populations containing large volumes of emergency cases.

ABSTRACT 79 (13W186) POSTER PRESENTATION

Title of Paper: 1000 Laparoscopic Cases: standardised techniques yield standard outcomes

Author(s): Muireann O'Sullivan, Maria Whelan, Naomi Fearon, Danielle Collins, Declan Buckley, Paul Neary

Department(s)/Institute(s): Department of Colorectal Surgery, Tallaght Hospital

Introduction: A number of case series and prospective randomised trials have documented the safety and efficacy of laparoscopic colectomy for a variety of colorectal pathology, including cancer. The use of a standardised approach allows for comparisons across

institutions and are replicable in other centres.

Aims/Background: To compare our laparoscopic colorectal experiences to international norms.

Method: A retrospective analysis was performed on a consecutive series of laparoscopic resections performed in Tallaght Hospital using a standardised laparoscopic technique and enhanced recovery pathway. Patients were assessed for operation type, indication for surgery, rate of conversion to open, complications, duration of stay and readmission within 30 days.

Results: Over 1000 (n=1003) consecutive colorectal resections were identified between March 2005 and March 2013. The age range of the patients was 16-89years. Resections comprised of anterior resections 43% (n=435), right hemicolectomy 17% (n=170), left hemicolectomy 10% (n=103), sub-total colectomy 5% (n=49), abdomino-perineal resection 2% (n=19), J pouch 2% (n=19) and others including ileocaecectomy, jejunal resection and proctectomy. The indications for surgery were colorectal neoplasia, diverticular disease; inflammatory bowel disease. The rate of conversion to open was: 12.66% Length of stay and complication rates were comparable to international standards.

Conclusion: This study validates previously published data with regards to standardised approach to laparoscopy within an enhanced recovery programme.

ABSTRACT 80 (13W187) POSTER PRESENTATION

Title of Paper: The Quality of Photographic Documentation of Caecal Intubation at Colonoscopy

Author(s): Antonia Courtney, Juliette Sheridan, Hugh Mulcahy, Glen Doherty, Garret Cullen

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

Introduction: Caecal intubation at colonoscopy is defined as the passage of the colonoscope tip to a point proximal to the ileocaecal valve and visualisation of the entire caecum. Colonoscopic examination is considered to be complete when identification of the caecal landmarks or intubation of the terminal ileum (TI) is recorded and photographic documentation is saved.

Aims/Background: To review consecutive colonoscopies performed by 24 endoscopists in an academic medical centre over a single month to examine the quality of photographic documentation of caecal or TI intubation.

Method: All patients undergoing colonoscopy at our centre in July 2013 were eligible for inclusion. Patients were identified from the electronic endoscopy reporting system. Procedures that were reported as complete including visualisation of the caecum were included. We recorded whether the endoscopist indicated that photographic documentation of caecal intubation had been performed and then assessed the quality of that photographic documentation by two independent reviewers. Data including the endoscopist performing the procedure, patient age, gender, indication for colonoscopy, bowel preparation, sedation, diagnosis and procedures performed during the colonoscopy were recorded.

Results: Two hundred and sixteen colonoscopies were performed during the study period. The completion (caecal or ileal intubation) rate was 94% (204/216). Median (interquartile range) midazolam dose was 4mg (3-5mg) and median (IQR) fentanyl dose was 50µg (50-100µg). The endoscopist reported photographic documentation of completion in 98% (199/204), but no photographs were taken in 5 of the 199 (2.5%). A picture of either the caecal pole (appendix orifice) or ileum was taken in 152 cases (75%), but this photo was of acceptable quality in 127 (62%). Endoscopists with a primary interest in gastrointestinal disease were significantly more likely to obtain satisfactory photographic documentation than others (69% vs 23%, p=0.008).

Conclusion: This retrospective observational study found that only 62% of reportedly complete colonoscopies had adequate photographic documentation of completion, with GI physicians and surgeons performing better than their non-GI counterparts. Photographic documentation of caecal intubation is an important quality indicator and measures should be implemented to improve performance.

ABSTRACT 81 (13W189) POSTER PRESENTATION

Title of Paper: A Retrospective Analysis of Outcomes for Anti-TNF Naive Inflammatory Bowel Disease Patients Treated with Adalimumab or Infliximab

Author(s): Susan Hyland, Denise Keegan, Hugh Mulcahy, Glen Doherty, Garret Cullen

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

Introduction: Infliximab (IFX) and Adalimumab (ADA) are the two anti-tumour necrosis factor antibodies (anti-TNFs) used in the treatment of inflammatory bowel disease (IBD) in Ireland. There are no studies directly comparing clinical outcomes for these agents when used as primary anti-TNF therapy in Crohn's Disease (CD) and ulcerative colitis (UC).

Aims/Background: The aim of this study was to compare 12 month outcomes for IBD patients treated with either IFX or ADA as initial anti-TNF therapy at our institution.

Method: We identified all patients with CD and UC treated with either IFX or ADA as initial anti-TNF therapy at a single academic medical centre between 2007 and 2012. We used a prospectively maintained database and medical records to record clinical outcomes in the first 12 months after anti-TNF therapy was initiated. The primary outcome was anti-TNF discontinuation due to treatment failure at 12 months. Secondary outcomes included clinical response and remission, dose escalation, additional immunosuppression and surgery.

Results: Treatment was stopped in 53% of the patient population, 60% of the IFX group and 28% of the ADA group. Thirty three percent of the total group stopped anti-TNF therapy because of treatment failure at 12 months. Patients treated with IFX were more likely to fail biologic therapy compared to patients treated with ADA (35% vs 22% p=0.03). Of the total patient cohort, 79% had a clinical response and 50% were in clinical remission after their first year on treatment. Rates of response and remission for the IFX group were 75% and 48% respectively, and 92% and 58% respectively for the ADA group. There was no significant difference in response to either therapy in those with elevated CRP levels at treatment initiation.

Conclusion: Patients treated with IFX were more likely to stop their medication by 12 months due to treatment failure than those treated with ADA. Although ADA was associated with higher rates of initial clinical response than IFX, the rates of clinical remission were

comparable.

ABSTRACT 82 (13W190) POSTER PRESENTATION

Title of Paper: Low molecular weight heparin (LMWH) for hypertriglyceridemia induced pancreatitis: 2 case series

Author(s): Ahmed Abu Shanab, Zafar Khan, Fuad Aftab

Department(s)/Institute(s): Mallow General Hospital, Co.Cork, St. Vincent's University Hospital, Dublin

Introduction:

Aims/Background: Hypertriglyceridemia is reported to cause 1-4% of acute pancreatitis episodes and accounts for more than half of gestational pancreatitis cases. High serum triglyceride levels above 1,000mg/dl are usually considered necessary to ascribe pancreatitis induc

Method: We present 2 case series of hypertriglyceridemia induced pancreatitis treated with low molecular weight heparin and fibrate in addition to supportive management in our centre in 2012.

Results: The first patient (42 years old, male) presented with epiagstric and right upper quadrant pain. Triglycerides level was 3472 mg/dl. Although his amylase level was within normal range, computed tomography (CT) of abdomen and pelvis showed picture consistent of acute pancreatitis. The patient was treated with LMWH 5000 IU twice daily subcutaneously and Glofibrate 600 mg twice daily. Triglyceride levels decreased by more than 40% after 24 h. The second patient (39 years old, female) presented with similar symptoms. Her triglycerides were 7555 mg/dl with normal amylase. Acute pancreatitis was confirmed by CT scan. Treatment with LMWH and fibrate resulted in reduction of triglycerides by 80% in 48h.

Conclusion: Low molecular weight heparin plus fibrate can be considered safe modalities for rapidly reducing triglyceride levels in hypertriglyceridemia induced pancreatitis patients.

ABSTRACT 83 (13W191) POSTER PRESENTATION

Title of Paper: Transient elastography (Fibroscan) can predict prognosis and mortality in patients with chronic hepatitis C infection

Author(s): E.Elrayah,John Moloney,Brid Hughes,Ullah Naeem,Dniel Schmidth,AbuShanab Ahmed,Diarmid Houlihan,Masood Iqbal,Aidam McCormick

Department(s)/Institute(s): St Vincents University Hospital,Elm Park, Dublin,Ireland

Introduction: Measurement of liver stiffness by Transient elastography (fibroscan) is used as noninvasive test to assess the liver fibrosis in patients with chronic hepatitis C infection(HCV) .Fibroscan values are clinically usefull for predicting the stages of fibrosis and the progression of the liver disease.

Aims/Background: Measurement of liver stiffness noninvasively by Transient elastography (Fibroscan) can predict prognosis and mortality in Intravenous Drug Users (IVDU) patients with chronic hepatitis C infection (HCV) .

Method: Liver stiffness was measured by the fibroscan in 84 of IVDU patients who are attending the drug clinic for the Methadone programe in 2008.Patients clinical characteristics including demographic , body mass index (BMI), hepatitis screen ,alcohol dependence,HIV status, liver related death, After a follow up of 5 years, hepatic decompensation and the liver disease related death were correlated with the results of the liver stiffness measured by the fibroscan

Results: 84 patients involved in this study (66 male/18 female) with a mean age of 33.73 years, and mean BMI of 25.4. 65 of the patients(77.38%) were positive for hepatitis C antibodies ,49 out of them (58.33%) had a positive PCR for hepatitis C. 68 patients (79.06%) were negative for HbsAg , and only 14 they have Hb core Ab positive (16.6%) . 31 patients (36.9%) are alcohol dependent , 81 patients (96.4%) of the this cohort were tested for HIV none of them is positive for HIV. 7 (8.3%) patients were treated for chronic hepatitis C infection (HCV). fibroscan scores in this cohort range from 3 kpa to 75 kpa, with a median at 6.1kpa. 12 patients (14.2%) with a liver stiffness range (14.8kpa – 75 kpa) developed hepatic decompensation within 5years, 4 of them were treated for chronic hepatitis C infection (HCV). 13 patients (15.47%) died within 5 years, 7 of them (8.3%) because of decompensated liver disease secondary to hepatitis C ,with thier fibroscan scores range 14.8 – 75 kpa. 6 died of non liver causes (7.17%) .

Conclusion: Measurement of liver stiffness by transient elastography (fibroscan) can predict the prognosis and mortality in patients with compensated chronic hepatitis C infection, and this might help decision making for treatment of this group of patients.

ABSTRACT 84 (13W192) POSTER PRESENTATION

Title of Paper: FIT Screening-Detects early and proximal Colorectal Cancers; a direct comparison of screening detected and symptomatic cancers from a single centre.

Author(s): Paul Moore; Vikrant Parihar; Grainne Holleran; Paul Neary; Colm O'Morain; Deirdre McNamara

Department(s)/Institute(s): Tallaght Hospital/Trinity College

Introduction: Screening for Colorectal Cancer (CRC) using stool-based tests has been shown to reduce mortality and improve treatment outcomes due to earlier detection. Moreover, the detection and removal of adenomatous polyps reduces cancer incidence. Previous studies have suggested that gFOBT is less sensitive for proximal CRC. FIT has greater sensitivity compared to gFOBT and has the potential to enhance proximal and early cancer detection.

Aims/Background: To describe the characteristics of CRC diagnosed through the Tallaght/Trinity College CRC screening programme and our symptomatic service since 2009.

Method: A retrospective review was performed of the screening and symptomatic CRC databases at Tallaght Hospital over a 4 year period. Patient and tumour characteristics including gender, age, tumour location and stage were collated and compared between the groups. The databases were cross-referenced to exclude overlap. Tumours were staged 0-4 according to TNM classification. Right-sided tumours were considered proximal to the splenic flexure. The means between groups were compared using a student t-test using SPSS version 20. A p value <0.05 was considered significant.

Results: In all 414 cancers were identified, 358(86.5%) and 56 (13.5%) symptomatic and screening-detected cancers respectively. The majority 265 (64%) were men and the mean age as 65.4 years (Range 28-86 years). Overall stage distribution was 0=9%, 1=20%, 2=29%, 3=25%, 4=17%. In both cohorts, there was a male preponderance. Comparing screening-detected and symptomatic groups, there was no difference in gender or mean age. However,

there was significantly more elderly (>65 yrs) in the symptomatic group (55% vs 43%), p<0.004. As expected, screening-detected cancers were far less advanced with 86% versus 20%, stage 0 or 1 respectively, p<0.0001. (Table 1) Of interest, proximal tumours were more frequent in the screening group, 16% (n=9) vs 13% (n=46), p<0.02.

Conclusion: As expected, FIT screening detected cancers are of an earlier stage than symptomatic cases. Contrary to the UK gFOBT data, proximal cancers were frequent in our screening cohort and can be explained by FITs superior sensitivity. Enhanced detection of proximal lesions may reduce the risk of interval cancers and enhance screening performance. Long term follow-up studies will be required.

Table 1:

Stage % (N)	Stage 0	Stage 1	Stage 2	Stage 3	Stage 4
Screening-detected CRC	63% (35)	23% (13)	3% (2)	9 % (5)	2% (1)
Symptomatic CRC	0% (0)	20% (70)	33% (118)	28% (99)	19% (69)

ABSTRACT 85 (13W194) POSTER PRESENTATION

Title of Paper: The Role of Laparoscopic Sleeve Gastrectomy in the treatment of Morbid Obesity. Review of outcomes with a mean follow-up of over 2.5 years

Author(s): Moloney, B.1, Waldron, R.1, Curtin, M.1, Finucane, F.1, McAnena E.2, Lowe, D.1,2, McAnena, O. 1,2

Department(s)/Institute(s): Department of Surgery, Galway Roscommon University Hospitals Group

Introduction: The global prevalence of obesity has soared alarmingly in recent years, recently being termed by the WHO as a global epidemic. In cases of failed lifestyle and medical treatments, laparoscopic sleeve gastrectomy (LSG) is increasingly being considered as a primary surgical armamentarium for extreme morbid obesity.

Aims/Background: Following the introduction of LSG to institution since 2009, we examine a retrospective cohort to assess objective outcomes of this surgery with an average follow up time in excess of 2.5 years.

Method: In this cohort of patients who underwent LSG, We analysed the percent of excess weight loss (%EWL) and the effect on Body Mass Index (BMI), Hypertension and Diabetes. Intra-operative and post-operative complications were also reviewed.

Results: Since initiation, in excess of 150 LSG's have been performed. 93 patients were identified as having an adequate follow up. The average age was 44. Of these, 72% were female and 28% male. After two years, Average percentage of Excess Weight Loss (%EWL) was 54.2% due to an average decrease in weight by 44Kg. BMI was shown to be reduced by 15. Of the 42% of patients who had pre-existing Hypertension, after two years, 82% of patients had these medications reduced, while 31% had their antihypertensive medications discontinued. Pre-existing diabetes was identified in 31% of patients. Post-operatively, 96% of these patients had their medications reduced, while 70% of the patients had their medications discontinued. There was no mortality. Significant post-operative complications were identified in 7% of patients of which 4 required prolonged and/or repeat admissions as a consequence.

Conclusion: LSG is a proven alternative management for morbid obesity and associated co-morbidities. Our results are comparable to international standards. Resorting to surgery for morbid obesity requires careful preparation, both medically and psychologically to ensure optimal outcome in suitable candidates. Although post-operative complications can be considerable, it appears as though the benefits of LSG in the long term outweigh these risks.

ABSTRACT 86 (13W195) POSTER PRESENTATION

Title of Paper: Novel assessment of anal sphincter distensibility using EndoFLIP®

Author(s): Maha Alqudah1; Maria Whelan,Deirdre 2, McNamara 1, 2, Stephen Bligh1 , Paul Neary 2, Barry McMahon1, 5

Department(s)/Institution(s): 1Department of Clinical Medicine, Trinity College Dublin;2Department of Gastroenterology, Adelaide and Meath Hospital Dublin; 3 Department of Medical Physics and Clinical Engineering, Adelaide & Meath Hospital, Dublin.

Introduction: Faecal incontinence(FI) is the inability of the ano-rectal region to control defecation. The continenceof the ano-rectalregion is a result ofthe interplay of smooth and striated muscle of voluntary and involuntary internal and external sphincters. The underlying physiology of muscle function competence is still poorly understood and there is room for a much better understanding so that treatment can improve. The Endolumenal Functional Lumen Imaging Probe (EndoFLIP®) is a novelmeasurement devicethat canrecreate a real-time image of a sphincteric region as it is distended by a liquid-filled balloon. The diameter is measured at multiple points along the balloon and the intra-balloon pressure is also calculated.

Aims/Background: The aim of this study was to investigate the potential of using the EndoFLIP® in measuring anal sphincter function in healthy controls and faecal incontinencepatients.

Method: 20 healthy controls and 10 fecal incontinentadult subjects consented to the study. The probe was inserted anally, and the balloon was positioned precisely across the anal canal. Three ramp distensions to a volume of 40ml at a rate of 40ml/min were completed. A narrow zone formed the classic hour glass shape along the anal canal profile of volunteers from both groups.

measurements		control (n=20)	FI (n=10)	Pvalue
20ml volume	P (mmHg)	10.7±4.5	10.5±7.3	=0.13
	D (mm)	6.2±3.2	5.54±0.2	<0.01
	L (mm)	33.5±9.4	23.5±5.83	<0.01
30ml volume	P (mmHg)	22.5±8.1	16.04±7.46	<0.01
	D (mm)	5.7±0.4	6.05±1.36	<0.01
	L (mm)	19.25±5.44	14.5±3.69	<0.01
40ml volume	P (mmHg)	43.6±3.2	26.4±10.18	<0.01
	D (mm)	5.8±3.2	8.7±1.16	<0.01
	L (mm)	11.75±1.7	12.5±2.64	=0.3

Table 1

Rll to n int), and 3. Average narrow zone length (L) were calculated for continence (control) and incontinence groups (FI) throughout10, 20, 30 and 40ml balloon volumes (see table 1). The narrow zone for healthy volunteers was wider than the narrow zone for FI at low volume; however it became tighter at 30ml and 40ml volumes. Intra-balloon pressure for healthy volunteers was higher than the pressure for FI at 30ml and 40ml volumes.

Conclusion: This distensibility technique provided adistinct new way of studying the anal canal and hence may have a role in testing sphincter competence in patients with incontinence and anorectal dysfunction.

ABSTRACT 87 (13W196) POSTER PRESENTATION

Title of Paper: Determining the anal canal shape during squeeze and cough maneuvers using the EndoFLIP®

Author(s): Maha Alqudah1; Maria Whelan,Deirdre 2, McNamara 1, 2, Stephen Bligh1 , Paul Neary 2, Barry McMahon1, 5

Department(s)/Institution(s): 1Department of Clinical Medicine, Trinity College Dublin;2Department of Gastroenterology, Adelaide and Meath Hospital Dublin; 3 Department of Medical Physics and Clinical Engineering, Adelaide & Meath Hospital, Dublin.

Introduction: The Endolumenal Functional Lumen Imaging Probe (EndoFLIP®) is a novel imaging tool with the ability to measure the distensibility of sphincteric regions in the bodyusing the previously described method of impedance planimetry. In the ano-rectal region, the external anal sphincter (EAS) and the pelvic floor, together with the puborectal sling are under continuous voluntary control. These muscles can also undergo a reflex contraction when intra-abdominal pressure suddenly rises during coughing. Contraction of the puborectal sling is important in maintaining continence since it increases the ano-rectal angle, elevates the pelvic floor, and elongates the anal canal.

Aims/Background: The objective was to measure the distensibility of the anal sphincterobtain a profile of the anal canal as it changes during squeeze and cough maneuvers in healthy controlsat 20ml, 30ml and 40ml distension volumes.

Method: 20 healthy controls volunteers consented to take part in this study. The EndoFLIP®probe was inserted anally, and the balloon was positioned precisely across the anal canal. The volunteers were asked to perform two maneuvers: squeezing and coughing, at three step volumes 20ml, 30ml and 40ml.The narrow zone formed the hour glass shape that indicatedlocation at the sphincter in the anal canal for all volunteers. Three perspective measurements of distensibility were calculated for healthy volunteers for each step volume. The measurements are 1. Mean intra-balloon pressure P (P rest, P squeeze, Pcough)), 2. Average narrow zone diameter D (D rest, D squeeze, D cough)), and 3. Average narrow zone length L (L rest, L squeeze, L cough))

measurements		Rest(n=20)	squeeze(n=20)	cough(n=10)
20mL volume	P (mmHg)	11.02±7.77	24.74±8.76	51.32±18.56
	D (mm)	6.15±0.29	6.36±0.28	6.29 ±0.27
	L (mm)	34.75±6.38	42.50±5.50	43.25 ± 6.85
30ml volume	P (mmHg)	22.06±7.51	45.69±15.31	71.7±21.31
	D (mm)	5.85±0.48	5.97±0.42	5.88±0.38
	L (mm)	19.50±5.59	26.75±7.12	23±6.5
40mL volume	P (mmHg)	37.47±7.79	67.79±15.34	87.33±21.23
	D (mm)	6.08±1.43	5.84±0.39	5.52±0.43
	L (mm)	11.50±328	16.75±4.3	13.75±4.25

narrow zone during at 40mL ($p<0.001$), however no change happened on the narrow zone diameter at 20ml and 30ml. the narrow zone during squeezing and coughing was longer than the narrow zone during rest at 20ml, 30ml and 40ml volumes ($p<0.001$).

Conclusion: The new measurement of squeezing and coughing maneuvers using the EndoFLIP®device can provide new information about the changes in the anal canal profile during these maneuvers, as well as measure the changes in pressure. The results from the current study by the authors with incontinence patients can be compared with these results, possibly allowing clinicians to see the key differences between healthy control volunteers and incontinence patients

ABSTRACT 88 (13W198) POSTER PRESENTATION

Title of Paper: DIAGNOSTIC SPECTRUM OF UNINTENTIONAL (INVOLUNTARY) WEIGHT LOSS IN AN OUTPATIENT SETTING.

Author(s): Ciara Egan, Lookman Abdul, Rachel Fallon, Sharma Khan, Geraldine McCormack

Department(s)/Institute(s): Midlands Regional Hospital, Tullamore

Introduction: Involuntary weight loss is a common presenting symptom, however there are no current guidelines as to how weight loss should be investigated.

Aims/Background: The aim of this study was to examine whether involuntary weight loss is being appropriately investigated in the medical assessment unit in a regional hospital.

Method: A retrospective study was performed which examined patients who presented to the Medical Assessment Unit in Midlands Regional Hospital, Tullamore with weight loss between January 2012 and September 2013.

Results: Ninety patients were included in the study, 67% were female and 33% male. The age range of patients was 17-90 years with a mean of 60 years. The range of documented weight loss was between 0-24% (0-15kg) with a mean percentage weight loss of 8.1% body weight (5.4kg). Previous weights were available for comparison in 47%. Organic conditions resulting in or contributing to weight loss were identified in over half of all cases. Malignancy was identified in 8% of patients presenting with weight loss and 48% of patients had non-malignant organic disease. GI disease was present in 25% of all patients presenting with weight loss but only in a minority (33%) did it contribute significantly to weight loss. There was no cause found for weight loss in 32% of all cases. In 5% of patients presenting with weight loss the documented weight loss was zero. In patients found to have a significant organic cause of weight loss the cause was correctly identified in 61% at the initial AMAU assessment prior to any additional tests. The percentage of patients found to have an organic cause of weight loss who initially presented with abnormal routine blood results was 81%. Endoscopy was performed in 32% of patients, 68% of these were found to have organic disease but endoscopy led to the diagnosis in only 36%. Fifty per cent of patients were investigated with CT, of these only 53% were found to have an organic cause of weight loss and only 26% of CT scans contributed to the diagnosis. 3% of CTs and 5% of endoscopies were performed were on patients in whom the documented weight loss was zero.

Conclusion: It is acknowledged that significant weight loss is 5% or more of body weight over a 6 month period. Only 47% of the participants in our study had a previous documented weight to compare with current weight and establish actual weight loss. It is important that records are checked to avoid over investigation with invasive and expensive tests when reported weight loss can be grossly inaccurate. Many of our patients had endoscopy and CT, for which the diagnostic yield was low. We found that initial clinical

assessment was the best tool for identifying significant organic disease in our patient population.

ABSTRACT 89 (13W200) POSTER PRESENTATION

Title of Paper: Abdominal Phlegmons in Crohn's Disease patients attending UHL Gastroentrology Services

Author(s): Dr Hamid Yousuf, Dr Sumit Rana, Dr Maeve Skelly

Department(s)/Institute(s): Gastroentrology , UHL

Introduction: An abdominal phlegmon is an inflammatory mass that can develop in the setting of penetrating Crohn's disease (CD). Anti TNF agents are typically avoided in CD sepsis but paradoxically they may offer a satisfactory alternative to surgery once sepsis is settled

Aims/Background: To review the treatment experience of CD phlegmon over last 3 years in University Hospital Limerick.

Method: CT Abdomen reports under two consultant Gastroenterologists were reviewed from Jan 2010 to August 2013 .Patients with 1st diagnosis of CD phlegmon were identified .Their charts are reviewed and Demographical and clinical data was extracted

Results: 950 CT Abdomen reports were reviewed and 8 patients with CD phlegmon (4 male,4 female) are identified . Seven were smokers, one never smoked. Median age at time of CD diagnosis was 24.5(21 – 41) yrs.Median duration of CD at time of Phlegmon diagnosis was 2.5 yrs. According to Montreal classification 3 patients had ileal(L1), 2 colonic (L2) and 3 have ileocolonic (L3) disease.By definition all patients have penetrating (B3) disease. One patient was on Anti TNF and one was on 6 MP at time of Plegmon diagnosis. Of our eight patients six required Phlegmon drainage with antibiotics cover. (5 have radiological drain and one had Incisional drainage) .Mean duration of drain insertion was 3 (3 to 8) weeks. Three patients were on Anti TNF treatment at time of Phlegmon drainage with mean duration of treatment was 22 (6 to 31) months. Seven patients underwent surgical resection eventually. One had surgery within a month of Phlegmon CD without any prior medical management for CD. Currently we are managing our post surgical patients on following treatment. One is on 6MP, 1 on infliximab, one lost fup, 4patients are on Salazopyrine only. One patient is on Adalimumab started after phlegmon diagnosis recently and did not require surgery yet.

Conclusion: Our patients with CD phlegmons are young, having short duration of disease .Despite Anti TNF drugs patients with phlegmons ultimately proceeded to surgical resection. Although most of patients needed surgery but may be Anti TNF means less amount of bowel is lost.

ABSTRACT 90 (13W201) POSTER PRESENTATION

Title of Paper: Analysis of oral nutritional supplementation precribing practices

Author(s): David McMahon, Karen Boland, Frank E Murray

Department(s)/Institute(s): Department of Gastroenterology, Beaumont Hospital, Dublin 9

Introduction: Malnutrition is a major public health concern with an estimated 33 million people in Europe at moderate to high risk. Extrapolating from data published by the British Association for Parenteral and Enteral Nutrition (BAPEN), an estimated 143,000 Irish people are malnourished. Management of this condition is an ever increasing economic burden and oral nutritional supplements (ONS) are responsible for the second highest medication cost for the Health Service Executive (HSE).

Aims/Background: We aim to evaluate practices of ONS prescription at our institution, evaluating patient compliance, and targeted goal directed prescribing. In addition, we will record ONS prescribing practices in the community in a GP sample.

Method: We audited the use of ONS at Beaumont Hospital, reviewing the charts of 84 patients, and using a questionnaire to record patient attitudes to ONS. We also used a questionnaire based survey to record prescribing practices of general practitioners (GPs).

Results: 43% (n = 36) patients were prescribed ONS at the time of audit and 44.4% of these receivedddditional fortification including Calogen. 40% of patients prescribed ONS were referred to the Department of Nutrition and Dietetics during their stay. The majority of patients were elderly with a mean age of 75 years. 52.9% of patients receiving ONS had a degree of cognitive impairment. 64% of patients were largely compliant with ONS prescriptions and 16.4% rarely or never took their prescribed supplements but continued to receive them on a daily basis. Extrapolated across the hospital, this represents a significant economic burden. Our GP questionnaire showed that only 40% were aware of the presence of guidelines for ONS prescription. Only 50% questioned patients on compliance and taste. Furthermore, 100% believed that they may not identify patients at risk of malnutrition prior to development of complications of disease related malnutrition. Only 6% of those on ONS were prescribed in the community. These data suggest that malnutrition may be under-recognised in the community.

Conclusion: Increasing strain on financial resources within the HSE has led to the identification of ONS funding as a potential target for cost saving measures. While the use of food fortification and ONS is a critical step in improving malnutrition and preventing associated complications, development of cohesive guidance stressing the importance of weight based goals and targets may help to streamline ONS prescription. In turn, this may support early intervention for patients with disease related malnutrition.

ABSTRACT 91 (13W202) POSTER PRESENTATION

Title of Paper: Creation of a Colorectal Surgical Database: Planning and Development

Author(s): Gormley C, De Marchi J, Joyce WP.

Department(s)/Institute(s): The Galway Clinic; the Royal College of Surgeons in Ireland

Introduction: Surgical audits have become an essential component of modern healthcare systems. The practice of objectively assessing the activities and outcomes of surgical teams has numerous benefits, including: safer, more evidence-based and progressive surgical practices; facilitates and encourages comparative analyses between surgical teams; promotes high standards of care and highlight potential failings within a surgical department; overall, it promotes the ethos of continual assessment, high standards of clinical practice and striving toward overall improvement in patient care. Indeed, the audit is one of the main tools to ascertain whether optimal evidence-based practice is being implemented by surgical teams, as audits compare actual clinical practice with evidence-based standards of practice 1. A surgical audit comprises three key elements: the retrieval and collection of all pertinent data; the analysis of this data with regards to set clinical/performance guidelines; finally, feedback and communication of results back to

the surgical team being audited. 1,2,3 It is then the responsibility of the surgical team to rectify any discrepancies between evidence-based best practice and current clinical practice, should they exist. Indeed, it is possible to audit numerous elements of a surgical team including: auditing of structural elements such as resources and infrastructure; clinical processes, procedures, investigations and treatments; and finally outcomes, such as morbidity and mortality following various clinical interventions or treatments1. However, in certain specialities more specific and relevant data can be used to more accurately assess and audit clinical practice within that field. For example, in colorectal surgery in recent years several risk prediction scoring systems have been developed and validated to assess the risk of 30-day mortality in patients undergoing colorectal resection surgery4,5,6,7. These scoring systems facilitate and greatly enhance the auditing of surgical teams involved in the surgical management of colorectal disease. They act as internationally validated performance indicators for major colorectal surgery, and allow for outcome analysis and comparison between surgical teams, departments or hospitals. The main three scoring systems for which we collated data were: the Portsmouth-Physiological and Operative Severity Score for enUmeration of Mortality and Morbidity (P-POSSUM)8; the ColoRectal-Physiological and Operative Severity Score for enUmeration of Mortality and Morbidity (CR-POSSUM)9,10; and finally, the Association of ColoProctology of Great Britain and Ireland (ACPGBI)11. However, despite the agreed benefits of surgical audits with regards clinical practice and patient safety, a major limitation is often the requisite time needed to collect, collate and analyse the data. The nature of many modern surgical departments is one of an ever increasing workload, with limited financial and human resources with which to work. As such, it can be very difficult to find the personnel or finances to develop these crucial audits. The main goal of this study was to develop an innovative computerised database to facilitate retrospective and prospective collation of clinical practice parameters in major colorectal surgery. We ensured that it was a user-friendly system, allowing for ease of data input within busy surgical departments. Although this paper primarily deals with the establishment of the database itself, it also describes the main practical uses of said database – retrospective audit on past 317 colorectal resections, ongoing prospective data collection and future surgical audit and clinical research.

Aims/Background: The aim of this study was to establish a colorectal surgical database. The database was based on a dataset collected prospectively on 301 patients undergoing 317 major colorectal surgeries from 2004-2013. The database will include a large number of clinic

Method: The main outcome of this study was the establishment of a large colorectal database in an independent hospital, which will facilitate retrospective surgical audit on 317 major colorectal resections but also allow for prospective data accrual moving into the future.

Results: A database was established which included a plethora of demographic, physiological and operative attributes on 317 major colorectal resections. A user-friendly interface facilitates ease of input for prospective data. Secondary retrospective analysis is now to be carried out on all 317 major operations to assess and audit this colorectal surgical department, with particular emphasis on the P-POSSUM, CR-POSSUM and ACPGBI risk prediction scoring systems.

Conclusion: A fully functional colorectal database has been established in this independent multi-speciality hospital, and is currently being used for prospective data collection and retrospective surgical audit.

ABSTRACT 92 (13W203) POSTER PRESENTATION

Title of Paper: Peri-ampullary diverticulum - a rare cause of obstructive jaundice?

Author(s): N. Ullah, S. Anwar, D. Cadogan, N. Mahmud, A. Zaheer, D. O'Toole

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

Introduction: Periampullary duodenal diverticula (PAD) are found in 5-33% of patients undergoing an endoscopic retrograde cholangio-pancreatography (ERCP) and have been associated with both primary and secondary choledocholithiasis and with obstructive jaundice in the absence of lithiasis or another obstructing lesion.

Aims/Background: To determine the prevalence of PAD resulting in biliary obstruction in the absence of biliary lithaisis in patients referred to our institution for either endoscopic ultrasound (EUS) and/or ERCP.

Method: A retrospective study was performed on consecutively enrolled patient data records undergoing EUS and/or ERCP in a single institution from 2003 to June 2013. Data was analysed to determine incidence of PAD as well as eventual clinical implications.

Results: Overall, PAD was described in 473 (5.4%) of 5046 ERCPs and 3718 EUS. There were more females (n=259, 55%) than males (n=214, 45%), with a mean age of 72.8 years (range: 19-97). The findings at EUS and/or ERCP were as follow: normal biliary system in (n=11, 2.5%) patients; dilated common bile duct with no other cause (n=27, 6.0%); choledocholithiasis (n=331, 75%); biliary stricture (n=18, 4.0%); tumour (n=9, 2.0%); others (n=11, 2.5% – includes: PSC n=1, filling defect in CBD n=3, reflux of duodenal contents n=1, gallstones n=4, cholangitis n=2). ERCP failed in (n=33, 7.5%) patients. Among the 38 patients with normal biliary system and dilated CBD with no other cause - 27 had ERCP (with sphincterotomy performed in 20 patients), and 11 had EUS.

Conclusion: In 8.5% of PAD patients (with or without dilated ducts at EUS and/or ERCP), no cause of biliary obstruction was identified. Peri-ampullary diverticulum should be considered in the differential of patients presenting with biliary obstruction to avoid mismanagement.

ABSTRACT 93 (13W204) POSTER PRESENTATION

Title of Paper: Relationship between health behaviours, medical history, and perceived risk of developing colorectal cancer among screening invitees: do these vary between males and females?

Author(s): Nicholas Clarke (1), Linda Sharp(1), Nicola Shearer (2,3), Ronan Leen (2,3), Colm O'Morain (2,3), Deirdre McNamara (2,3)

Department(s)/Institute(s): (1) National Cancer Registry, Cork, Ireland, (2)Department of Gastroenterology, Adelaide and Meath Hospital, Dublin (3) Department of Clinical Medicine, Trinity College Dublin

Introduction: Several studies suggest colorectal cancer screening uptake is lower among males than females. Ireland's first population-based pilot screening programme for colorectal cancer began in 2008. (The Adelaide and Meath Hospital/Trinity College Dublin Colorectal Cancer Screening Programme (TTC-CRC-SP) has now completed two screening rounds among a target population of 10,000.

Aims/Background: Among TTC-CRC-SP invitees we investigated various aspects of participant's lives, lifestyles and health behaviours, and medical history, with a particular focus on exploring gender differences.

Method: At the beginning of the second screening round, along with the screening invitation and a faecal immunochemical kit (FIT), a sample of screening invitees received a short postal questionnaire. This included open and closed questions on socio-demographics, risk of developing CRC, family history of CRC, bowel symptoms, diet and smoking. Data was analysed in Stata using X2 tests.

Results: 1845 completed surveys were received, (42% males and 58% females). 38% were aged less than 60,; 51% aged 60-69. 40% reported having private health insurance, and 20% described themselves as smokers. There were no differences between males and females in terms of age, private health insurance and smoking status. However a higher proportion of females than males had a family history of CRC (17% v 10%: $p<0.05$) and more felt at risk of developing CRC (17% v 12%: $p<0.05$). Overall 41% reported that they had one or more of 7 possible bowel symptoms, and this proportion was higher among females than males (43% v 35%: $p<0.05$). Those who reported having bowel symptoms felt at greater risk of developing CRC (27% v 7%: $p<0.05$). While significantly fewer males reported having a balanced diet (65% v 74%: $p<0.05$), those who ate a balanced diet felt less at risk of developing CRC (76% v 68%: $p<0.05$). Significantly more participants who did not have a balanced diet reported bowel symptoms (50% v 37%%: $p<0.05$). There was no association between smoking and feeling at risk of CRC, however significantly more smokers reported bowel symptoms (40% v 46%: $p<0.05$).

Conclusion: Lifestyle, symptoms and beliefs about CRC risk were inter-related and gender differences were observed. These results indicate a need for greater understanding of the factors that influence FIT-based CRC uptake, and particularly how these differ between males and females.

ABSTRACT 94 (13W206) POSTER PRESENTATION

Title of Paper: A multicentre study of novel, unlicensed biologic use in Crohn's Disease

Author(s): O'Connor A, Keegan D, Thomson K, O'Brien L, Mulcahy H, Cullen G, Leyden J, MacMathuna P, Doherty G

Department(s)/Institute(s): Department of Gastroenterology, Mater University Hospital, Centre for Colorectal Diseases, St Vincents University Hospital

Introduction: For patients with Crohn's Disease who do not achieve remission, are intolerant of or lose response with standard biologic therapy, novel therapeutic agents such as Ustekinumab, Certolizumab, Natalizumab, Thalidomide and Tocilizumab are a useful option and have been used in several centres in Ireland on a named patient or compassionate use basis.

Aims/Background: To benchmark the use of novel, unlicensed biologics in tertiary referral IBD centres in Ireland. To gather information on the indications for, utility of , duration of use, success and tolerance of these agents.

Method: Tertiary referral centres were contacted and a designated proforma completed for patients who had received the named drugs.

Results: To date we have identified 21 patients who received Certolizumab, 10 who received ustekinumab, 2 received natalizumab and 1 each who received tocilizumab and thalidomide. 14 had pure colonic disease, 11 had ileocolonic disease, 7 had small bowel disease and 2 had perianal disease.

Conclusion: Use of unlicensed biologic treatments is growing for patients with difficult to manage Crohn's Disease. Certolizumab is the most commonly used novel, unlicensed biologic treatment for Crohn's disease in Irish hospital medicine with colonic disease the commonest indication.

ABSTRACT 95 (13W207) POSTER PRESENTATION

Title of Paper: Post-operative mortality in gastrointestinal surgery- a twelve year analysis.

Author(s): Heeney A, Hand F, Bates J, Mealy K

Department(s)/Institute(s): Wexford General Hospital

Introduction: Clinical audit is vital to measure performance, reduce clinical risk and improve quality of care. In the current era where reconfiguration of healthcare delivery is a widely debated issue, knowledge of surgical activity along with outcomes is necessary. Post-operative mortality is one of the most universal and measurable outcomes following surgery and consequently surgical death rates are increasingly used as a benchmark to measure hospital and surgeon quality.

Aims/Background: The aim of this study was to evaluate surgical activity within the spectrum of gastrointestinal procedures along with respective post-operative mortality within a general surgical department and to analyse operative trends and factors associated with oper

Method: We analysed prospectively collected data detailing all surgical admissions, gastrointestinal procedures and associated mortalities over a twelve year period (2000-2012) from a regional Irish hospital. We evaluated type of operation, patient factors and cause of death.

Results: There were a total of 8,959 operations performed across the specialities of Upper GI, Hepatobiliary and Colorectal surgery between the 1/1/2000 and 31/12/2011. Overall in-hospital post-operative mortality rate was 1.55%. Mortality rate differed significantly between elective and emergency procedures (0.55% vs 2.55%, $p<0.001$). 41% of patients that died post-operatively had surgery for underlying malignancy. The primary cause of death was sepsis (26.8%). Factors found to independently increase post-operative mortality rates were emergency surgery (0R 4.903, CI 3.105-7.741, $p<0.001$), age over 70 years (OR 3.059, 2.033-4.603, $p<0.001$) and having a major procedure carried out (OR 11.561, CI 6.505-20.545, $p<0.001$).

Conclusion: Following a detailed analysis of deaths following gastrointestinal surgery, it is unsurprising that post-operative mortality most commonly occurs following emergency surgery for high-risk, elderly patients with serious pathology. Mortality figures in this study are in line with published literature and although they alone are not an accurate representation of surgical performance, in the absence of other quality outcome measures they can be used as a surrogate marker when all confounding factors are accounted for.

ABSTRACT 96 (13W208) POSTER PRESENTATION

Title of Paper: Skin cancer in an Irish inflammatory bowel disease cohort

Author(s): Juliette Sheridan*, Julianne Clowry‡, Denise Keegan*, Kathryn Byrne*, Harry Comber¥, Sandra Deady¥, Garret Cullen*, Hugh Mulcahy*, Aoife Lally‡ And Glen Doherty*.

Department(s)/Institute(s): *Department of Gastroenterology, St. Vincent's University Hospital, Elm Park, Dublin 4, ‡ Department of Dermatology, St. Vincent's University Hospital, Elm Park, Dublin 4. ¥ National Cancer Registry Ireland, Kinsale Road, Cork.

Aims/Background: Thiopurines such as azathioprine (AZA) and 6-mercaptopurine (6-MP) and anti-tumour necrosis factor (TNF) are effective in the management of patients with inflammatory bowel disease (IBD) in whom aminosalicylates, antibiotics and corticosteroids have failed to induce or maintain remission. Long-term use of these agents has been linked to a greatly increased risk of non-melanoma skin cancer in organ transplant recipients. There is some evidence to suggest that IBD patients receiving thiopurines might be at increased risk of skin cancer. The majority of patients attending our clinic are potentially at an increased risk of skin cancer already with their "Celtic Irish skin". Our aim was to investigate the incidence of skin neoplasm in this cohort and the potential causative role of thiopurine or anti -TNF use.

Method: Data from the St. Vincent's University Hospital IBD database (n=3,000) was crosslinked to the National Cancer Registry in Ireland to enable determination of the incidence skin cancers (both melanoma and non melanoma cancers) in this patient group within the time period January 1st 1994 to October 1st 2013. We performed a retrospective study and evaluated the incidence of skin neoplasm in IBD patients treated with thiopurines or anti-TNF agents with patients not treated with these drugs. We included 2,107 patients whom were divided in groups depending on medication exposure. We also studied baseline clinical characteristics of patients in both groups (age when the disease was diagnosed, sex, type of IBD, smoking status at time of diagnosis)

Results: 2,107 patients were included in the analysis. 810 patients (38.4%) had received thiopurines (azathioprine or 6-mercaptopurine). 519 patients (24.6%) had received anti-TNF treatment (infliximab, adalimumab or certolizumab). Skin cancer was identified in 52 patients (2.5%); basal cell carcinoma (33 patients), squamous cell carcinoma (14 patients) and malignant melanoma (5 patients). A diagnosis of either non-melanoma skin cancer or malignant melanoma was not significantly associated with thiopurine or anti-TNF exposure.

Conclusion: In our experience, thiopurine therapy or anti-TNF did not significantly increase the incidence of skin neoplasm in IBD patients. However, as increased numbers of Irish IBD patients are exposed to more aggressive combination therapy incorporating thiopurine and anti-TNF treatment for longer time periods, an increased risk of skins cancers may be more apparent and advice in sun protection remains prudent in immunosuppressed patients.

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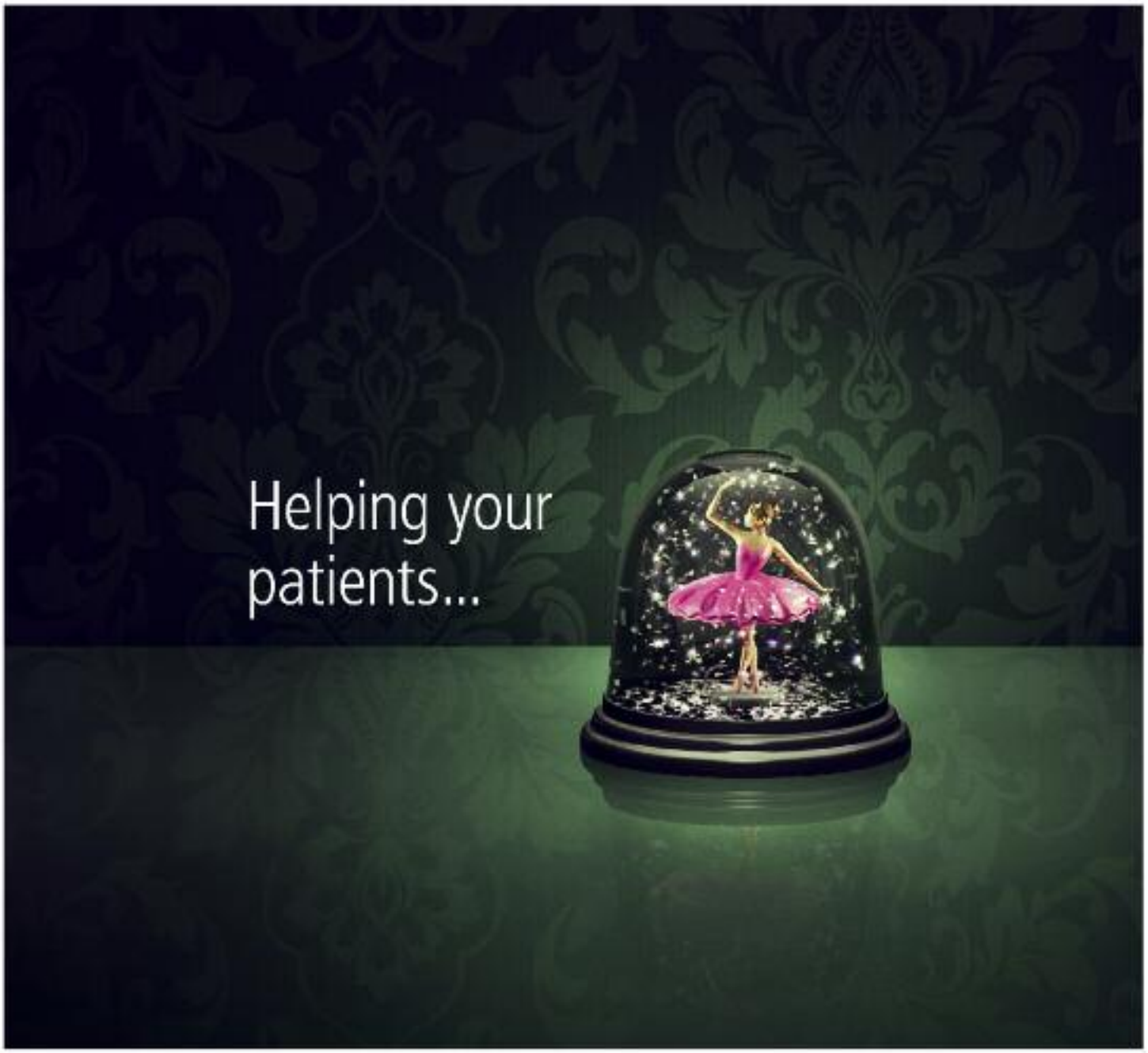

Remicade® 100mg Powder for Concentrate for Solution for Infusion (Infliximab) *Prescribing Information: Refer to full SPC and before prescribing Remicade.* **Indications:** *Rheumatoid Arthritis (RA).* Remicade, in combination with methotrexate (MTX), is indicated for the reduction of signs and symptoms, 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 for 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-MP or 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. *Maintenance infusion across adult indications:* In carefully selected adult patients who have tolerated at least 3 initial 2-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 >6 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 2 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 infusions 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. *Administration:* Remicade can be reconstituted and within 30 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 other 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 retreatment 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 given as a single dose followed by the maintenance dose recommendations. *Paediatric population, 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 infliximab 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 III/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

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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 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 tests 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. An invasive fungal infection such as aspergillosis, candidiasis, pneumocystosis, histoplasmosis, coccidioidomycosis or blastomycosis should be suspected in patients if a serious systemic illness 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. *Hepatobiliary events:* Very rare cases of jaundice and non-infectious hepatitis, some with features of autoimmune hepatitis have been observed. Isolated cases of liver failure resulting in liver transplantation or death have occurred. *Vaccinations:* 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 postmarketing 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. Melanoma 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 I/II) and discontinued in face of new or worsening symptoms of heart failure. *Others:* Patients requiring surgery whilst on Remicade therapy should be closely monitored for infections. *Haematologic reactions:* Discontinuation of Remicade therapy should be considered in patients with confirmed significant haematologic 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 symptom, depression, insomnia, vertigo, dizziness, hypoaesthesia, paraesthesia, 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 & soles), 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 III clinical studies, 18% of infliximab-treated patients compared with 5% of placebo-treated patients experienced an infusion related reaction. In post-marketing spontaneous reporting, infections are the most common 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: October 2013.

Spring Meeting 2013 (Big)

Dr Ronan Ryan speaking on Interventional radiology - HC v cholangio

Dr Mark Taylor speaking on Cystic Tumours of the pancreas

Dr Neil Patterson speaking on Hepatology Training

Dr Paul Lynch and Professor Brian Johnston

Dr Johnny Cash making a presentation of a hand painted Belfast designed plate to Prof Aidan McCormick outgoing President of ISG.

Spring Meeting 2013 (Big)

Dr Tony Tham and Dr Glen Doherty at BIG Meeting Belfast

Dr William Dickey speaking on Bowel cancer screening - the NI experience

Mr Jutsin Geoghan speaking on Bariatric Surgery

Mr Kourosh Khosraviani speaking on Gastrointestinal Surgical Training

Mr Eamon Mackle President of USG presenting Dr Helen Coleman with 1st Oral Prize

Spring Meeting 2013 (Big)

Dr Gavin Harewood

Dr Johnny Cash, Peter Cassidy AbbVie, Brenda Egan AbbVie presenting Mary Forry IBD Nurse Specialist Beaumont Hospital with AbbVie Bursary Award

Spring Meeting 2013 (Big)

Dr Neill McDougal, Prof Aiden McCormick, Peter Cassidy of Abbvie and Prof Humprey O'Connor incoming President of ISG

Prof Aiden McCormack, Peter Cassidy and Prof Humprey O'Connor with Aoife Carey accepting 2nd poster prize

Spring Meeting 2013 (Big)

Prof Aiden McCormick and Meadhbh Collison being presented with the Hepatology Award

Dr Gavin Harewood, Dr Steve Patchett & Dr Kevin Ward with Mary Forry IBD Nurse Specialist Beaumont Hospital.

Prof Colm O'Morain been presented with the lifetime achievement award by Prof Aiden McCormick and Prof Humprey O'Connor

Dr Glen Doherty speaing on Immunomodulators for how long

Prof Ian Gilmore President of BSG, speaking at the BIG meeting Belfast

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References:

1. Worthington J et al. Curr Med Res Opin 2008;24(2):481–488.
2. Bitoun A et al. Aliment Pharmacol Ther 2008;24:1331–42.
3. Ell C et al. Am J Gastroenterol 2007;102:1–11.

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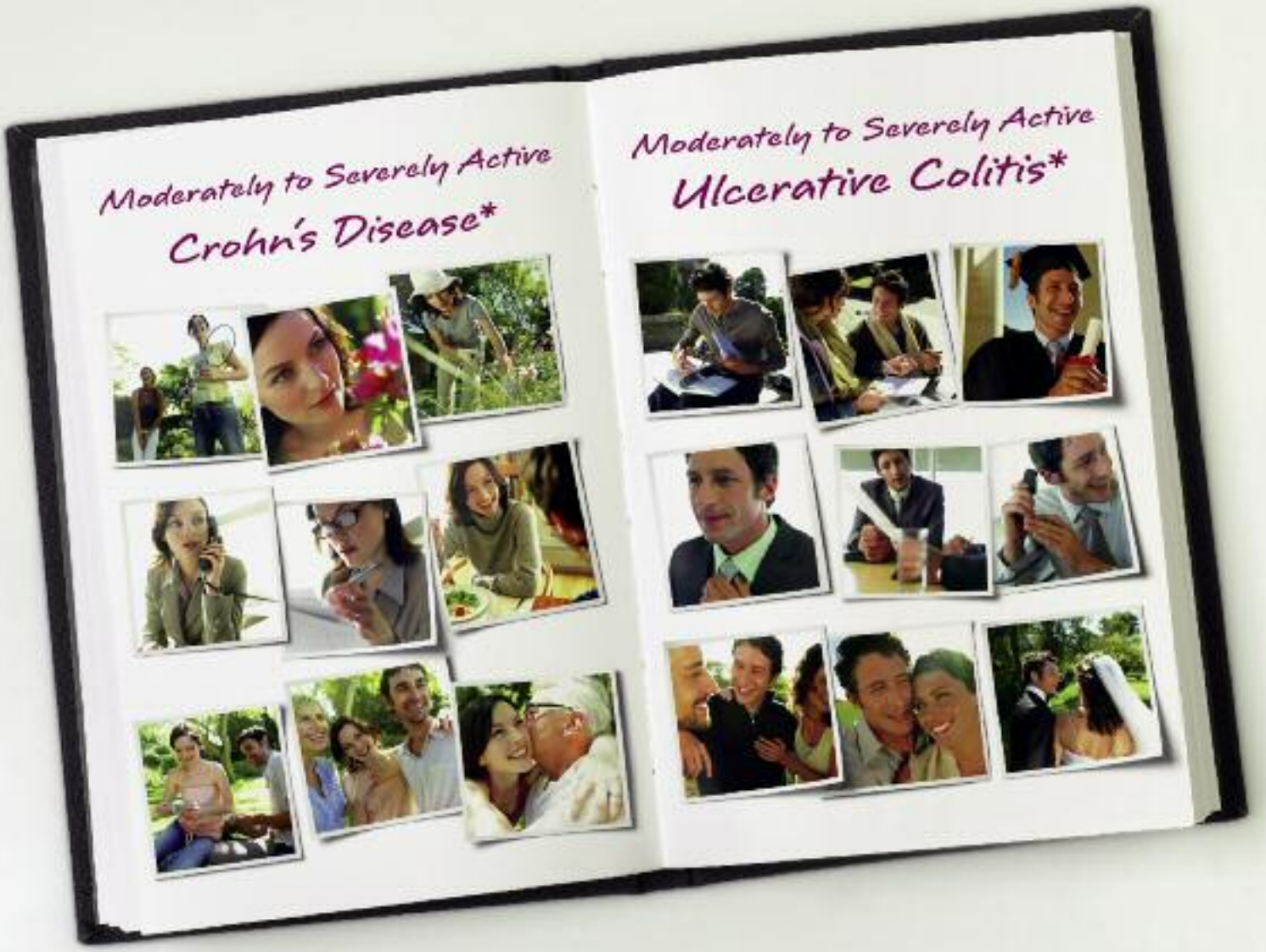
HUMIRA



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