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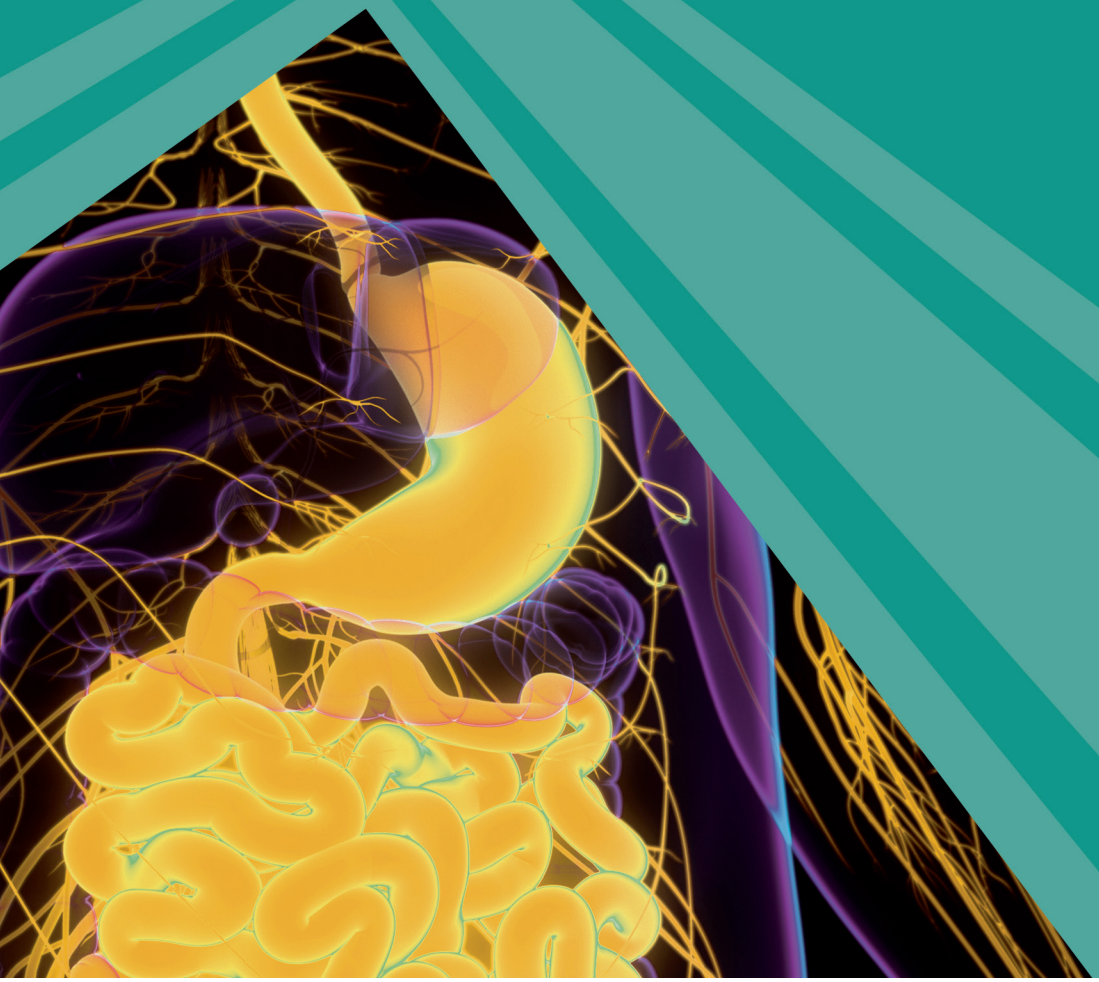
Irish Society of Gastroenterology in collaboration with the Irish Association of Coloproctology

Winter Meeting

12-13 November 2020



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Welcome Message

Dear Friends and Colleagues,

I am delighted to welcome you to our first ever virtual Irish Society of Gastroenterology meeting. We are thrilled to be jointly hosting this meeting with the Irish Association of Coloproctology, another first in our series of collaborations with other societies, nationally and internationally. Our original plan was to have such a meeting as a face to face event with the benefits that this brings in terms of networking but alas this was not to be because of COVID. Nevertheless the fact that we have come this far in bringing this program to you demonstrates the cooperation between our two societies that have the joint aim of providing excellent healthcare for our mutual patients.

We have an exciting program lined up for you that covers the breadth of gastroenterology, hepatology and coloproctology. Some of the highlights of our program are mentioned here and I am only sorry we don't have enough space to include everyone. One of the most famous gastroenterologists internationally, Doug Rex from Indiana and President elect of the American Society of Gastrointestinal Endoscopy will give us tips on resecting large colonic polyps. And on the subject of colon polyps, we will also be hearing from Kieran Sheehan (Dublin) and Robin Kennedy (St Marks). There will be two talks on colorectal cancer, ie the use of colonic stents and the rise of early onset colorectal cancer from Jo Vandervoort (Belgium) and Matt Rutter (Newcastle) respectively. Guadalupe Garcia-Tsao from Yale will be updating us on portal hypertension. Michael Wallace, editor of Gastrointestinal Endoscopy will look into the future with artificial intelligence and endoscopy. David Jones from Newcastle will tell us about what is new in primary biliary cholangitis. The new epidemic of fatty liver will be discussed by Ian Rowe (Leeds) and Helen Heneghan (Dublin). There will be a talk on pancreatitis from the inspirational Amritha Sethi (New York). Inflammatory bowel disease will be covered by Remo Pannaccionne (Calgary) and its management in pregnancy by Catherine Nelson-Piercy from London. There will also be oral abstract presentations from our up and coming young investigators. Posters will be available to view electronically.

I would like to thank our colleagues in industry who are supporting us despite these challenging times. Without their support, this meeting would not be possible to hold. I would like to thank the enormous efforts of our Chief Executive, Michael Dineen, and his team in bringing this meeting to fruition by facing one challenge after another with resolve.

Finally, thank you all for joining us and I hope you enjoy the meeting. I hope to meet up with you face to face soon whenever it is allowed.
Best wishes.

Yours sincerely,
Tony Tham
President, Irish Society of Gastroenterology
Consultant Gastroenterologist, Ulster Hospital, Belfast, N Ireland

John Burke
Honorary Clinical Senior Lecturer RCSI

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Entyvio® is indicated in adult patients with moderately to severely active ulcerative colitis (UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist.

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Entyvio® (vedolizumab) 300 mg powder for concentrate for solution for infusion
ABBREVIATED PRESCRIBING INFORMATION
Refer to the Summary of Product Characteristics (SmPC) before prescribing.
Presentation: 300 mg powder for concentrate for solution for infusion. **Indication:** Adult patients with moderately to severely active ulcerative colitis(UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist. **Dosage & Administration:** Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn's disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. Ulcerative colitis:
Recommended dose regimen 300mg administered by intravenous infusion over 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Discontinue treatment if no evidence of therapeutic benefit by week 10. If patients experience a decrease in response, they may benefit from increased dosage frequency to 300mg every 4 weeks. Corticosteroids may be reduced/discontinued in patients who respond to treatment with Entyvio. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Crohn's disease: Recommended dose regimen is 300mg administered by intravenous infusion over 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Patients who have not shown evidence of therapeutic benefit may benefit from a dose at week 10. Continue therapy every 8 weeks from week 14 in responding patients. Therapy should be discontinued if no evidence of therapeutic benefit is observed by week 14. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Paediatric populations: No data available in children aged 0-17 years. Not recommended. Elderly patients: No dosage adjustment required. Renal or hepatic impairment: Entyvio has not been studied in these populations. No dose recommendation can be given. **Contraindications:** Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, cytomegalovirus, listeriosis and opportunistic infections such as Progressive Multifocal Leukoencephalopathy (PML). **Warnings and Precautions:** Patients should be observed continuously during infusions for signs/symptoms of hypersensitivity reactions. Patients should continue to be observed for two hours following infusion completion for the first two infusions and one hour for subsequent infusions. Infusion-related reactions (IRR): Hypersensitivity reactions have been reported, the majority were of mild to moderate severity. Discontinue treatment if anaphylaxis or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IRR, slow or interrupt infusion. Consideration for pre-treatment with antihistamine, hydrocortisone and/or paracetamol should be given prior to next infusion, for patients with history of mild/moderate IRR to Entyvio. Infections: Not recommended in patients with active, severe infections until infections are controlled. Consider withholding in patients who develop severe infection while on treatment with Entyvio. Before initiating treatment, patients must be screened for TB. If latent TB is diagnosed, anti-tuberculosis appropriate treatment must be initiated prior to Entyvio treatment. Progressive Multifocal Leukoencephalopathy (PML): John Cunningham (JC) virus infection resulting in PML and death has occurred in patients treated with other integrin receptor antagonists and systemic immunosuppressive agents. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs/symptoms. Malignancy: Underlying increased risk of malignancy in UC and CD. Immunomodulatory products may increase risk. Prior and concurrent use of biological products: No clinical data available for Entyvio use in patients previously treated with natalizumab or rituximab. Patients previously exposed to natalizumab should wait at least 12 weeks prior to initiating Entyvio therapy. Entyvio not recommended for concomitant use with biologic immunosuppressants as no clinical data available. Live and oral vaccines: Patients may continue to receive non-live vaccines. Patients recommended to be up-to-date with all appropriate immunisations prior to initiating Entyvio. Live vaccines may be administered concurrently only if benefit clearly outweighs risk. **Interactions:** No interaction studies performed. Concomitant administration of corticosteroids, immunomodulators (azathioprine, 6-mercaptopurine, and methotrexate) and aminosalicylates did not have a clinically meaningful effect on Entyvio pharmacokinetics. **Fertility, pregnancy and lactation:** Women of child-bearing potential should use adequate contraception and continue for at least 18 weeks after last Entyvio treatment. Preferable to avoid use of Entyvio during pregnancy unless benefits clearly outweigh potential risk to both the mother and foetus. Entyvio has been detected in human milk. The effect on infants is unknown. Use of Entyvio in lactating women should consider the benefit of therapy against potential risks to the infant. **Undesirable Effects:** Very Common (≥1/10): nasopharyngitis, headache, arthralgia. Common (≥1/100, <1/10): bronchitis, gastroenteritis, upper respiratory tract infection, influenza, sinusitis, pharyngitis, paraesthesia, hypertension, oropharyngeal pain, nasal congestion, cough, anal abscess, anal fissure, nausea, dyspepsia, constipation, abdominal distension, flatulence, haemorrhoids, rash, pruritus, eczema, erythema, night sweats, acne, muscle spasm, back pain, muscular weakness, fatigue, pain in extremities, pyrexia. Other serious undesirable effects: respiratory tract infection, pneumonia, anaphylactic reaction, anaphylactic shock. **Refer to the SmPC for details on full side effect profile and interactions. UK Basic NHS Price:** £2,050 for one vial (300mg powder for concentrate for solution for infusion). **Legal Classification:** POM. **Marketing Authorisation:** EU/1/14/923/001 Additional information is available on request from: Takeda UK Ltd. Building 3, Glory Park, Glory Park Avenue, Wooburn Green, Buckinghamshire, HP10 0DF. Tel: 01628 537900 Fax: 01628 526617. Takeda Products Ireland Ltd. 3013 Lake Drive, Citywest Business Campus, Dublin 24. Tel: +353 (0)1 642 0021 Fax: +353 (0)1 642 0020. **PI Approval Code:** UK/EYV/1712/0182(3) **Date of revision:** March 2019

UK: Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Takeda UK Ltd. Tel- 01628-537900

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

C-APROM/UKI/ENTY/0001 October 2020

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Irish Society of Gastroenterology Winter Meeting
in collaboration with the Irish Association of Coloproctology
12 & 13 November 2020

Virtual Meeting

Thursday 12 November

15.00 **Oral Free Papers 1- 3**

15.24 **Industry Promotional Video**

15.30 ***"Managing Portal Hypertension"***
Dr Guadulupe Garcia-Tsao
Yale School of Medicine, USA.

15.55 ***"Artificial Intelligence in Endoscopy"***
Prof Michael B Wallace
Mayo Clinic, Florida, USA

16.20 ***"Primary Biliary Cholangitis"***
Prof David Jones
Professer of Liver Immunology
Newcastle, UK

16.45 **Liver Session**
"Epidemic of NAFLD & its impact today"
Dr Ian Rowe
Consultant Hepatologist
St James Hospital Leeds
&
Prof Helen Heneghan
Bariatric Surgeon
St Vincent's University Hospital. Dublin

17.25 **Industry Promotional Video**

17.30 ***"The Rise of Early Onset Colorectal Cancer"***
Prof Matt Rutter
North Tees & Hartlepool NHS Trust, UK.

Friday 13 November

13.30 **Industry Promotional Video**

13.36 **Oral Free Papers 4 - 6**

14.00 ***"Endoscopy in Pancreatitis"***
Prof Amrita Sethi
Director of Pancreaticobiliary
Columbia University, Medical Centre – NYPH

14.25 **IBD Session**
"Deep Remission in Crohn's"
Prof Remo Panaccionne
Director IBD Clinic,
University of Calgary, Western Ontario, Canada

14.50 ***"Managing the Pregnant Patient with IBD"***
Prof Catherine Nelson-Piercy
Imperial College, London

15.50 **Industry Promotional Video**

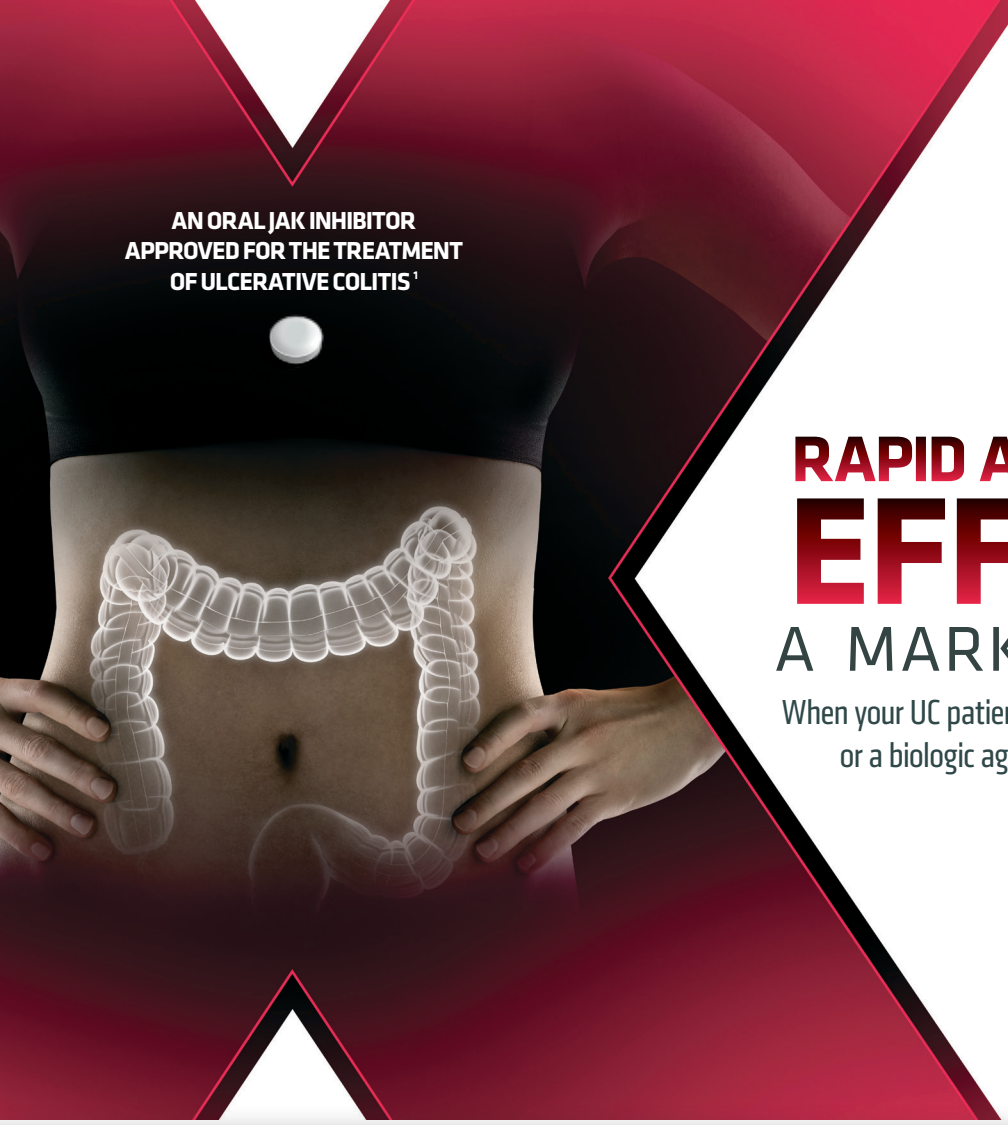
15.55 ***"Colonic Stentsobstructing Colorectal Cancer"***
Dr Jo Vandervoort
Chief of Gastro
Onze Lieve Vrouwziekenhuis Hospital, Belgium

16.20 **Plenary Session for IACP Symposium:**
"Challenging Colorectal Polyps"

"Endoscopic resection of large colorectal polyps"
Prof Doug Rex
Consultant Gastroenterologist,
University Hospital, Indiana, USA.

"Challenges to Pathology in the new era of Endoscopy/screening"
Prof Kieran Sheahan
Consultant Histopathologist. SVUH

"Surgical perspective"
Prof Robin Kennedy
Consultant Surgeon
St Marks Hospital, London



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Sustained steroid-free remission as well as mucosal healing†[1,3]
A well characterised safety profile in UC[1,4]

XELJANZ*▼ (tofacitinib) Prescribing Information:
Please refer to the Summary of Product Characteristics (SmPC) before prescribing XELJANZ 5 mg or 10 mg film-coated tablets or XELJANZ 11 mg prolonged release tablets. **Presentation:** Film-coated tablet containing tofacitinib citrate, equivalent to 5 mg or 10 mg tofacitinib. Prolonged-release tablets containing tofacitinib citrate, equivalent to 11 mg tofacitinib. **Indications: All presentations:** In combination with methotrexate (MTX) for the treatment of moderate to severe active rheumatoid arthritis (RA) in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying antirheumatic drugs. Can be given as monotherapy in case of intolerance to MTX or when treatment with MTX is inappropriate. **5 and 10 mg film coated tablets:** In combination with MTX for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior disease modifying antirheumatic drug (DMARD) therapy. For the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic agent. **Dosage:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of the condition for which tofacitinib is indicated. Tofacitinib is given with or without food. **RA:** The recommended dose is 5 mg orally twice daily or 11 mg once daily which should not be exceeded. Patients treated with tofacitinib 5 mg film coated tablets twice daily may be switched to tofacitinib 11 mg prolonged release tablets once daily on the day following the last dose of tofacitinib 5 mg film coated tablets. Patients treated with tofacitinib 11 mg prolonged-release tablets once daily may be switched to tofacitinib 5 mg film coated tablets twice daily on the day following the last dose of tofacitinib 11 mg prolonged-release tablets. **PsA:** The recommended dose is 5 mg administered twice daily, which should not be exceeded. **UC:** The recommended dose is 10 mg given orally twice daily for induction for 8 weeks. For patients who do not achieve adequate therapeutic benefit by week 8, the induction dose of 10 mg twice daily can be extended for an additional 8 weeks (16 weeks total), followed by 5 mg twice daily for maintenance. Tofacitinib induction therapy should be discontinued in any patient who shows no evidence of therapeutic benefit by week 16. The recommended dose for maintenance treatment is tofacitinib 5mg given orally twice daily. Tofacitinib 10 mg twice daily for maintenance treatment is not recommended in patients with UC who have known venous thromboembolism (VTE) risk factors, unless there is no suitable alternative treatment available. For patients with UC who are not at increased risk for VTE, tofacitinib 10 mg orally twice daily may be considered if the patient experiences a decrease in response on tofacitinib 5 mg twice daily and failed to respond to alternative treatment options for ulcerative colitis such as tumour necrosis factor inhibitor (TNF inhibitor) treatment. Tofacitinib 10 mg twice daily for maintenance treatment should be used for the shortest duration possible. The lowest effective dose needed to maintain response should be used. *Dose interruption:* Tofacitinib treatment should be interrupted if a patient develops a serious infection until the infection is controlled. Interruption of dosing may be needed for management of dose-related laboratory abnormalities including lymphopenia, neutropenia, and anaemia. It is recommended not to initiate dosing in patients with an absolute lymphocyte count (ALC) less than 0.75 x 10^9/l, an absolute neutrophil count (ANC) less than 1x10^9 /l or in patients with haemoglobin less than 9 g/dL. *Renal impairment:* No dose adjustment is required in patients with mild or moderate renal impairment. Patients with severe renal impairment the dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal renal function is 5 mg twice daily or 11 mg prolonged release tablet once daily. Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal renal function is 10 mg twice daily. Patients with severe renal impairment should remain on a reduced dose even after haemodialysis. *Hepatic impairment:* No dose adjustment is required in patients with mild hepatic impairment. Patients with moderate hepatic impairment dose should be reduced to 5 mg once daily when the indicated dose in the presence of normal hepatic function is 5 mg twice daily or 11 mg prolonged release tablet once daily. Dose should be reduced to 5 mg twice daily when the indicated dose in the presence of normal hepatic function is 10 mg twice daily. Tofacitinib should not be used in patients with severe hepatic impairment. *Elderly:* No dose adjustment is required in patients aged 65 years and older. Use with caution as increased risk and severity of adverse events. In patients over 65 years of age tofacitinib should only be considered if no suitable alternative treatment is available. *Drug-drug Interactions:* Tofacitinib total daily dose should be reduced by half in patients receiving potent inhibitors of cytochrome (CYP) P450 3A4 (e.g., ketoconazole) and in patients receiving 1 or more concomitant medicinal products that result in both moderate inhibition of CYP3A4 as well as potent inhibition of CYP2C19 (e.g., fluconazole). Coadministration of XELJANZ with potent CYP inducers (e.g., rifampicin) may result in a loss of or reduced clinical response. Coadministration of potent inducers of CYP3A4 with XELJANZ is not recommended. **Contraindications:** Hypersensitivity to any of the ingredients, active tuberculosis (TB), serious infections such as sepsis, or opportunistic infections, severe hepatic impairment, pregnancy and lactation. **Warnings and Precautions:** Patients treated with tofacitinib should be given a patient alert card. There was a higher incidence of adverse events for the combination of tofacitinib with MTX versus tofacitinib as monotherapy in RA clinical studies. Tofacitinib should be avoided in combination with biologics and potent immunosuppressants such as azathioprine, 6-mercaptopurine, ciclosporine and tacrolimus. *Venous thromboembolism (VTE):* Serious VTE events including pulmonary embolism (PE), some of which were fatal, and deep vein thrombosis (DVT), have been observed in patients taking tofacitinib. Tofacitnib should be used with caution in patients with known risk factors for VTE, regardless of indication and dosage. Tofacitinib 10 mg twice daily for maintenance treatment is not recommended in patients with UC who have known VTE risk factors, unless there is no suitable alternative treatment available. Promptly evaluate patients with signs and symptoms of VTE and discontinue tofacitinib in patients with suspected VTE, regardless of dose or indication. *Infections:* Serious and sometimes fatal infections have been reported in patients administered tofacitinib. Rheumatoid arthritis patients taking corticosteroids may be predisposed to infection. Patients should be closely monitored for infections, with prompt diagnosis and treatment. Treatment should be interrupted if a serious infection develops. As there is a higher incidence of infections in the elderly and in the diabetic populations in general, caution should be used when treating the elderly and patients with diabetes. *Tuberculosis:* Patients should be evaluated for both active and latent TB prior to being treated with tofacitinib, patients who test positive for latent TB should be treated with standard antimycobacterial therapy before administering tofacitinib. *Viral Reactivation:* In clinical studies viral reactivation and cases of herpes zoster have been observed. Screening for viral hepatitis should be performed in accordance with clinical guidelines prior to starting therapy with tofacitinib. The impact on chronic viral hepatitis is not known. *Vaccinations:* Prior to initiating tofacitinib, it is recommended that all patients be brought up to date with all immunisations in agreement with current immunisation guidelines. Live vaccines should not be given concurrently with tofacitinib. *Malignancy:* Lymphomas and other malignancies have been observed in patients treated with tofacitinib. Patients with highly active disease may be at higher risk than the general population. The effect of tofacitinib on the development and course of malignancies is not known. NMSCs have been reported, the risk of NMSC may be higher in patients treated with tofacitinib 10 mg twice daily than in patients treated with 5 mg twice daily. Periodic skin examination is recommended in patients at increased risk. *Interstitial lung disease:* Caution is recommended in patients with a history of chronic lung disease as they may be more prone to infection. Asian patients are known to be at higher risk of ILD, caution should be exercised with these patients. *Gastrointestinal perforations:* Tofacitinib should be used with caution in patients who may be at increased risk e.g. diverticulitis or concomitant use of corticosteroids or NSAIDs. *Cardiovascular risk:* Risk factors should be managed as part of usual standard of care. *Hypersensitivity:* Cases of drug hypersensitivity associated with tofacitinib administration have been reported. Allergic reactions included angioedema and urticaria; serious reactions have occurred. If any serious allergic or anaphylactic reaction occurs, tofacitinib should be discontinued immediately. *Laboratory Parameters:* Increased incidence of lymphopenia and neutropenia have been reported and decreases in haemoglobin and should be monitored in accordance with the SmPC. Monitor ANC and haemoglobin at baseline, 4-8 weeks and 3 monthly, ALC at baseline and 3 monthly. Tofacitinib has been associated with increases in lipid parameters, maximal effects are observed at 6 weeks. Monitoring should be performed 8 weeks after initiation and managed according to hyperlipidemia guidelines. Increases in liver enzymes greater than 3x ULN were uncommonly reported, use caution when initiating with potential hepatotoxic medicinal products. *Gastrointestinal obstruction with a non-deformable prolonged-release formulation:* Caution should be used when administering tofacitinib 11 mg prolonged release tablets to patients with pre-existing severe gastrointestinal narrowing (pathologic or iatrogenic). **Pregnancy & Lactation:** Use of tofacitinib during pregnancy and breast-feeding is contraindicated. **Side Effects:** *RA:* The most common serious adverse reactions were serious infections; pneumonia, cellulitis, herpes zoster, UTIs, diverticulitis, appendicitis and opportunistic infections. The most commonly reported adverse reactions during the first 3 months in controlled clinical trials were headache, upper respiratory tract infections, nasopharyngitis, diarrhoea, nausea and hypertension. *UC:* The most commonly reported adverse reactions in patients receiving tofacitinib 10 mg twice daily in the induction studies were headache, nasopharyngitis, nausea, and arthralgia. Commonly reported adverse reactions (≥1/100 to <1/10), were pneumonia, influenza, herpes zoster, urinary tract infection, sinusitis, bronchitis, nasopharyngitis, pharyngitis, anaemia, headache, hypertension, cough, abdominal pain, vomiting, diarrhoea, nausea, gastritis, dyspepsia, rash, arthralgia, pyrexia, oedema peripheral, fatigue, blood creatine phosphokinase increased. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** 51A. **Marketing Authorisation Number:** EU/1/17/1178/003 – 5 mg (56 film-coated tablets); EU/1/17/1178/007 – 10 mg (56 film-coated tablets); EU/1/17/1178/012 – 11 mg (28 prolonged-release tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. **For further information on this medicine please contact:** Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. **For queries regarding product availability please contact:** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 467 6500.

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

Last revised: 06/2020.
Ref: XJ 9_0.

* XELJANZ is indicated for patients with moderately to severely active UC who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic agent.
** The recommended dose of XELJANZ is 10 mg given orally twice daily for induction, followed by 5 mg twice daily for maintenance. Please refer to the Summary of Product Characteristics for full dosing information.
‡ In a post-hoc analysis of data from phase 3 trials of induction therapy with tofacitinib in patients with UC.
† Sustained steroid-free remission: remission and using no corticosteroids for at least 4 weeks prior to the visit at both Week 24 and Week 52. Improvement of endoscopic appearance of the mucosa (mucosal healing) was defined as a Mayo endoscopic subscore of ≤1 at Week 8 for induction and Week 52 for maintenance.

References:
1. XELJANZ Summary of Product Characteristics. **2.** Hanauer et al. Clinical Gastroenterology and Hepatology 2019;17:139–147. **3.** Sandborn WJ et al. N Engl J Med 2017; 376(18): 1723–1736. **4.** Sandborn WJ et al. Clinical Gastroenterology and Hepatology 2019;17(8):1541-1550.

PP-XEL-IRL-0564 | Date of preparation: October 2020

Biographical Sketches

Dr Guadulupe Garcia-Tsao
Yale School of Medicine. USA.

Guadalupe Garcia-Tsao is Professor of Medicine at Yale School of Medicine (Digestive Diseases), the Chief of the Section of Digestive Diseases at the Veterans Administration Connecticut Healthcare System and Director of the Clinical Core of the Yale Liver Center.
Dr. Garcia-Tsao is a leading expert on cirrhosis, portal hypertension and related complications. Her research has been mainly patient-oriented research and she has authored over 150 PubMed-verified original research publications that have been cited over 35,000 times, with an H-index of 86 (Google Scholar, August 2020).
Dr. Garcia-Tsao served as the President of the American Association for the Study of Liver Diseases in 2012 and is currently Associate Editor for the New England Journal of Medicine. She has received numerous awards including the International Recognition Award (European Association for the Study of the Liver) and the Distinguished Clinician Educator and Mentor Award (American Association for the Study of Liver Diseases).

Prof Michael B Wallace
Mayo Clinic, Florida, USA

Dr. Wallace is the Fred C. Andersen Professor of Medicine and Director of Digestive Disease Research at Mayo Clinic in Jacksonville Florida. He also is the current Editor in Chief of Gastrointestinal Endoscopy and former associate editor of Gastroenterology.
He received his medical degree from Duke University School of Medicine in 1992. He completed a residency program in Internal Medicine in 1995 and a fellowship in Gastroenterology and Hepatology in 1998 at the Brigham and Women's Hospital in Boston, Massachusetts and a Master's in Public Health with a focus on clinical research at the Harvard School of Public Health.
Dr. Wallace completed an advanced endoscopy fellowship in Endoscopic Ultrasound (EUS) and Therapeutic Endoscopic Retrograde Cholangiopancreatography (ERCP) in 1999 at the Medical University of South Carolina.
He joined the Mayo Clinic and was promoted to professor in 2007, and to Chair of the Division in 2010. Dr. Wallace served multiple roles for the AGA, ASGE and ACG including Associate Editor for Gastroenterology 2006-09. Since 2015, he has been Editor in Chief of Gastrointestinal Endoscopy. From 2021, he will serve as Chief of Gastroenterology at Sheikh Shakhbout Medical City/Mayo Clinic Abu Dhabi.
Dr. Wallace's research focuses on advanced endoscopic imaging and therapies for gastrointestinal neoplasia. He holds multiple active NIH grants in advanced imaging of early neoplasia.
Dr. Wallace has published more than 350 peer reviewed manuscripts and more than 300 abstracts, books, book chapters, review articles and editorials. He has mentored more than 30 gastroenterology and research fellows and received the national "mentor of the year" award from both the ASGE and AGA.

Prof David Jones
Professer of Liver Immunology
Newcastle, UK

Liver Disease Theme Lead and Dean NIHR Academy, Professor Jones leads the Liver Disease research theme. He is also Professor of Liver Immunology for the Faculty of Medical Science at Newcastle University. Additionally, he is Honorary Consultant Hepatlogist with the Newcastle upon Tyne Hospitals NHS Foundation Trust. Dave also holds the position of NIHR Dean for Faculty Trainees, and is an NIHR Senior Investigator.
Dave has an international reputation for his work in autoimmune liver disease and leads the UK-PBC research consortium (MRC Stratified Medicine), which has the largest cohort of fully phenotyped primary biliary cholangitis/ cirrhosis (PBC) patients. His areas of expertise are stratified therapeutics and symptom management.
Roles
Professor of Liver Immunology, Newcastle University; Honorary Consultant Hepatlogist, Newcastle Hospitals NHS Foundation Trust; Dean for NIHR Faculty Trainees

Dr Ian Rowe
Consultant Hepatologist
St James Hospital Leeds

Dr Ian Rowe trained at the University of Glasgow and, following general medical training at Queens Medical Centre in Nottingham, specialised in Gastroenterology and Hepatology in Birmingham. He was awarded a Medical Research Council Research Training Fellowship in 2009 and subsequently an NIHR Clinical Lectureship at the University of Birmingham and the Liver and Hepatobiliary Unit at the Queen Elizabeth Hospital Birmingham. In 2015 he was appointed as a University Academic Fellow at the University of Leeds and Honorary Consultant at the Leeds Liver Unit. His main research interests are in improving the outcomes of patients with liver disease and those following liver transplantation. His clinical practice is in hepatocellular carcinoma and liver transplantation.

Prof Helen Heneghan
Bariatric Surgeon
St Vincent's University Hospital. Dublin

Ms Helen Heneghan is a Consultant Bariatric Surgeon at St. Vincent's University Hospital, Dublin. She is a graduate of NUI Galway, and completed basic surgical training in Galway University Hospital. In 2012 she was awarded a PhD in the molecular expression of breast cancer and obesity from NUI Galway. She then completed the RCSI Higher Surgical Training scheme in General Surgery in 2016. During her training, she spent two years in the Bariatric Metabolic Institute in Cleveland Clinic, Ohio. She then completed her training with a Bariatric Fellowship in the UK (Chester, Liverpool).
She has co-authored 60 publications in peer-reviewed journals and has written 5 book chapters on the topics of bariatric and endocrine surgery.
Specialit: Bariatric Surgery
Subspeciality Expertise: Bariatric Surgery, Gastrointestinal Malignancies, General Surgery

Prof Matt Rutter
North Tees & Hartlepool NHS Trust, UK.

Matt Rutter is Professor of Gastroenterology at Newcastle University and the University Hospital of North Tees. He specialises in advanced diagnostic colonoscopy, polypectomy and IBD. He sits on the BSG Endoscopy Research committee and BCSP Advisory committee. He is founder and ex-chair the ESGE Quality Improvement in Endoscopy committee and chairs the BCSP Research committee, JAG National Endoscopy Database committee and World Endoscopy Organisation interval cancer subcommittee.
He has published and lectured worldwide on quality in endoscopy, screening and colonoscopic surveillance, receiving the BSG Hopkins Endoscopy Prize in 2006 and 2020 and the RCP Goulstonian Lectureship in 2008. He co-authored BSG (2010), NICE (2011), European (ECCO, 2012) and SCENIC (USA, 2015) colitis surveillance guidelines, was the lead author for the BSG/ACPGBI management of large non-pedunculated colorectal polyps guidelines (2015), and lead author for the BSG/ACPGBI/PHE post-polypectomy surveillance guidelines (2020).
He is regional screening lead for QA in colonoscopy, GI research lead for North East & North Cumbria LCRN and is one of the core faculty for the Northern Region Endoscopy Training Centre.

Prof Amrita Sethi
Director of Pancreaticobiliary
Columbia University,
Medical Centre – NYPH

Amrita Sethi is an Associate Professor of Medicine at Columbia University Medical Center in New York and is the Director of Interventional Endoscopy and the Advanced Endoscopy Fellowship Program Director. She completed her GI fellowship at Medical College of Virginia, and then her Advanced Endoscopy Fellowship at University of Colorado. She has been an attending advanced endoscopist at Columbia since 2008. Her practice interests include ERCP and cholangioscopy, therapeutic EUS, ESD, POEM and other areas of third space endoscopy and endoscopic innovation.
In addition to her work with the national GI societies, such as the ASGE, AGA and ACG, she is the founder and president of Women in Endoscopy (WIE), a global organization started to foster mentorship and promote leadership for women in interventional endoscopy. She is also the current President of the NYSGE. This past year, she received the ASGE's Master Endoscopist Award which recognizes her accomplishments and contributions to the endoscopic community.

Prof Remo Panaccionne
Director IBD Clinic,
University of Calgary,
Western Ontario, Canada

Dr. Panaccione is currently the Dean of Admissions and Professor of Medicine at the Cumming School of Medicine where he also acts as the Director of the Inflammatory Bowel Disease Clinic and Gastroenterology Research at the University of Calgary.
Dr. Panaccione graduated from the University of Western Ontario (London, Ontario) with a degree in Medicine in 1993. He went on to complete his Internal Medicine and Gastroenterology training at the University of Western Ontario before completing advanced training in Inflammatory Bowel Disease at the Mayo Clinic in Rochester, Minnesota.
He joined the faculty of Medicine at the University of Calgary in 1999. He is an internationally recognized expert in inflammatory bowel disease. He has lectured nationally and internationally on various topics in inflammatory bowel disease and has delivered over 200 lectures in the last five years.

Prof Catherine Nelson-Piercy
Imperial College, London

Catherine Nelson-Piercy trained as a physician, specialising in obstetric medicine. She specialises in the care of women with medical problems in pregnancy. She offers pre-pregnancy counselling for women with pre-existing medical problems and those with problems in previous pregnancies. Catherine runs special joint clinics for women with renal disease, cardiac and rheumatic disorders, hypertension and epilepsy in pregnancy.
She is the immediate past president of the International Society of Obstetric Medicine, editor in chief of the journal 'Obstetric Medicine: the medicine of pregnancy' and has over 200 publications. She has been one of the central assessors for the confidential enquiry into maternal deaths in the UK since 2005 and is a trustee for the charity APEC- Action on Pre-eclampsia.

Dr Jo Vandervoort
Chief of Gastro
Onze Lieve Vrouwziekenhuis Hospital, Belgium

Dr Jo Vandervoort graduated from the Catholic University of Leuven (KUL), Belgium as a gastroenterologist in 1995.
While training for 2 years he entered an international fellowship in Advanced Therapeutic Endoscopy with David Carr-Locke as his mentor at the Harvard Medical School affiliated with Brigham and Women's Hospital in Boston, USA. During this period his close colleague was Dr Tony Tham, President ISG.
His first appointment was in 1998 in the Onze-Lieve-Vrouw Hospital in Aalst, Belgium, with specific expertise in endoscopic hepatobiliairy therapy and the use of SEMS in the entire GI-system.
In 2013, he became the Chief of the departement of Gastroenterology - Endoscopy & GI-oncology.
In 2014 he participated in the formulation of the ESGE-guidelines on the use of SEMS in obstructive colon cancer, as well as the update on these guidelines in 2020.

Prof Doug Rex
Consultant Gastroenterologist,
University Hospital, Indiana. USA.

Douglas K. Rex, M.D. is a Distinguished Professor Emeritus at Indiana University School of Medicine and a full-time clinical gastroenterologist at Indiana University Hospitals. He is a past President of the American College of Gastroenterology and the current President-elect of the American Society for Gastrointestinal Endoscopy.

Prof Kieran Sheahan
Consultant Histopathologist. SVUH

Professor Kieran Sheahan: MB, BCh, BAO. ,B.Sc. ,FRCPI , FFPath , FCAP , FFRCPath is a Consultant Histopathologist at St. Vincent's University Hospital (SVUH), Dublin & is Clinical Professor at University College Dublin School of Medicine. He trained at the Mallory Institute of Pathology, Boston, where he is also Adjuvant Professor of Pathology at Boston University Medical School. He is also a Director of the Centre for Colorectal Disease, SVUH. He is the Chair of the Histopathology steering committee for the Irish National 'BowelScreen' programme & is on the Working Committee of the National Histopathology Quality Improvement Programme of the Faculty of Pathology. He was the founding Treasurer & former President of the Irish Society of Surgical Pathology (ISSP). He is currently on the Board of the International Collaboration on Cancer Reporting (ICCR). His research interests include prognostic & predictive markers in colorectal cancer, familial gastrointestinal cancer, & application of immunohistochemical & molecular genetic techniques in pathology. He has numerous collaborations internationally. He is author of numerous original publications in peer-reviewed biomedical journals, & reviews & book chapters. He is co-editor of the upcoming Morson & Dawson's Gastrointestinal Pathology (6th edition)

Prof Robin Kennedy
Consultant Surgeon
St Marks Hospital, London

Robin Kennedy worked as a consultant surgeon in Somerset UK, then St Mark's Hospital, London. The work involved developing and testing new approaches in bowel surgery. He designed and helped set up the English National Programme for training consultants in laparoscopic colorectal surgery and helped set up the National Programme in Enhanced Recovery Care. He retired from full-time practice in January 2017, but continued to teach Danish consultant surgeons laparoscopic complete mesocolic excision. Currently, Robin chairs The Griffin Institute in northwest London, a biotechnology research and surgical training centre. He is also involved in the design of novel surgical equipment. The post of Visiting Professor in the Department of Surgery and Cancer, Imperial College London, was awarded in 2017.

ISG Board Members

Dr Tony C.K. Tham
President ISG
Consultant Gastroenterologist
Ulster Hospital, Dundonald, Belfast

Dr Tham qualified from the Queen's University of Belfast's medical school. He trained as a gastroenterologist and physician in the Northern Ireland training program. He completed his training as an Advanced Gastroenterology Fellow in the Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA.
He is a Consultant Physician and Gastroenterologist in the Ulster Hospital, Dundonald, Belfast. He is the President the Irish Society of Gastroenterology. He is the chair of Ireland's National Clinical Program for Gastroenterology and Hepatology Clinical Advisory Group. He was the Chair of the British Society of Gastroenterology Clinical Services and Standards Committee and formerly the Society's quality improvement and guidelines lead.
He has more than 80 publications in peer reviewed journals. He is the first author of a book entitled "Gastrointestinal Emergencies" which has been published as a 3rd edition and translated into Polish and Chinese. He has contributed to several other book chapters. He has been co-author of guidelines on ERCP, lower gastrointestinal bleeding, Barretts oesophagus, perianal Crohns, non medical endoscopy workforce and UK gastroenterology services. He was the Guidelines Editor for Gut. He is on the International Editorial Board of the journal Gastrointestinal Endoscopy; Associate Editor of the World Journal of Gastrointestinal Endoscopy; Diagnostic and Therapeutic Endoscopy. He has received several awards for being a top reviewer for Gastrointestinal Endoscopy.
He was the Head of the School of Medicine, Northern Ireland Medical and Dental Training Agency (deanery). He is the Vice Chair of the Specialist Advisory Committee for general internal medicine at the Joint Royal Colleges of Physicians Training Board and Training Program Director in General Internal Medicine in Northern Ireland. He is an examiner for the Royal College of Physicians of Edinburgh and also Queen's University.
He has led service improvements for patients in Northern Ireland including those with gastrointestinal consequences in pelvic radiation disease, and inflammatory bowel disease.

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

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

Dr Manus Moloney
Hon Treasurer ISG,
Consultant Gastroenterologist
University of Limerick Hospital

Dr Manus Moloney graduated in 1987 from Trinity College Dublin, trained in gastroenterology at the Mater and St James Hospital Dublin before moving to the Liver unit at King's College Hospital in London, training in hepatology and completing an MD thesis on Immunogenetics of Primary Sclerosing Cholangitis. Completed training at Ashford Hospital in Kent and Guy's Hospital. Dr Moloney returned to Ireland in 2000 to take up a Consultant post at Nenagh Hospital and Limerick Regional Hospital, now the University of Limerick Hospital Group. Dr Moloney is currently serving as endoscopy lead for the group, main interests include management of Inflammatory Bowel Disease and interventional endoscopy.

Dr Patrick Allen
Consultant Gastroenterologist
South East Trust

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

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

Glen grew up in Northern Ireland and graduated in Medicine at Trinity College Dublin in 1998. He was awarded his PhD by NUI in 2006 and completed his gastroenterology training in Ireland followed by an advanced IBD fellowship at Beth Israel Deaconess Medical Center and Harvard Medical School, Boston. Since 2010 he has worked as a consultant gastroenterologist at St Vincent's University Hospital in Dublin and as a senior clinical lecturer in the School of Medicine and Medical Science at University College Dublin. His research interests are in the role of innate and adaptive immunity in

inflammatory bowel disease (Ulcerative Colitis and Crohns Disease) and in the importance of the host immune response in gastro-intestinal neoplasia, particularly colorectal cancer and Barrett's oesophagus. With his colleagues at the Centre for Colorectal Disease at SVUH/UCD he has an established track record in clinical research on a range of digestive disorders and is actively involved in clinical trials in IBD.

Professor Laurence Egan,
Professor of Pharmacology
NUI Galway

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

Professor Deirdre McNamara
Consultant Gastroenterologist
Tallaght Hospital, Dublin

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

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

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

Dr Susanne O'Reilly
Gastreoenterology SpR
St. Vincents Hospital, Dublin

Susanne is a Gastroenterology SpR, currently undertaking her MD entitled 'endoscopic, histological and psychosocial factors associated with a national colorectal cancer screening programme' at the Centre for Colorectal Disease, St Vincent's University Hospital. Her interests include IBD, interventional endoscopy and cystic fibrosis-related GI disease.

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Abstract Submissions selected for Oral Presentation 2020

Abstract No.	Ref:	Title of Paper	Author	Date & Time of Presentation:
1	20W103	The significance of Low Grade (LGD) and Indefinite for Dysplasia (IED) in Barrett's Oesophagus	Lisa O' Byrne	15.00 12 November
2	20W105	Anti-Drug Antibodies Detected in the Presence of Adequate Infliximab Drug Levels In IBD Patients in Clinical Remission have Limited Clinical Significance	Jayne Doherty	15.08 12 November
3	20W116	The impact of online visual instructions on the delivery of patient care in functional GI disorders (FGID)	Ciaran Judge.	15.16 12 November
4	20W129	Crohn's disease is associated with elevated levels of the proinflammatory CXCR3 ligands (CXCL9, 10 and 11) with an associated reduction in Paneth cell-derived antimicrobial peptides in ex-vivo ileal b	Fiona Jones	13.36 13 November
5	20W175	Association between Ex vivo Human Ulcerative Colitis Explant Cytokine Secretion Profiles and Disease Behaviour	Roisin Corcoran	13.44 13 November
6	20W187	Prospective evaluation of FIT and FCP as an alternative to colonoscopy for identifying organic bowel disease in low risk risk patients referred from primary care	Ciara Egan	13.52 13 November

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Winter Meeting 2019

Best Video - Dr Syafiq Ismail

1st Oral Prize Dr Serhiy Semenov

Winter Meeting 2019

Poster Distinction 1st Prize Dr Sarah Cooper

2nd Poster Prize Dr Lisa Coffey

ORAL PRESENTATIONS

ABSTRACT 1 (20W103)

The significance of Low Grade (LGD) and Indefinite for Dysplasia (IED) in Barrett's Oesophagus

Author(s)
Lisa M. O' Byrne (1) , Marie O' Brien (1), Cian Muldoon (1), Ciara Ryan (1), Martin Buckley (2), Thomas Murphy (2), Rob Reynolds (2), Stephen Patchett (3), Elaine Kay (3), Halsema Azam (3), William Robb (3), Mayilone Arumugasamy (3), Padraic Mc Mathuna (4), Jan Leyden (4), Siobhan Gargan (4), Glen Doherty (5), Kieran Sheahan (5), Chris Collins (6), Amar Nath (6), Jacintha O'Sullivan (1), Claire L Donohoe (1), Narayanasamy Ravi (1), Dermot O' Toole (1), John V. Reynolds (1)
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Introduction
A multicentre Irish collaboration on Barrett's oesophagus (RIBBON Network) established a Registry identify and manage patients.
Aims/Background
The aim of this study was to characterise low grade (LGD) and indefinite for dysplasia (IED) in terms of prevalence, and progression to high grade dysplasia (HGD) or invasive adenocarcinoma (OAC).
Method
Detailed endoscopic, pathological and clinical data was collected over 10 years. Patients were included if they had an initial of Indefinite for dysplasia (IED) or Low-Grade Dysplasia (LGD) or had an initial episode of Non Dysplastic Barrett's Oesophagus (NDBO) with a subsequent episode of IED or LGD.
Results
From 860 patients, with a total follow up of 3492 patient years, 252 patients had IED, 258 had LGD at diagnosis and 350 patients had NDBO initially with progression to LGD or IED. Of these, 18% progressed, with an incidence for OAC of 1.9% per year, HGD of 2.6 % per year, and a combined rate of 4.6% per year. Median time to progression in the NDBO group was 4.7 years while this was 1.1 years for IED and 9 months for LGD. Regression to NDBO occurred in 61.4% of cases.
Conclusions
This study revealed that almost one in twenty patients with LGD or IED progress each year to HGD or OAC, a fivefold increase compared with NDBO alone. The short duration to progression of LGD and IED at diagnosis suggests a high risk of incident cancer, highlighting the need for strict surveillance and consideration of endoscopic therapy.

ABSTRACT 2 (20W105)

Anti-Drug Antibodies Detected in the Presence of Adequate Infliximab Drug Levels In IBD Patients in Clinical Remission have Limited Clinical Significance

Author(s)
J Doherty, R Varley, M Healy, C Dunne, F MacCarthy, S McKiernan, K Hartery, D Kevans.
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Introduction
Immunogenicity, with the development of antibodies-to-infliximab (ATI), increases drug clearance and can lead to loss of infliximab (IFX) response in inflammatory bowel disease (IBD) patients. The reporting of ATI is variable between commercial assays. Uniform thresholds for clinically relevant antibody titres are lacking. It is unclear how ATI affect treatment outcome when adequate trough IFX concentrations are present and ATI are detected.
Aims/Background
We aimed to assess the impact of ATI detected in the presence of adequate IFX levels on the outcome of IFX therapy in IBD patients in clinical remission.
Method
As a pilot project, a proactive therapeutic drug monitoring (TDM) strategy was utilised in our unit with IFX and ATI levels, assessed at trough, in all IBD patients receiving IFX therapy. Baseline demographics were collected. Patients were grouped based on disease activity status. An adequate trough IFX level was defined as IFX concentration > 3 µg / mL. ATI positivity was considered as an ATI concentration > 10 AU / mL. Receiver operating characteristic (ROC) analysis was performed to evaluate the classifying performance of ATI concentration for low IFX levels. Survival analysis was performed to determine IFX persistence in patients with adequate IFX levels and positive ATI. Follow up TDM assessments, where available, were documented to determine changes in ATI concentration over time in patients with adequate IFX levels.
Results
N=108 patients were included (36% ulcerative colitis, 60% Crohn's disease, 4% IBD-U). 35% were receiving concomitant immunomodulators. N=59 (56%) of patients were in remission. 44%, 30% and 26% of patients had IFX levels < 3 µg / mL, 3 – 7 µg / mL and > 7 µg / mL respectively. Median [range] ATI concentration was 11 AU / mL [0 – 800]. ATI positivity occurred in 25%, 19% and 8% of IFX groups with levels < 3 µg / mL, 3 – 7 µg / mL and > 7 µg / mL respectively. There was a weak inverse correlation between trough ATI and IFX concentration, pearson correlation coefficient -0.24, p=0.01. ATI concentration performed poorly as a classifier of low IFX levels, AUC 0.568 (95% CI 0.41 – 0.72), p=0.39. 83% (15 of 18) of patients in remission with adequate IFX levels and positive ATI remained on IFX for the duration of follow up with a mean (95%CI) cumulative time on IFX of 111.2 weeks (95% CI 105.1 – 117.3). In this group, there was no significant change in ATI titre comparing index with follow up TDM assessments (p=0.14).
Conclusions
ATI positivity in the presence of adequate IFX levels is common when proactive TDM assessments are performed in IBD patient populations. For patients in clinical remission ATI positivity in the presence of adequate IFX levels has limited clinical significance. Care should be taken to avoid unnecessary therapy alterations in this patient subgroup when proactive TDM strategies are being utilized.

ABSTRACT 3 (20W116)

The impact of online visual instructions on the delivery of patient care in functional GI disorders (FGID)

Author(s)
1. Dr Ciaran Judge 2. Aidan Kaar 3. Julie O'Neill 4. Lillian Barry 5. Lucy Quinlivan 6. Dr Mary Nwaezeigwe 7. Dr Carthage Moran 8. Dr Jane McCarthy 9. Dr Martin Buckley
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Introduction
Functional upper GI disorders such as rumination syndrome and functional heartburn are increasingly common, with considerable morbidity in addition to healthcare and societal costs. Non-invasive therapies like diaphragmatic breathing (DB) are safe and effective in treating these conditions. Awareness and recognition of FGID is improving, however technology now provides exciting possibilities for optimising management of these challenging conditions.
Aims/Background
We aim to determine if a series of online patient education videos provides superior outcomes and patient-engagement than the current standard of care.
Method
We conducted a pilot study in a single tertiary GI referral centre. All adult patients referred to the GI physiology lab with clinical suspicion of the above conditions were considered for inclusion. They were included if the diagnosis was confirmed upon investigation. Self-reported questionnaires were completed 2 weeks prior to their procedure while taking their usual anti-acid medication, and again on the day of their procedure while off the medications in the interim. All patients receive education on diaphragmatic breathing. Patients were then randomised to receive either directions to a custom-made online educational video (treatment group) or a written description and instructions on DB (control group). Patients completed the intervention for 6 weeks and then completed a final set of online questionnaires.
Results
34 patients were identified with 11 suitable for inclusion in the final cohort (n=6 in treatment group; n=5 in control group). Median age 53 [22 – 66], 75% female, BMI 28.2 kg/m2 [20.8 – 37.6 kg/m2]. Clinical characteristics included: 86% were taking PPI at baseline, 34% had underlying psychiatric co-morbidities, and 54% had missed >1 day of work with symptoms. The main indications for referral were refractory GORD (55%) and belching (27%). Supragastric belching was found in 82% of all cases, regardless of indication. The treatment group reported an overall increase in daily adherence to DB therapy (83% vs 40%), and a reduction in PPI use (50% vs 20%). There was also a non-significantly superior reduction in belching. 66% of patients in the video group found it to be an excellent source of information and guidance on DB.
Conclusions
Diaphragmatic breathing appears to be helpful in treating the symptoms of functional upper GI disorders. The video series was well received and was associated with a reduction in PPI use. This study would benefit from larger numbers to further investigate the potential clinical benefit from these educational tools.

ABSTRACT 4 (20W129)

Crohn's disease is associated with elevated levels of the proinflammatory CXCR3 ligands (CXCL9, 10 and 11) with an associated reduction in Paneth cell-derived antimicrobial peptides in ex-vivo ileal b

Author(s)
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Introduction
Despite an expanding array of treatment options, a significant proportion of Crohn's disease (CD) patients fail to respond to currently available therapies, underpinning the importance of biological insights into disease pathogenesis. The proinflammatory chemokines CXCL9,10+11 bind to the CXCR3 receptor, highly expressed on effector T-cells. Mouse models of chronic ileitis have shown that CXCR3+ effector T cells drive the loss of paneth cells that play an important role in innate immunity and mucosal barrier function. In the TNFΔΔARE mouse ileitis-model, small molecule inhibition of the CXCR3 receptor reverses paneth cell loss and restores antimicrobial peptide levels.
Aims/Background
The aim of this study was to evaluate the role of chemokines that bind to CXCR3+ effector T-cells in adult patients with ileal CD and to compare this to healthy controls.
Method
13 CD patients and 16 controls attending for endoscopic evaluation were prospectively recruited at St.Vincent's University Hospital and ileal biopsies were collected in media. RNA was extracted using the Quiagen kit, DNAse treated using DNAse I(Invitrogen) and reverse transcribed using M-MLV reverse transcriptase(Promega). Target cDNAs were quantified using an Applied BiosystemsTM QuantStudioTM 7 Flex Real-Time PCR System.
Results
Our results show an increase in the relative mRNA expression of CXCR3 associated chemokines with significantly higher levels of CXCL9, CXCL10 and CXCL11 in ileal CD patients compared to healthy controls. This coincides with a reduction in paneth cell-derived antimicrobial peptides with significantly lower levels of alpha defensins (DEFA5,DEFA6) and lysozyme in CD patients compared to healthy controls.
Conclusions
This study supports data from animal models and provides a hypothesis for the loss of paneth cells in patients with ileal CD with important therapeutic potential utilizing CXCR3 receptor blockade.

ABSTRACT 5 (20W175)

Association between Ex vivo Human Ulcerative Colitis Explant Cytokine Secretion Profiles and Disease Behaviour

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Introduction
The clinical course of ulcerative colitis (UC) is variable. Identifying patients at high risk of disease progression would allow personalised therapy with the potential for improved outcomes.

Aims/Background
We aimed to evaluate the association between ex vivo human UC explant cytokine secretion profiles and disease behaviour.

Method
Twenty four patients with UC undergoing endoscopy were prospectively recruited. Endoscopic biopsies were collected and cultured to generate tissue conditioned media (TCM). TCM was analysed via 54 V-plex ELISA to assess cytokine secretions. Disease progression was defined as the requirement for corticosteroid therapy, UC-related hospitalisation, UC-related surgery or the introduction of a new immunomodulatory agent. Secreted cytokine concentrations were compared based on progression status. As a secondary endpoint cytokine profiles were compared between anti-TNF failure patients and patients not exposed to or successfully treated with anti-TNF therapy.

Results
Disease progression during follow up occurred in 12 (50%) patients. IL2, IL7 and IL8 secretion was significantly lower in individuals with disease progression compared to those without progression. Anti-TNF failure status was significantly associated with an increase in the following secreted cytokines: Exotaxin-3, FLT-1, GMSCF, IL10, IL12/23p40, IL12p70, IL17A/F, IL8, MDC, VEGF, PIGF, SAA and TARC.

Conclusions
Reduction in secreted IL2, IL7 and IL8 were associated with disease progression in ex vivo human UC explants. Increased secretion of IL-23 pathway- associated cytokines was observed in anti-TNF failure patients consistent with previous reports. While further evaluation and validation is required, the ex vivo human UC explant model has potential as a precision medicine tool in inflammatory bowel disease.

ABSTRACT 6 (20W187)

Prospective evaluation of FIT and FCP as an alternative to colonoscopy for identifying organic bowel disease in low risk risk patients referred from primary care

Author(s)
Ciara Egan, Orla Smith, Fiona Jones, Darragh Storan, Miriam Tosetto, Jan Leyden, Glen A Doherty
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Centre for Colorectal Disease, St Vincent's University Hospital GI Unit, Mater Misericordiae University Hospital School of Medicine, University College Dublin

Introduction
Colonoscopy is a valuable procedure for diagnosing organic bowel diseases such as colorectal cancer and IBD. However most patients who undergo colonoscopy do not have significant organic bowel disease. The application of non-invasive triage tests could significantly improve patient access for individuals with a higher likelihood of abnormal findings and assist in managing demand when endoscopy capacity is constrained due to the COVID-19 pandemic.

Aims/Background
To assess the diagnostic accuracy of using FIT and FCP to determine the presence of significant bowel disease in patients referred from primary care for routine colonoscopy.

Method
This was a prospective multi-centre study examining symptomatic patients referred from primary care triaged for non-urgent (routine – P2) colonoscopy. FIT and FCP were performed preceding colonoscopy in all patients. The primary outcome was the diagnostic accuracy of FIT and FCP to identify significant bowel disease.

Results
130 patients were recruited in the study. Less than 4% of patients referred had significant bowel disease at colonoscopy. Risk factors for significant bowel disease included family history of colorectal cancer, smoking, male gender and PPI use. Using FIT with a cut off of <10µg/g(50ng/ml) together with FCP with a cut off of 50ng/g there is a sensitivity of 100% and specificity of 80% for detecting significant bowel disease in this cohort.

Conclusions
Use of two faecal biomarkers in patients referred from primary care for routine colonoscopy shows excellent diagnostic accuracy for identifying those with significant bowel disease. Up to 80% of those referred could safely avoid colonoscopy where there are negative faecal biomarkers and absent risk factors for colorectal cancer.

POSTER PRESENTATIONS

ABSTRACT 7 (20W102)

Inflammatory Bowel Disease and Pregnancy – Clinical Care Guidelines

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Introduction
Inflammatory bowel disease (IBD) are chronic inflammatory intestinal disorders commonly affecting women during their reproductive years. IBD affects young people, with more than 50% diagnosed before 32 years of age and 25% of women conceive subsequent to their diagnosis. Of relevance to pregnancy and fecundity is that IBD often necessitates the use of potent immunomodulator and biologic therapy as well as abdominal and pelvic surgery. Issues concerning fertility, antepartum pregnancy management, mode of delivery and lactation are influenced by disease activity, medications, perianal disease and previous ileoanal pouch surgery.
Aims/Background
Given the complexity of managing both a chronic inflammatory disease and pregnancy we felt a clinical care guideline would benefit both clinicians and patients.
Method
We performed a review of recent studies and recommendations regarding the management of inflammatory bowel disease and pregnancy in an attempt to produce a succint clinical care guideline relevant to both gastroenterology and obstetric health care providers
Results
Recommendations in relation to preconception counseling, fertility, fecundity and assisted reproduction, the medical management of IBD during pregnancy, mode of delivery, management of ostomies during pregnancy and postpartum management were made following a review of recent literature.
Conclusions
Multidisciplinary management with input from high-risk obstetricians, fertility specialists, gastroenterologists and colorectal surgeons is recommended following the review. Clinicians should strive to maintain remission, avoid surgery, minimize interventions and prevent exposure to teratogenic medications. Care should incorporate pre-conception advise/therapy to ensure disease remission, regular review during pregnancy with gastroenterology and obstetrics, maintenance monotherapy if achievable, vaginal delivery if appropriate and post-partum review soon after delivery.

ABSTRACT 8 (20W104)

Macroscopic Diagnosis Of Coeliac Disease In The West Of Ireland: "How Are We Doing?"

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Introduction
Coeliac disease (CD) is one of the most common autoimmune diseases world-wide with a particularly high prevalence in the West of Ireland.
Aims/Background
We elected to review the macroscopic appearance of D2 in newly diagnosed coeliacs over a 4-year period. In particular, we intended to determine the proportion of biopsies that were taken solely based on the macroscopic appearance of D2.
Method
This was a retrospective cohort study, which analyzed endoscopy reports of newly diagnosed coeliac patients in the West of Ireland between 2014-2018 inclusive.
Results
184 index OGDs were included, 116 in females and 68 in males, with an average age of 43 years (4 – 89 yrs). OGDs were carried out by Consultant Gastroenterologists (78), SpRs/Registrars (101), Nurse Endoscopist (3) and unspecified (2). 154 OGDs (84%) were performed in patients with positive coeliac serology or clinical suspicion of CD. Of the remaining 30 OGDs, 50% had D2 biopsies performed because of abnormal macroscopic appearance. These were described as flat (10%), scalloped (10%), nodular (3.33%), oedematous (10%), duodenitis (16.66%) and ulcerated (3.33%). Registrars/SpRs and Consultant Gastroenterologists reported macroscopic abnormalities in 55% and 44% of cases respectively (p=0.724)
Conclusions
52.7% of newly diagnosed coeliacs had an abnormal macroscopic appearance to D2. 50% of those who had no clinical or serological suspicion of CD had a diagnosis made because of macroscopic abnormalities of D2. SpRs/Registrars were as good as consultants in picking up such abnormalities. This highlights the importance of close inspection of D2 in all upper GI endoscopies irrespective of the indication for the procedure.

ABSTRACT 9 (20W106)

Cost Effectiveness of a Proactive Therapeutic Drug Monitoring Strategy in Patients with Inflammatory Bowel Disease Receiving Infliximab

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Introduction
Proactive therapeutic drug monitoring (TDM) is widely used in clinical practice, however, has not been clearly demonstrated to result in improved anti-TNF therapy outcomes compared with clinically-based dosing strategies. While the use of proactive TDM incurs additional assay-related costs this strategy may be cost-effective due to TDM-driven anti-TNF therapy dose de-escalation and discontinuation.
Aims/Background
We aimed to assess whether use of proactive-TDM is a cost-effective strategy in routine clinical practice.
Method
As a pilot project, a proactive TDM strategy was utilised in our unit with infliximab (IFX) levels and antibody-to-infliximab (ATI) levels, assessed at trough, in all inflammatory bowel disease (IBD) patients receiving IFX therapy. Baseline demographics, IFX

dosing schedules and use of concomitant immunomodulators were documented. Patients were grouped based on disease activity status. Trough IFX and ATI levels were documented for all patients. Patients with IFX levels outside the therapeutic range of 3 – 7 µg / mL had IFX therapy dosing adjusted as appropriate. IFX dose adjustments were not protocolised and were at attending physician's discretion. IFX dosing regimens following proactive TDM were documented and the net effect on IFX infusions number over the subsequent year extrapolated. Increase or decrease in drug-related costs on an annualized basis were then estimated.

Results

N=108 patients were included (36% ulcerative colitis, 60% Crohn's disease, 4% IBD-U). 35% were receiving concomitant immunomodulators. 56% were in remission at the time of TDM assessment. 44%, 30% and 26% of patients had IFX levels < 3 µg / mL, 3 – 7 µg / mL and > 7 µg / mL respectively. IFX levels were significantly lower in patients with active disease compared with those in remission (p=0.008). Following proactive TDM assessment, 37%, 11%, 36%, 13%, 2% and 1% of patients had no treatment change, therapy discontinuation, interval shortening, interval lengthening, dose increase and dose decrease respectively. Cost-effectiveness analysis focused on patients in remission (n=59). The use of proactive TDM-based IFX dosing resulted in a projected annualized reduction of 19.5 and 28.5 infusions due to IFX discontinuation and interval lengthening respectively; the projected annualized increase in infusions was 39.1 and 4.3 due to IFX interval shortening and dose increase respectively. This resulted in a net projected reduction of 4.7 IFX infusions per annum. Utilising publicly available list prices for originator and biosimilar IFX and accounting for TDM assay cost (2065 Euro), projected cost savings resulting from proactive-TDM use were 9105.0 and 6840.7 Euro per annum respectively.

Conclusions

Proactive TDM in IBD patients in remission resulted in a modest reduction in the projected annualized number of infusions in our unit with consequent minor drug-related cost savings. Proactive-TDM encouraged cost-effective prescribing of IFX, however, the effect was minor. The frequency at which proactive TDM should be performed and whether subsequent rounds of proactive-TDM would continue to deliver similar cost savings is uncertain and requires further evaluation.

ABSTRACT 10 (20W107)

Degree of Histological Activity is not Associated with Vedolizumab Therapy Outcome in Ulcerative Colitis

Author(s)

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Introduction

Histological inflammation is known to be associated with increased risk of disease relapse in patients with ulcerative colitis (UC). Vedolizumab (VDZ) is a gut selective anti-integrin which inhibits intestinal immune cell-trafficking. Whether the degree of histological activity at the time of VDZ therapy initiation is associated with therapy outcome is not known.

Aims/Background

We aimed to determine if there is an association between histological activity at the time of VDZ initiation and outcome of therapy.

Method

A retrospective review was performed to identify UC patients treated with VDZ who had undergone an endoscopic assessment prior to therapy commencement. Baseline demographic data, information on therapy outcome and Mayo endoscopic sub score (MES) was collected for all patients. Endoscopic biopsies were retrieved and were scored for histological activity using the Geboes Score (GS). For Kaplan Meir analyses of primary endpoint, the cohort was dichotomised around a GS grade of 5. Primary endpoint was VDZ therapy outcome defined as persistence on VDZ therapy over time. Secondary endpoints included association between GS and MES and the association between a combined endoscopic and histological endpoint (MES = 3 & GS grade 5) and VDZ therapy outcome.

Results

N=33 patients were included [median age 44.3 years; 36% male gender]. 24%, 43% and 33% of the cohort had proctitis, left-sided colitis and extensive colitis respectively. 67% of subjects had prior anti-TNF exposure. Median time from endoscopy to commencement of VDZ was 9 weeks. Median study follow-up was 68 weeks (range 6.1 – 228.7). 3%, 21%, 42% and 33% had MES of 0, 1, 2 and 3 respectively. GS grade was significantly associated with MES (p = 0.04). GS grade was not associated with time to discontinuation of VDZ (p=0.64). Combined endoscopic and histological endpoint was not associated with time to discontinuation of VDZ (p=0.43). The presence of lamina propria eosinophils was not associated with time to discontinuation of VDZ (p=0.92).

Conclusions

GS grade is associated significantly with MES which has been demonstrated previously. Neither histological activity alone nor in combination endoscopic activity were associated with outcome of VDZ therapy. Assessment of histological activity does not appear to provide additional information when selecting patients for VDZ therapy.

ABSTRACT 11 (20W112)

Endoscopic mucosal resection (EMR) of colonic polyps in the older patient– is it safe?

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Introduction

Controversies surround the risk of performing endoscopic mucosal resection (EMR) in patients ≥ 75 years coupled with difficulties encountered with co-morbidities which are often heavily prevalent in this population.

Aims/Background

We sought to analyse the safety of EMR of large colonic polyps (20mm or greater) in patients ≥ 75.

Method

We performed a retrospective analysis of all patients who underwent EMR of polyps ≥ 20mm between 1st January 2019 and 1st January 2020. In our institution, polyps found to be ≥ 20mm are usually brought back for a therapeutic procedure. Statistical analyses were performed with GraphPad Prism 6.0 (GraphPad Software, Inc., San Diego, CA). Differences between groups were considered to be significant at a P value of <0.05. Fisher Exact test was used to

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Antibody response to other vaccines may be diminished. With severe liver function disorders: increased systemic bioavailability expected. Central serous chorioretinopathy or other causes may result in blurred vision/visual disturbances. Consider referral to ophthalmologist. Suppression of the HPA axis and reduced stress response: supplementary systemic glucocorticoid treatment may be needed. Avoid concomitant treatment with CYP3A4 inhibitors. Do not use in patients with galactose or fructose intolerance, glucose – galactose malabsorption, sucrase – isomaltase insufficiency or total lactase deficiency or congenital lactase deficiency. In autoimmune hepatitis evaluate transaminase levels every 2 weeks for the first month and then every 3 months. **Interactions:** Co-treatment with CYP3A inhibitors including cobicistat containing products may increase side effects and should be avoided where possible. Beware concomitant administration of cardiac glycosides and saluretics. 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Further information available on request.

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DrF19/236
Date of preparation: February 2020

determine statistical significance.

Results

There was no statistically significant difference between patients less than 75 and those over 75 with regard to post EMR admission [p = 0.1365 OR: 2.99 (95% CI: 0.77-11.64)], death [p= 0.3091 OR: 6.80 (95% CI: 0.27-170.0)], perforation [p=0.5239 OR: 2.26 (95% CI: 0.14-36.88)] or bleeding [p= 1.00 OR 1.05 (95% CI: 0.40-2.76)].

Conclusions

Our analysis shows that EMR in patients ≥ 75 years appears to be safe. However, given that this is a retrospective analysis there are confounding factors such as pre-selected patients for therapeutic intervention. Further large-scale prospective research is required to determine outcomes such as cancer prevention benefit as well as cost effectiveness. The use of life expectancy scores may play a role in deciding which patients should have surveillance +/- therapeutic intervention in the future.

ABSTRACT 12 (20W113)

Coeliac: a gut feeling. An investigation into what factors influence patterns of clinical presentation in adult onset coeliac disease

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Introduction

Anxiety and depression are common in coeliac disease (CD) patients, and many psycho-social explanations have been considered. However, as the gut-brain axis is becoming increasingly understood, biological mechanisms have been proposed, including vitamin or mineral deficiencies and gut inflammation.

Aims/Background

To investigate associations between anxiety/depression and symptom severity, vitamin status, and gut inflammation in untreated adult patients presenting with a serologic indication of coeliac disease.

Method

The Hospital Anxiety and Depression Scale, Coeliac Symptom Index and Perceived Stress Scale questionnaires were administered to 17 patients over a 14-month period. Duodenal biopsies were obtained to determine histological Marsh score. Iron, B12, folate, vitamin D and thyroid function tests were reviewed.

Results

HADS-A scores correlated with symptom severity (rs=0.62, p=0.008) but not with any haemotological investigations or degree of intestinal inflammation. No patients scored highly for depression. Iron deficiency was the most common deficiency observed (n=6). Greater symptomatology was associated with female sex (females vs males, average CSI scores 32.1 vs 23.6; t17= 2.1, p<0.05), younger age at presentation (rs= -0.55, P=0.02), and lower Marsh score (Marsh 0 vs Marsh 3C, mean scores 36 vs 24.5; t5= 6.2, p=0.009).

Conclusions

Anxiety experienced by CD patients at presentation is likely a reactive form due to gastrointestinal symptoms rather than a biological process specific to CD. Older patients tend to present less symptomatically, highlighting the need for screening of at-risk individuals. The degree of villous atrophy does not correlate well with clinical presentation. Highly symptomatic patients should be screened for anxiety at presentation.

ABSTRACT 13 (20W114)

Predictors of treatment response to interferon in chronic hepatitis B

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Introduction

Treatment of chronic hepatitis B with Interferon has benefits over nucleoside analogues; limited duration and lower cost. Disadvantages are the side effects and variable efficacy.

Aims/Background

Establishing factors that predict a response to treatment would allow selection of patients and avoid adverse reactions in those in whom treatment is futile.

Method

We selected 35 patients with chronic hepatitis B who were treated with interferon based on HBV viral load, ALT and histological grade between 2005-2019. Success was determined by eAg seroconversion and sustained viral response. Medical records were reviewed to establish HBV viral load and ALT at four time points, at 0, 12, 24, 48 weeks of treatment. Pre-treatment variables: gender, nationality, genotype, histological grade, and fibroscan were also assessed. Data was analysed with SPSS to find associations between these factors and successful treatment outcomes.

Results

Only 26 patients were included because of dropout due to side effects. Successful treatment was seen in 30.7% of our cohort; EAg Seroconversion 11.5%, sustained virological conversion 19.2%. We could not identify any associations between pre-treatment factors and treatment outcome. However we did notice that ALT significantly decreased over the timepoints in the positive treatment group (p=0.005) compared to the negative group meaning an early decrease in ALT could indicate successful treatment.

Conclusions

There is a low but definite response to interferon treatment in our patients with chronic hepatitis B. With no predictive factors, this figure can be used to counsel patients prior to therapy.

ABSTRACT 14 (20W115)

The safety and efficacy of combination biological therapy in refractory inflammatory bowel disease in an Irish cohort.

Author(s)

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Introduction

Refractory inflammatory bowel disease (IBD) continues to pose a dilemma despite an increasing number of therapeutic options available. There has recently been renewed focus on combining biologic agents to tackle recalcitrant cases. In theory, combination of two therapeutic mechanisms may produce synergistic effects, however the clinical utility of such an approach remains undetermined.

Aims/Background

This study aims to provide real-world data on the use of combination biologic therapy (CBT) for refractory IBD in the Irish cohort.

Method

We conducted a retrospective review of patients receiving or who had received treatment with combination biological therapy (CBT) for IBD across four Irish teaching hospitals. Demographics and clinical data were collected by retrospective chart review. Clinical severity was assessed by partial Mayo Clinic Score (PMCS) and Harvey Bradshaw Index (HBI) in UC and CD, respectively. CBT was defined as the use of any two biologic agents for the treatment of IBD, for a period of at least 12 weeks. Clinical response and remission were assessed, in addition to changes in biochemical markers and adverse events.

Results

21 patients were identified (UC = 8, CD = 13). Median age was 40 [18 – 56], 71% were male and 19% smokers. In the UC cohort, 50% had extensive disease, baseline PMCS was 6 [5 – 8], FC 529 [77 – 1321], CRP 10 [1 – 92]. In the CD cohort, 54% had ileocolonic disease, 70% stricturing (Montreal B2) disease, 39% had perianal involvement and 85% had previous surgery. Baseline HBI was 7 [5 – 17], FC 687 ug/g [38 – 1194 ug/g] and CRP 8 mg/L [1 – 39 mg/L]. In the total cohort, patients had previously failed 4 [3 – 4] single biologic agents. Disease severity improved significantly in both UC and CD. Clinical response was seen in 50% of UC patients, and 69% of CD patients. Adverse events were seen in 14% (3) cases, involving UST + ADA (n=2) , and UST + VDZ (n=1). The commonest combination regimens were VDZ + ADA (26%), and VDZ + TOF (24%). VDZ was used in 86% of regimens.

Conclusions

Combining biological therapies may provide us with a novel therapeutic approach to refractory IBD. These real-world data suggest efficacy and safety with CBT in a cohort with significant previous biological exposure.

ABSTRACT 15 (20W117)

Quality Improvement Project For Infection Risk Management In An Endoscopy Unit During A Pandemic Setting (COVID-19)

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Introduction

Adherence to infection control measures facilitates safe continuation of services during pandemics and increases preparedness for future resurgences, or novel epidemics.

Aims/Background

To identify and improve compliance with national and international guidance on endoscopy service provision during a pandemic setting.

Method

This full-cycle audit searched PubMed and the HSE's website to provide the two standards of care. Pre-, Intra-, and Post-Procedure categories were investigated. Data was collected via prospective convenience sampling and a web-based application was used for data input. Eligibility criteria was GI endoscopic procedures. One month intervention period of education, Infection Control consulting, and championing for resources was instituted, after which a re-audit was undertaken.

Results

Comparing Cycle 1 (n=40) to post-intervention Cycle 2 (n=40); No cases (0%) were telephone risk assessed 24 hours pre-procedure - improving to 33 (82.5%), 32 cases (80%) were appropriately triaged - improving to 36 (92%), PPE compliance improved greatest amongst endoscopy nurses (97.5% to 100%) and dis-improved considerably with lead endoscopists (77.5% to 27.5%). Concordance of PPE was highest Nurse-to-Nurse (C1: 100%, C2: 100%), and lower between Endoscopist-to-Nurse (C1: 80%, C2: 27.5%), and Endoscopist-to-Assistant endoscopist (C1: 69.25%, C2: 0%). Lead endoscopist's hand hygiene was appropriate in 13 cases (31%) which doubled to 61%. At 7-14 days post-procedure, telephone follow up was 0% with no improvement at re-audit.

Conclusions

There is a role for ongoing education and awareness of guidance statements to reduce to the risk of transmission and to avoid undue disruptions to endoscopy service provisions. This project provides a template for further quality improvement.

ABSTRACT 16 (20W118)

Compliance Rates In Elective Outpatient Colonoscopy: Patient Compliance Barriers With Mechanical Bowel Preparation (MBP)

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Department(s)/Institutions

Department of Surgery at Cork University Hospital

Introduction

For complete mucosal visualisation and optimised colonoscopy quality, appropriate mechanical bowel preparation (MBP) prescription and patient compliance with MBP regime are required prior to performance of colonoscopy.

Aims/Background

In this study we aimed to quantify patient compliance with pre-colonoscopy MBP guidance and determine potential predictors of poor compliance.

Method

To assess predictors of compliance a bespoke patient questionnaire was designed and administered using an interview style by a single investigator in the endoscopy department prior to outpatient colonoscopy. For analysis data was dichotomised into 'compliant' or 'non-compliant'. Compliant was defined as >90% of prescribed liquid laxative consumed in two separate doses as reported by the patient. Adherence to fasting guidelines (clear liquid diet for >24 hours prior to colonoscopy) and patient specific characteristics were also analysed. Statistical analysis was performed using SPSS, version 22.

Results

Forty-five patients were studied (30 female and 15 male). Comprehension of pre-colonoscopy directions was 100%. Patient-reported adherence with fasting guidance was 87% (n=39) and compliance with MBP was 89% (n=40). Previous colonoscopy associated with non-compliance to fasting guidance (P= 0.031). No other significant association with compliance existed within the variables analysed including sex, age, ethnicity, distance travelled,

dosing regimen and indication (p> 0.05).

Conclusions

Overall, patient compliance with MBP for colonoscopy is good. Patients presenting for repeat colonoscopy offer an opportunity for improved education regarding fasting compliance to improve endoscopy service utilisation.

ABSTRACT 17 (20W119)

Factors Associated With Duration Of Colonoscopy In An Elective Outpatient Setting

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Introduction

Duration of colonoscopy procedure can vary widely and is dependent on multiple modifiable and non-modifiable factors. The increased demand on outpatient endoscopy services as we emerge from the COVID-19 pandemic further highlights the need to better understand modifiable factors that influence colonoscopy duration.

Aims/Background

Identify specific risk factors for prolonged colonoscopy in an outpatient endoscopy unit. Correlate results to optimise time management in endoscopy units.

Method

A prospective cohort study was performed in an elective outpatient colonoscopy setting involving patient and endoscopist questionnaires and chart review. The following time points were measured: TPT=total procedure time, CIT=caecal intubation time, WT=withdrawal time. Number of polyps identified/resected and endoscopist experience were also recorded. Adequacy of mechanical bowel preparation (MBP) was quantified using the validated Boston Bowel Preparation Scale (BBPS).

Results

Data from forty-five patients (n=30 female and n=15 male) was analysed. Endoscopist experience (number of colonoscopies performed) had a significant (inverse) relationship with TPT (p= 0.003). Procedural adjuncts were also associated with TPT including: polyp detection rate (p=0.001), number of polypectomies (p<0.0001) and number of biopsies performed (p=0.026). Finally, BBPS grade was significanlty associated (inverse) with CIT (p=0.03) but not TPT (p=0.656).

Conclusions

To clear the backlog facing endoscopy units a transient change may be required. The single greatest modifiable risk factor is endoscopist experience. Therefore, movement of experience endoscopists into a strict procedural role may be suitable temporarily. Also, strict bowel cleansing agent compliance must continue to be encouraged.

ABSTRACT 18 (20W120)

Polyp Excision Rates Post-COVID-19: Personal Protective Equipment Does Not Impair Performance

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Introduction

The UK JAG on GI Endoscopy's minimum standard for polyp detection rates in colonoscopy is 15%. The COVID-19 pandemic precipitated the use of restrictive PPE which might reduce dexterity and decrease PDRs.

Aims/Background

We audited our polyp excision rates both prior to and post the COVID-19 pandemic in order to assess whether restrictive PPE led to a diminution therein.

Method

Our endoscopy database was queried for all colonoscopies performed between 01/01/2014 and 29/02/2020 (Pre-COVID-19, n=18,231) and between 01/03/2020 and 02/09/2020 (Post-COVID-19, n=825). A PER was calculated for each period as a proxy for PDR. A comparative odds ratio was calculated. An ordinary least squares regression, using number of polyps excised as the dependent variable and procedure in the post-COVID-19 period as a primary explanatory variable, was performed. The regression was controlled for age, male gender and procedure coded as therapeutic (as opposed to diagnostic).

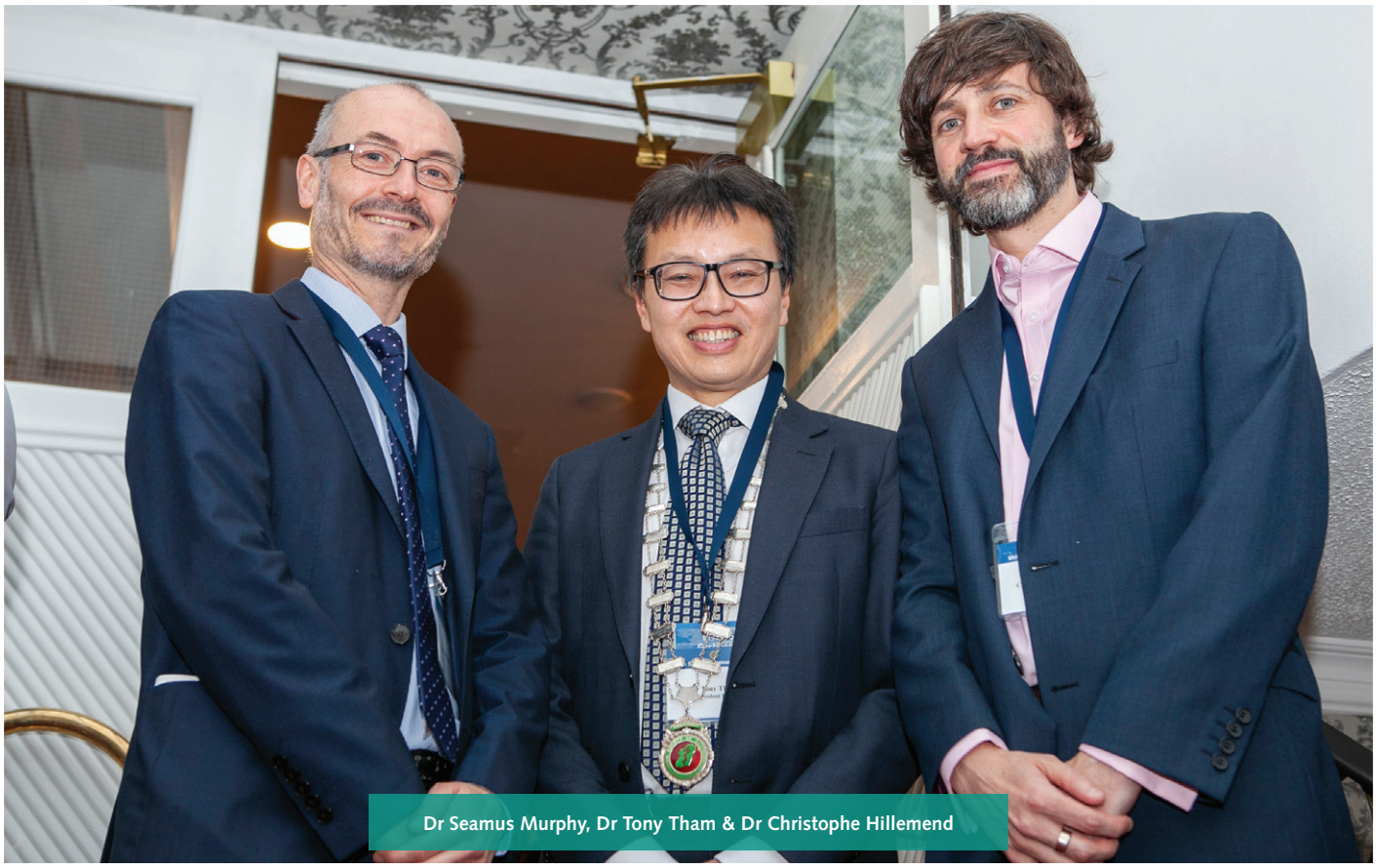
Results

4,346 and 209 patients had at least one polyp excised in the pre-COVID-19 (PER 23.8%) and post-COVID-19 (PER 25.3%) periods respectively. Odds ratio 1.08 (95%CIs: 0.92, 1.27). OLS regression established positive relationships between number of polyps excised and age (0.004, 95%CIs: 0.003, 0.005), male gender (0.10, 95%CIs: 0.07, 0.13) and procedure coded as therapeutic (1.75, 95%CIs: 1.71, 1.78). It demonstrated no significant relationship between procedure in the post-COVID-19 period (-0.003, 95%CIs: -0.07, 0.07) and number of polyps excised.

Conclusions

Odds ratios comparing PERs and an OLS regression analysing number of polyps excised failed to demonstrate any significant difference between the pre-COVID-19 and post-COVID-19 eras.

Winter Meeting 2019



Dr Seamus Murphy, Dr Tony Tham & Dr Christophe Hillemend

Mr Adrian Ireland & Dr Martin Buckley

Winter Meeting 2019

Dr Eoin Slattery, Dr Juliette Sheridan & Dr Karen Hartery

Dr Fiona Jones, Dr Jane Doherty, Dr Lakshman Kumar & Dr Orla Smith

ABSTRACT 19 (20W122)

First line diet and lifestyle intervention reduced medication use in patients with Irritable Bowel Syndrome

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Introduction
Irritable bowel syndrome (IBS) is a functional gastro-intestinal disorder affecting 10-15% of the Western population. Management includes both non-pharmacological and pharmacological treatment. It is estimated that 33% - 91% of patients receive a prescription for medication. There is a dearth of research on the effect of non-pharmacological interventions on the requirement for medications.
Aims/Background
To compare the use of medication in patients with IBS before and after diet and lifestyle intervention
Method
Baseline clinical data including the global symptom question (GSQ) ('do you currently have satisfactory relief of your gut symptoms?') and medication use were recorded from consecutive patients before diet and lifestyle intervention from a clinical specialist dietitian. The assessment was repeated three months later. Data were analysed using SPSS (IBM, v.24). Paired categorical data were analysed using McNemar's test, and a paired t-test was used to compare continuous data.
Results
N=116 patients received diet and lifestyle intervention, of which n=100 (86.2%) reported symptomatic improvement (GSQ=yes). In those who improved, the mean (SD) number of daily medications reduced from 0.76 (0.1) to 0.57 (0.7) following three-month intervention (P=0.025, 95% CI (0.24, 0.36)). When comparing those requiring no medication, 1 medication, or 2+ medications daily, there was a reduction in medication use following the intervention (McNemar's Test, P=0.034).
Conclusions
Non-pharmacological management improved symptoms for patients with IBS and reduced use of medication. Moreover, the success rate of the intervention was high with almost 9 in 10 patients achieving symptomatic relief. We suggest that all patients with IBS have access to a specialist dietitian.

ABSTRACT 20 (20W124)

Recurrence of Primary Biliary Cholangitis after Liver Transplantation in an Irish cohort

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Introduction
Primary Biliary Cholangitis (PBC) accounts for 4% of total indications for liver transplantation (LT). Recurrence of PBC (rPBC) has been reported from 17% up to 46%; due to whether the centres performed protocolled liver biopsies after LT and on the length of the follow-up, as recurrence has a late onset. Montano-Loza et al in 2019 demonstrated that rPBC has an impact on survival. Several risk factors have been associated with rPBC, such as related to the donor, donor-recipient, procedure related, immunosuppression related and the use of prophylactic UDCA.
Aims/Background
Assess the incidence of rPBC and their long-term outcomes in relation to graft loss, retransplantation and death, as well as the risk factors associated with rPBC.
Method
Retrospective review of all patients transplanted from January 2000 to December 2015 for PBC.
Results
During the study period 801 transplants were performed and 63 due to PBC (7.8%). 85% were women and mean age was 54. PBC recurred in 31.7% (n:20) during the follow-up (4.027 days: 3-7019). Age at time of transplantation <50 years old (OR, 3.3: 95% CI, 1.07-10,1) was the only risk factor associated with recurrence. 31.3% (n:19) of grafts were loss due to death (n:13); retransplantation (5) and one patient is currently being reassessed for LT.
Conclusions
rPBC was diagnosed in 31,7% of patients. Younger age at the time of transplantation was the only risk factor associated with rPBC.

ABSTRACT 21 (20W125)

Non-Invasive Fibrosis Markers Evolution After HCV SVR

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Introduction
Transient elastography (TE) has become the gold standard for assessing patients with HCV. Previous studies have demonstrated significant decrease in liver stiffness measurements (LSM) after SVR, however LSM might be overstated when compared to histological staging. The initial LSM decrease is considered to be secondary to the decrease of liver inflammation and afterwards presumably to reduction in collagen content. No previous data from the evolution of non-invasive fibrosis markers has been reported from an Irish cohort.
Aims/Background
Assess the evolution of LSM, FIB4 and APRI after SVR.
Method
Retrospective review from January 2015 to December 2019 of all patients who had HCV SVR and TE pre-treatment and at any time after end of treatment (EOT).
Results
Mean age (n:225) was 50 years old (std 10.7; 29-77); 65% were male and 62% had cirrhosis as per TE. LSM, FIB4 and APRI had a significant decrease after SVR (p<0,000). Median LSM decrease was 4.2Kpa (IQR -3-3, 15.4), FIB4 0.73 (IQR 0.14, 1.74) and APRI 0.79 (IQR 0.27, 1.46). 37% had a TE during the first 4months after EOT, 39% between 4 months and the first year and 24% after the first year. Low platelets and higher initial LSM were associated with a bigger decrease in LSM, FIB4 and APRI4 values after treatment (p<0.05). Male sex and alcohol intake were also associated with a higher decrease in LSM after SVR.
Conclusions
LSM, FIB4 and APRI had a significant decrease after SVR. Low platelets and higher LSM were associated with a higher decrease in LSM, FIB4 and APRI4 after SVR.

ABSTRACT 22 (20W126)

Correlation of Radiological, Endoscopic (ERCP) and Histological Findings of Biliary Strictures In a Tertiary Referral Hospital

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Introduction
Biliary strictures (BS) frequently present a diagnostic challenge, which requires a multidisciplinary approach. Cross-sectional abdominal imaging can localize pathology and provide roadmap to plan therapeutic ERCP. Histological assessment is required to exclude malignancy.
Aims/Background
We aim to assess concordance of radiologically diagnosed BS with endoscopic ERCP findings. Our secondary outcome is to assess the yield of endoscopic histological brushings and BS management.
Method
Data were obtained from radiology and histopathology departments as well as from Endoscopy Reporting System (ENDORAAD). ERCP procedures performed from January 2018 to March 2020 were retrospectively assessed. All procedures were performed in Beaumont hospital by four experienced consultant gastroenterologists
Results
There were 68 cases of BS with biliary brushings recorded. Mean age was 71years. (33 - 95) with 42 (62%) males. 35 (51%) cases were patients of Beaumont Hospital with others from peripheral referring hospitals. The median sedation dose used for ERCP was midazolam 4mg, fentanyl 75mcg and pethidine 50mg. Of the 68 patients, 55 (81%) had stricture identified at ERCP. 13 (19%) cases were managed through Interventional radiology (PTC). Of the 55 patients with BS findings at ERCP, 7 radiology reports were not obtainable. In the remaining 48 cases, only 22 were commented to have BS radiologically pre-ERCP. This showed a low concordance rate of 46%. At ERCP, 52 of 55 (95%) patients had biliary stents placed for drainage. Biliary brushings were classified from C1 to C5 with C4 indicates malignancy suspicion whereas C5 confirmed malignancy. Our study cohort showed 18 cases (26%) C4 and 19 (28%) C5 giving a total of 37 cases (54%) of significant histological results.
Conclusions
Biliary strictures remain a diagnostic conundrum and the stakes in achieving early and accurate diagnosis are high, due to failure risk to diagnose malignancy. Multidisciplinary MDT approach remains key factor as inter-observer variation can be minimized and will lead to best management outcome.

ABSTRACT 23 (20W127)

Endoscopic Submucosal Dissection: The First Irish Experience

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Introduction
Endoscopic submucosal dissection (ESD) is an advanced endoscopic technique for resection of superficial lesions in the gastrointestinal (GI) tract. The advantage ESD has over endoscopic mucosal resection (EMR) is that it allows for en bloc resection of lesions, regardless of size. Compared to EMR however, ESD takes longer, and has increased rates of complication.
Aims/Background
We describe the first cohort of patients to undergo ESD in a tertiary referral centre in Ireland.
Method
ESD procedures were performed in Beaumont hospital between Sept 2019 and January 2020 by a single endoscopist. An ERBE 'T-type' hybrid knife with ERBE VIO 300D electro surgical unit was used. All cases were discussed at multidisciplinary meetings in our centre.
Results
5 patients (3 female) underwent ESD. 3 gastric (LGD, HGD, T1a adenocarcinoma), 1 rectal (TVA with HGD), and 1 ascending colon (TA with HGD) lesions were removed. The ascending colon lesion was removed using a 'hybrid' ESD and EMR technique. The median age was 59 years (range 53-84). The median lesion size was 30mm (range 25-32). The median procedure time was 80 min (range 70-120). No immediate or delayed complications were seen. All patients were admitted and discharged the following day. All cases resulted in R0 resection.
Conclusions
ESD is an effective technique in the management of early GI neoplasia, and may reduce the need for surgical intervention. The learning curve is steep and risk of complications higher than EMR, though this early Irish experience is promising. Discussion regarding how to implement this service nationally is required.

ABSTRACT 24 (20W128)

Value of Pre-assessment of Elderly Patients prior to Direct Access Endoscopy.

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Introduction
Endoscopy is the gold standard for investigation of gastrointestinal symptoms. However, procedure related complications are twice more common in over 85 year old population than their younger counterparts (66-69 year olds). The decision to perform endoscopy, particularly in the elderly cohort, must balance of benefit and risk. Potential alternatives diagnostic modalities should be considered in frail elderly.
Aims/Background
To assess direct assess endoscopy referral pathway in symptomatic octogenarians.
Method

Winter Meeting 2019

Dr Billy Stack, Kathleen Creaby, Sheila King RCPI & Prof Frank Murray

Dr Tariq Ahmad, Speaker

Retrospective study analysing Healthlink direct access endoscopy referrals to an academic teaching hospital from April 2019-January 2020. Clinical data, radiology, endoscopy and histology reports were obtained from electronic patient record.

Results

68 octogenarians were referred for direct access endoscopy. Thirteen referrals were rejected for insufficient information or inappropriate indication. Of the 55 triaged referrals, 28 (51%) were sent to clinic, 11(20%) to direct colonoscopy and 17(31%) to direct OGD. Of those triaged to clinic, 11(39.28%) referred for endoscopic investigation, 6 (21.42%) booked for alternate radiological investigations and 11(39.28%) had neither arranged. Malignancy was detected in 5 patients (9.09%), of which 3 were detected at endoscopy. The predicted 10-year survival was 8.88% (median Charlson Co-morbidity Index(CCI) = 5.5) in the clinic group compared to 21.21% (median CCI = 5) the direct endoscopy group. The median time to OGD and colonoscopy after clinic assessment was 24 and 22.5 days, respectively.

Conclusions

Majority of elderly patients reviewed in clinic were not referred for endoscopic investigation. This highlights the value of pre-assessment of elderly co-morbid patients. Incorporation of Charlson Comorbidity Index can be helpful if triaging direct access endoscopy referrals.

ABSTRACT 25 (20W130)

Colorectal cancer stage among routine and urgent colonoscopy referrals as compared to surveillance and screening populations: a single tertiary-centre evaluation.

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Introduction

Colorectal cancer (CRC) is the second most common cancer in Ireland, accounting for almost 12% of all cancer deaths. The national bowelscreen programme(NCSS) aims to reduce morbidity and mortality from CRC, however, evaluation of symptomatic patients referred for colonoscopy remains a priority. Triage of these patients is difficult, often relying on incomplete information with NICE guidelines now recommending FIT as a screening tool.

Aims/Background

The aim of this study was to evaluate the referral pattern of patients with a confirmed CRC diagnosis at our institution and the impact on disease stage.

Method

Patients with a confirmed diagnosis of colorectal cancer attending a single academic centre were identified using the endoscopy reporting system, cross-referenced with the hospital CRC database.

Results

381 patients with CRC from March 2014-March 2020 were identified with a slight male predominance (M=220;F=161). NCSS population= 122; Symptomatic population=256(Routine=96, Urgent=160); Routine Surveillance=3. Median age was significantly higher in the symptomatic population(urgent=72,routine=70), compared to the NCSS(65), p=0.000. 19.2% had metastatic disease at time of assessment with a higher rate among urgent referrals(27%,n=34) compared to those in the NCSS(13.2%,n=14) and routine(14.5%,n=11),pearson-chi-square 0.014. There was a higher than expected rate of metastatic disease in the 40-60 age group who accounted for 21% of the total population but 36.7% of those with metastases(Pearson-chi-square 0.005). pT1 tumours accounted for 7.8%(n=24); pT2 15.3%(n=47); pT3 44.2%(n=136) and pT4 32.8%(n=101). There was a significant difference in the tumour stage among referral groups(Pearson-chi-square 0.001). 50% of pT1 tumours were among NCSS(n=12), compared to routine(12.5%,n=3) and urgent(37.5%,n=9). 51.5% of pT4 tumours were among urgent referrals(n=52), with 19.8%(n=20) in routine and 28.7%(n=29) in NCSS patients.

Conclusions

This study highlights the importance of appropriate triage and resource allocation to urgent symptomatic colonoscopy referrals who present at an older age with late stage disease.

ABSTRACT 26 (20W131)

Tsats What We Like To See!" – A Haemochromatosis Monitoring and Management Evaluation

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Introduction

Ireland has the highest prevalence of Hereditary Haemochromatosis in the world. Despite this, Irish hospitals lack a unifying protocol of monitoring and management targets dedicated to conferring the best outcomes.

Aims/Background

To compare current treatment standards in our Hospital to the 'Clinical Guidelines for Haemochromatosis' set out by Beaumont Hospital in June 2019.

Method

A service evaluation project was carried out of all patients managed with Hereditary Haemochromatosis at a Model 2 Hospital in Limerick City. Data collection included demographics, venesection treatment phase, end organ damage evaluation based on severity and availability of genotyping.

Results

A total of 126 patients were included, 40 (32%) of whom were female. Mean age at presentation was 52 yrs of age. We found that 7 out of 16 patients (44%) of those with severe iron overload (initial ferritin >1000) achieved the standards for end-organ monitoring (HbA1c,TFTs, ECHO). 11.5% of patients lay in Reduction Phase 1(Ferritin >300) and remained so for several months. One patient was found to have documented cirrhosis and was reaching none of the recommended targets for monitoring (six monthly AFP and liver ultrasound). For 32 (25%) patients, the genotype, a key determinant of outcomes, could not be established from the records.

Conclusions

Overall, we unveiled that a significant proportion of Haemochromatosis patients are falling short of treatment recommendations and further effort is needed to optimise the health of this large subset of Irish society. The implementation of a dedicated protocolized Haemochromatosis clinic may assist in this endeavour.

ABSTRACT 27 (20W132)

The addition of castor oil as a booster in colon capsule regimens significantly improves completion rates and polyp detection.

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Introduction
Incomplete excretion rates are problematic for colon capsule endoscopy (CCE). Widely available booster regimens perform poorly. Recently published same day CCE protocol in IBD using castor oil appeared effective.
Aims/Background
Assess the effectiveness of adding castor oil as an additional booster in our CCE practice.
Method
All patients received split bowel preparation with Moviprep© prior to CCE. Control booster regimen included 750ml Moviprep© with 750ml water (booster 1) on reaching the small bowel, a further 250ml Moviprep© with 250ml water 3 hours later and a bisacodyl suppository 10mg after 8 hours, if not excreted. Cases followed the same regimen and were given 15ml of castor oil with booster 1. A nested case control design with 2:1 (control:case) ratio was employed. Demographics, completion rates, image quality, transit time and polyp detection were compared between groups.
Results
186 CCEs (mean age 60 years (18-97), 56% females, n=104), including 62 cases have been analysed. Cases and controls were matched for age and gender. Overall CCE completion was 77% (144/186), image quality was adequate/diagnostic in 91% (170/186), mean transit time 3.5 hours (0.25-13) and polyp detection rate was 57% (106/186). Completion rates were significantly higher with castor oil, 87% cases (54/62) vs 73% controls (90/124), p=0.01. Similarly, polyp detection rates were higher 82% (51/62) vs 44% (55/124), p=0.0001, OR 5.8. Transit times and image quality were similar, 3.2 and 3.8 hours, adequate/diagnostic in 90% (56/62) vs 92% (114/124), respectively.
Conclusions
In our unselected cohort, castor oil addition as a CCE booster significantly improved completion rates and polyp detection.

ABSTRACT 28 (20W133)

Factors that led to failed cannulation in ERCP in tertiary centre in one year.

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Introduction
Mercy University Hospital is a leading tertiary hospital in gastroenterology in Ireland.It is also the only centre for hepatobilary and upper GIT surgery in South of Ireland. ERCP is one of the most challenging endoscopic techniques indicated in a range of pancreatic and biliary diseases . A side viewing duodenoscope allows selective cannulation of the biliary system, and insertion of cannulae into pancreatic/common bile duct, with the biliary system delineated by contrast injection and X-ray imaging. Due to the presence of other modalities for diagnosis like CT, MRI and EUS ,ERCP should be reserved for therapeutic purposes due to complications risk.1 For the individual components of ERCP Ductal cannulation is defined as: Deep cannulation of the duct (though introduction of contrast into the duct was not mandatory if a satisfactory wire position was obtained) We aim in this study to evaluate the factors that led to incomplete cannulation in our centre in the ERCP cases that were performed in one year
Aims/Background
We aim to assess if KPI standards for cannulation at ERCP were achieved and to identify the factors that led to failed cannulation in patients attended Mercy University Hospital in Cork in one year.
Method
The data for the ERCP patients from January 2019 upto Decemeber 2019 were checked. Patients in whom both biliary /pancreas duct not opacified were ticked.The endoscopy reports for these patients were checked and the charts for them were pulled and run through.
Results
: 312 cases of ERCP were performed by a single endoscopist (MB) in the period specified. The cannulation was successful in 93.0% (291) . 6.1 % (n=19) were identified as failed cannulation . 57.9 % (n=11) of unsuccessful patients were males and 42.1 % (8) were females. Age groups range 40-60 years 6. 60—75 years 6 and 7 more than 75 years. The indication for ERCP was stone (n=8), pancreatitis (n=2), pancreatic mass (n=3), jaundice (n=4), CBD leak (n=1) and duodenal adenoma (n=1). The causes for failure to cannulate were: distorted antomay due to tumour (n=11) stricture due to chronic pancreatitis (n=1) acute pancreatitus (n=1) difficult anatomy due to the presence of diverticulum (n=1) uncooperative pts (n=2)
Conclusions
International KPI standards are being maintained at MUH. The audit will be repeated in 1 year to ensure ongoing adherence to standards.

ABSTRACT 29 (20W136)

Evolving Outpatient Services in Changing Times: Virtual, Centralised Infliximab Monitoring in IBD Positively Impacts Patient Satisfaction and Reduced Outpatient Waiting Times

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Introduction
Biologic therapy has become the mainstay of management for moderate to severe inflammatory bowel disease (IBD). Therapeutic drug monitoring (TDM) is pivotal to patient care. A weekly IBD nurse and consultant-led virtual biologic clinic was established for patients receiving infliximab with proactive TDM and review of disease biomarkers.
Aims/Background
To standardise and respond to TDM results in a timely manner outside OPD visits.

Method
We identified actions arising from virtual review including dose amendment and drug discontinuation. A patient satisfaction survey and evaluation of impact on service delivery was carried out.
Results
192 patients were included. 80 patients (42%, n=40 UC/IBDU, n=39 CD, n=1 pouchitis) had changes to therapy over 6 months. 24 patients (12.5%) had dose de-escalation or discontinuation. Of those who discontinued infliximab, 52% switched biologic, 13% remain on no medical therapy, and the remainder proceeded to surgery. In a patient satisfaction survey, 86% were pleased with virtual clinics with 79% preferring a combination of virtual and in-person consultations. New patient referral wait-list for gastroenterology clinic fell by 20% arising from these changes.
Conclusions
Our nurse-led virtual clinic was established to standardise TDM and evolve mechanisms for patient follow up during the pandemic. This pilot project led to 20% reduction in new patient waiting lists and enhanced service flexibility in response to patients' appetite for alternative models of follow-up. 42% patients had dose changes and ongoing evaluation of this model will include determination of influence on hospitalization, endoscopic outcomes and overall economic impact.

ABSTRACT 30 (20W137)

Impact of COVID-19 Pandemic on Endoscopy Access of Symptomatic Upper Gastrointestinal Bleeds (UGIB)

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Introduction
The COVID-19 pandemic has greatly impacted endoscopy services globally. UGIB a significant cause of mortality is a common reason for hospital admission. Guidelines recommend early upper GI endoscopy.
Aims/Background
- To compare time-to-endoscopy in admissions with UGIB during COVID restrictions (March-June 2020) with those in Pre-COVID-times (March-June 2019). - To review management and outcomes of patients admitted with UGIB over a 12-month period
Method
Retrospective HIPE coding from an academic teaching hospital over 12 months 2019-20 was used. All patients admitted with codes hematemesis, UGIB etc. were included, with data obtained from their electronic health records.
Results
Sixty-nine emergent admissions with UGIB were identified via HIPE over 12-month period 2019/2020. Seventy-three percent of patients underwent inpatient endoscopy. Overall average time-to-endoscopy was approx. 26.44h, with 26% performed within 24h. Secondly, admissions with UGIB March-June 2019 were compared with those of March-June 2020: 21 patients (12-female) underwent gastroscopy in first arm compared to 25 patients (12-female) in the second arm. Average time to endoscopy during March-June 2020 (COVID-19 pandemic restrictions) was improved at 19.9 h versus 45.57 h during March-June 2019 (p-value 0.003). Average GBS score at 6.9 was higher but not significant in admissions during COVID restrictions compared with 4.9 in admissions pre-COVID (p-value 0.31).
Conclusions
Our study reveals no negative impact of COVID-19 pandemic on access to endoscopy in a cohort of symptomatic upper GI bleed with higher GBS; rather, we demonstrated improved times. This study further validates the use of GBS in clinical setting.

ABSTRACT 31 (20W138)

A Review of treatment decisions for all hepatocellular cancers (HCC) presented at the Northern Ireland regional HPB MDM in 2019

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Introduction
HCC usually arises in patients with liver cirrhosis. Although some treatments can achieve cure, the majority of HCC patients receive palliative measures. In September 2017, NICE approved the use of Sorafenib for patients with advanced stage HCC who have Child-Pugh A cirrhosis.
Aims/Background
To determine the treatment option selected for patients with a new diagnosis of HCC who were referred to the NI regional HPB MDM in 2019 and compare outcomes with 2017.
Method
The MDM database was reviewed to identify all HCC cases from 2019. NICE TA474 criteria were applied to determine those eligible for sorafenib. Results were compared with an audit of HPB MDM outcomes from 2017.
Results
80 patients were identified. 19 (23%) were detected via HCC screening programme. 32 (40%) were offered surgery or radiological intervention (54% in 2017). 4 had TACE, 6 RFA, 8 TACE and RFA, 3 SIRT, 1 SABR, 7 resections. 2 patients underwent transplant assessment (one also received SABR). 1 on the transplant waiting list received TACE. 1 patient had a rare subtype and received palliative chemotherapy. 17 (36%) of the 47 patients recommended for palliative supportive care were Child Pugh A and eligible for considering systemic therapy. Of the 17, 4 patients received sorafenib and 3 received levatinib. In 2017, no patients received systemic therapy.
Conclusions
The introduction of systemic therapy for HCC in 2017 through NICE TA474 has resulted in 15% (7 of 47) of HCC patients who were not suitable for surgery or radiological intervention receiving a therapeutic intervention (compared to 0% in 2017).

ABSTRACT 32 (20W139)

Assessment of Aerobic Cardiovascular Capacity in Patients Undergoing Liver Transplantation Assessment

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Introduction
Orthotopic liver transplantation (OLT) is associated with significant peri-operative cardiovascular morbidity. OLT candidates therefore undergo a series of investigations including estimation of VO2 at peak exercise. Access to cardiopulmonary stress testing (CPET) is limited and the Covid-19 pandemic has exacerbated this. The 6 minute walk test (6MWT) is a simple submaximal objective measure ideally completed over a 30M course. The patient is asked to walk for a total of 6 minutes between 2 cones marking out the distance. A simple calculation generates an estimated Vo2 Max.
Aims/Background
Aims: To investigate if the 6MWT was a reliable alternative assessment of cardiovascular fitness for patients undergoing liver transplantation
Method
Patients in a single regional liver centre undergoing assessment for OLT from January 2020 to July 2020 were selected. Each patient underwent 6MWT and CPET. VO2 maximum was estimated for both. Pearson's correlation co-efficient and statistical significance was calculated using Microsoft Excel.
Results
20 patients, 15 male, were included. Mean age 52yrs, range 27-67. Patients generated an average of 124 Watts on CPET testing (range 58-237W) and walked an average of 519 metres in 6MWT (range 140m – 1020m). The mean estimated VO2 maximum was 17.6mls/Kg/min (range 11-31) for 6MWT and 20.98mls/Kg/min (range 11.7-43) for CPET. There was a significant positive correlation between results of VO2 max estimated by CPET testing and 6MWT in patients being assessed for liver transplantation, $r(18)= 0.93$, $p<0.001$. All patients were subsequently listed on the UK OLT waiting list.
Conclusions
The 6-minute walk test provides a reliable alternative assessment of cardiovascular aerobic fitness for patients undergoing liver transplantation. Further study is required to correlate outcome following transplantation with 6-minute walk test results.

ABSTRACT 33 (20W140)

Liver Patients Knowledge Of Changing Health Advice During The Current Covid-19 Pandemic

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Introduction
The first case of Covid-19 was diagnosed in Ireland in March 2020 and vulnerable groups including immunosuppressed patients were advised to 'cocoon' . We received a number of worrying calls from patients about stopping immunosuppression.
Aims/Background
We decided to contact our own cohort of immunosuppressed patients by phone to establish if they were cocooning, knew about Covid and give advice as required.
Method
Our Hepatology Nurse phoned 132 patients during the month of April from the database kept in our own Hepatology Department: 84 with autoimmune hepatitis (AIH) and 48 post liver transplant (LT).
Results
All patients were aware of covid-19 and they all knew the symptoms to watch out for. Sixty four (76%) of AIH and 40 (83%) of LT patients knew what self-isolation meant. However , 29 (38%) of AIH and 9 (19%) of LT patients were not cocooning. The reasons given for not cocooning were: not aware (n=20 and 8): working (n=10 and 1): going out to shop (n=29 and 8) in the AIH and LT groups resp.
Conclusions
This enquiry has shown us that the public health notices regarding Covid-19 have been well received and understood. However, there is a worrying gap in patient knowledge with 1 in 4 AIH and 1 in 5 LT patients not taking correct precautions. This study highlighted the importance of having an up to date in house database in the absence of a national registry which allowed us to maintain patient contact and give clear advice when health recommendations change.

ABSTRACT 34 (20W141)

Small Bowel Capsule Endoscopy in the West of Ireland: A Closer Look at the First Year

Author(s)
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Introduction
The small bowel is the least common site of blood loss from the gastrointestinal (GI) tract but the commonest site of obscure GI bleeding. Blood loss from the GI tract is the most common cause of iron deficiency anaemia (IDA) in men and postmenopausal women. In those with persistent IDA post endoscopic investigation, adequate iron replacement and management of other potential underlying causes (i.e. NSAID use), SBCE or enteroscopy are crucial tools for further investigation and diagnosis. In fact The European Society of Gastrointestinal Endoscopy (ESGE) recommends SBCE as the first line investigation in patients with obscure GI bleeding. SBCE is also indicated to assist in the diagnosis of small bowel Crohn's disease.
Aims/Background
This is a retrospective review of all SBCE performed in University College Hospital Galway since the introduction of the service in March 2019 to July 2020.
Method
All patients who had completed SBCE during this time were included. Data were collected from Pilcam studies. Demographics, indication for procedure and outcome were recorded. Quality of bowel preparation, transit time and need for patency testing were also analysed. The use of anticoagulation or antiplatelet therapy was recorded.
Results
In total, 122 patients underwent SBCE during the study period. Pathology was seen in 89 (67%) of the cases. 81 (66%) were referred for investigation of obscure GI bleeding or iron deficiency anaemia. Of the 89 cases where a pathology was found, 31 (34%) were taking anticoagulation/antiplatelet therapy. 54 (61%) were found to have angiodysplasia/angioectasia with 50% of these patients taking antiplatelet/anticoagulant medication. 36 patients were referred for diagnosis or assessment of small bowel Crohn's disease with 13 (33%) of these having positive findings.
Conclusions
The introduction of SBCE in our centre has proven to be a useful addition for investigation of obscure GI bleeding and other small bowel pathology with positive findings detected in two thirds of the patients. It can be performed in an outpatient setting and has a very high completion rate. The use of anticoagulant/antiplatelet therapy may increase the risk of obscure GI bleeding/IDA due to angiodysplasia.

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Maintenance treatment: 2g once daily. *Sachets and 500mg tablet:* Children over 6 years old: Active disease: individual dosing, starting with 30-50 mg/kg/day in divided doses (total dose should not exceed 4g/day). Maintenance treatment: individual dosing, starting with 15-30 mg/kg/day in divided doses (total dose should not exceed 2g/day). *Enema:* Adults: one enema at bedtime. *Suppositories:* Adults: 1 suppository daily. ***Contraindications:*** patients with known hypersensitivity to salicylates or any of the excipients and patients with severe liver and/or renal impairment. ***Special Warnings and Precautions:*** Blood tests (differential blood count: liver function parameters such as ALT or AST; serum creatinine) and urinary status should be determined prior to and during treatment, at the discretion of the treating physician. Caution is recommended in patients with impaired hepatic function. PENTASA should not be used in patients with impaired renal function. 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Very Rare: Acute Pancreatitis. ***Nature and Contents of Container:*** *Sachets:* Cartons contain 50 x 1g sachets, 60 x 2g sachets or 30 x 4g sachets. *Tablets:* Cartons contain 100 x 500mg and 60 x 1g tablets in blister strips. *Enema:* Cartons contain 7 x 100ml enemas. *Suppositories:* Cartons contain 28 x 1g suppositories in blister strips. ***Marketing Authorisation Number:*** *Sachet 1g:* 03194/0075. *Sachet 2g:* 03194/0102. *Sachet 4g:* PL 03194/0117. *Tablets 500mg:* 03194/0044. *Tablets 1g:* 3194/0108. *Enema:* 03194/0027. *Suppositories:* 03194/0045. ***Marketing Authorisation Holder:*** Ferring Pharmaceuticals Ltd., Drayton Hall, Church Road, West Drayton, UB7 7PS, United Kingdom. ***Legal Category:*** POM. ***Basic NHS Price:*** £30.74 for 50 x 1g sachets. £73.78 for 60 x 2g sachets. £73.78 for 30 x 4g sachets. £30.74 for 100 x 500mg Tablets. £36.89 for 60 x 1g Tablets. £17.73 for 7 x enemas. £40.01 for 28 x 1g suppositories. **Date of Preparation of Prescribing Information:** January 2019. 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References: 1. Pentasa Sachet 1 g. SmPC. **2.** Pentasa Sachet 2 g. SmPC. **3.** Pentasa Sachet 4 g. SmPC. **4.** Pentasa Slow Release Tablets 500 mg. SmPC. **5.** Pentasa Slow Release Tablets 1 g. SmPC. **6.** Sulfasalazine 250 mg/5 ml Oral Suspension. SmPC. **7.** Octasa 400 mg MR Tablets. SmPC. **8.** Asacol 400 mg MR Tablets. SmPC. **9.** Mezavant XL 1200 mg, Gastro-resistant, Prolonged Release Tablets. SmPC. **10.** Salofalk 500 mg Gastro-resistant Prolonged Release Granules. SmPC. **11.** Colazide 750 mg Capsules. SmPC. **12.** Olsalazine Sodium 250 mg Capsules. SmPC. **13.** Salazopyrin En-Tabs. SmPC. **14.** Salazopyrin Tablets SmPC. **15.** Dignass AU, *et al. Clin. Gastroenterol Hepatol.* 2009;7(7):762-9. **16.** Flourie B, *et al. Aliment Pharmacol Ther.* 2013;37(8):767-75. **17.** Pentasa Enema 1 g. SmPC.

FERRING PHARMACEUTICALS

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Winter Meeting 2019

Dr Danny Cheriyan

Dr Brian Christopher

Dr Hilary Kerr

Prof Larry Egan

ABSTRACT 35 (20W143)

Increasing Radiation Exposure From Computed Tomography in Liver Transplant Recipients

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Introduction
Radiation exposure from diagnostic imaging; in particular computed tomography (CT), is increasingly recognised as a potentially significant carcinogen.
Aims/Background
We aimed to estimate the amount of radiation exposure from CT scans performed on liver transplant recipients as part of their workup and post-operative course, and assess whether the number and type of scans were changing over time.
Method
135 elective, non hepatoma, first time liver transplant recipients encompassing the time periods 2007-2008 and 2017-2018 were included. CT scans performed at St. Vincent's University Hospital two years prior to, and one year after transplantation were analysed
Results
There was an increase in estimated effective radiation dose per patient in 2017/18 compared to 2007/08 (77.8mSv + 6.2 vs 56.7mSv + 5.9, $p < 0.05$). This change was mainly due to an increased number of pre-transplant CT scans per patient (2.9 0.3 vs 1.4 0.14, $p = 0.0001$). High radiation dose scan protocols were more frequently used in 2017/18, with 4-phase liver CT accounting for a larger proportion of scans both pre-transplant (61% vs 43%, $p = 0.004$) and post transplant (29% vs 13%, $p = 0.002$)
Conclusions
Radiation exposure from diagnostic imaging has increased among liver transplant recipients at our institution over the last decade. This appears to be due to an increase in the number of CT scans performed, and a shift towards higher dose scan protocols. The risk/benefit ratio of these changes in clinical practice needs to be evaluated.

ABSTRACT 36 (20W144)

Skin Cancer Awareness Among Liver Transplant Recipients In Ireland – An Answer To A Burning Question

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Introduction
Liver transplant recipients (LTRs) are a high-risk group for developing cutaneous malignancy secondary to immunosuppression. However studies suggest that patients have suboptimal awareness of the risk and are poorly compliant with sun protection.
Aims/Background
To evaluate the sun protection practices of Irish LTRs and their awareness of the risk of cutaneous malignancy.
Method
Single centre cross-sectional study of all LTRs attending hepatology clinics in a large tertiary hospital. 63 patients were telephoned and questioned regarding their frequency and method of photoprotection and knowledge of skin cancer risk. Secondary outcomes related to adherence to national malignancy screening programmes including cervical, breast and bowel screening.
Results
50 patients responded to our survey (79% response rate). The majority of patients reported different methods of photoprotection with 74% (37) using sunscreen, 58% (29) sun avoidance and 52% (26) using physical protection. 66% (33) use sunscreen on sunny days with daily application in only 16% (8) . 86% (43) of our LTRs are aware of their increased risk of cutaneous malignancy however 68% (34) have never undergone a skin check. Secondary outcomes regarding general malignancy screening showed 76.9% (10) of women were up-to-date with cervical screening, 87% (7) availed of mammograms and 82% (23) were bowel screening compliant.
Conclusions
Immunosuppressed LTRs are a high-risk group for developing skin cancer but despite awareness of this risk, photoprotection and sunscreen use amongst Irish LTRs is substandard. It is vital to promote education and increase specialist dermatology clinics to ensure adequate protection for this vulnerable group.

ABSTRACT 37 (20W146)

Preconception Counselling in IBD or Lack Of ? An Opportunity to Improve Obstetric Outcomes in IBD Patients.

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Introduction
25% of women with IBD become pregnant after diagnosis. Ideally, all women contemplating pregnancy should have preconception counselling. This allows the IBD physician to deal with maternal concerns, strive for disease remission, stop teratogenic medications and ensure smoking cessation.
Aims/Background
We sought to assess documentation of preconception counselling in our cohort of patients with IBD who became pregnant while attending the IBD services in Beaumont Hospital.
Method
IBD patients who were managed during their pregnancies were identified from the IBD database. All available clinic letters prior to conception since diagnosis were reviewed to assess if preconception counselling had been discussed and documented.
Results
32 patients were identified (14 CD ,17 UC). 14 were on anti-TNF medication, 5 on thiopurines, 6 on aminosalicylates and 3 on oral steroids at the time of conception. No pregnancies occurred in patients taking methotrexate. 6 patients were flaring or had recent flares at conception. Documentation of pre conception counselling was recorded in 8 patients (25%). Smoking status was documented in 3 cases (9%). Where documented - counselling was discussed by a consultant in 7 of the 8 cases and by an NCHD in one. We found

no significant association between rates of documented counselling based on IBD subtype, use of biologic or immunosuppressive medications.

Conclusions

Documentation of preconception counselling was poor in our study. Smoking and active disease are associated with poor obstetric outcomes in IBD - at the very least smoking cessation should be discussed. We have subsequently developed an updated IBD and pregnancy handbook. We propose that all patients of child bearing age receive written literature regarding preconception counselling to minimize obstetric complications. In addition, appropriate documentation is mandatory given the medicolegal implications for the physician in the unfortunate event of an adverse birth outcome.

ABSTRACT 38 (20W147)

A Review of the Psychosocial Experiences of Patients Living with Stomas in the West of Ireland

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Introduction

Having a stoma significantly impacts a patient's lifestyle, both physically and psychologically. Peri-operative optimisation of coping strategies is of great importance in both elective and emergency cases.

Aims/Background

We aimed to examine the psychosocial impacts of stoma creation as experienced by patients in the Mayo University Hospital (MUH) catchment area, and to investigate whether patients feel there are adequate supports in place to manage these.

Method

A survey was administered to patients with stomas who benefit from outpatient colorectal care in MUH. Patients were made aware of a local stoma support group and prior knowledge of this investigated. Respondents were asked to comment on whether community supports for stoma patients were adequate.

Results

Of respondents, 36 underwent stoma creation electively (ileostomy/colostomy) and 23 emergently. 75% of elective patients and 65% of emergency patients were aware of the stoma support group. However, 47% of elective and 52% of emergency patients felt the West of Ireland was lacking in support structures for patients with stomas. The majority of patients were not put in touch with a mentor but felt they would have benefitted from same (75% of elective and 50% of emergency). The most frequently reported issue was a paucity of pre-operative information regarding living with a stoma (47% elective and 65% emergency).

Conclusions

In the West of Ireland, patients with stomas are generally coping well, but there is a concensus that supports available are currently inadequate and that perhaps patients would benefit from a mentoring programme peri-operatively to enhance coping strategies.

ABSTRACT 39 (20W148)

Effect of the Move to Specialty Take on Quality of Care Metrics for the Gastroenterology Service at Tallaght University Hospital

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Introduction

The mode of take switched from one where patients admitted over a 24-hour period remained with one consultant, to one where same are divided across services by specialty.

Aims/Background

We audited the switch's impact on length-of-stay and hours-until-OGD for patients with a diagnosis of UGI bleed.

Method

The LOS pertaining to all medical admissions for the first six months of Specialty Take were compared with the five months preceding its inception through ordinary least squares regression. Our ED database was queried for all referrals from 01/01/17 to 31/12/19 with diagnoses pertaining to UGIB. These were cross-referenced with our endoscopy and theatre databases to construct an hours-until-OGD metric. A modified Glasgow Blatchford Score was calculated. Hours-until-OGD pertaining to admissions during Specialty Take were compared to those for the preceding 2.5 years through OLSR.

Results

Specialty Take was associated with a significant reduction in LOS for general medical and gastro patients with LOS $\leq$ 14 days, returning 835 (p=0.00, 95%CIs: 367.6, 1,303.3) and 278 (p=0.00, 95%CIs: 58.24, 497.3) bed days respectively to the services over the studied period. Specialty Take was not associated with a faster time to OGD (-6.95 hours, p=0.49, 95%CIs: -26.9, 13.0). Modified GBS had a significant negative relationship with hours until OGD (-2.89 hours, p=0.002, 95%CIs: -4.9, -0.9).

Conclusions

Specialty Take has decreased LOS but not time to OGD. This may be secondary to delayed bed allocation post admission and to a worsening demand/supply ratio for inpatient OGDs. Analysis of these two factors is required to further define the problem.

ABSTRACT 40 (20W149)

Stable Trends in Radiation Exposure Amongst Patients with a New Diagnosis of Inflammatory Bowel Disease at an Irish Tertiary Referral Hospital

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Introduction

The utilisation of diagnostic imaging has risen dramatically over time. IBD patients are particularly vulnerable to this inclination.

Aims/Background

We evaluated trends in the radiation doses to which our service exposed our new IBD referrals over time.

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Method
Searches of new referrals to our IBD clinic during two 24-month periods beginning 01/06/2005 (n=84) and 01/01/2013 (n=63) were conducted. The numbers of AXRs, CT APs, Barium Swallows, Meals, Follow-Throughs and Enemas, CT Colonographies and MRI SBs were collated for each patient for the five-year period subsequent to their first attendance. Cumulative effective radiation doses were calculated using estimates provided in leading radiology journals. Linear regression using the ordinary least squares method examined the relationship between cumulative dose, period of diagnosis, age, gender and category of IBD.
Results
The mean cumulative effective radiation doses for the earlier and later periods were 4.7mSv (95% CI, 1.86 to 7.54) and 7.4mSv (95% CI, 3.60 to 11.26) respectively. No significant relationship was demonstrated between age (-0.03mSv, 95%CIs: -0.20, 0.12), male gender (0.69mSv, 95%CIs: -4.00, 5.39), or later referral period (3.06mSv, 95%CIs: -1.67, 7.78) and cumulative dose. A diagnosis of Crohn's (as opposed to UC) had a strongly positive relationship with total radiation dose (5.89, 95%CI: 1.07, 10.70). 12 MRI small bowels were completed during period 2, none during period 1.
Conclusions
Our evaluation shows an upward trend, failing to meet statistical significance, in the radiation doses to which patients with new diagnoses of IBD were exposed to by our service.

ABSTRACT 41 (20W150)

Keeping the Endoscopy Ship Afloat Against The First Wave Of COVID -19 -An Analysis Of The Utilisation Of A Private Institution To Bolster MMUH GI Services During COVID-19

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Introduction
During COVID-19, endoscopy departments operated at a reduced capacity due to social distancing guidelines, staff redeployment and subsequent restrictions on procedure numbers in the unit. Furthermore, the HSE, BSG and JAG released practical guidelines on safe endoscopy during COVID-19. To help meet the need for urgent procedures during the pandemic, we sent a cohort of patients to a private hospital to maximise utilisation of the private endoscopy unit.
Aims/Background
To analyse the use of a private institution to support GI services during COVID-19.
Method
We analysed the processes involved in 205 endoscopy procedures over a 2 month period May-June 2020. We examined referral letters, endoraad and histology reports, and follow up letters that were uploaded to the MMUH IT system.
Results
205 urgent endoscopy procedures were outsourced to a private institution. 167 (81.7%) were completed. 38 were not completed due to patient factors – refusal, DNA, another illness precluding attendance. 99 patients (59.2%) were discharged to the GP. Follow up was required for 68 patients (40.7%) in MMUH; 35 for symptoms, 5 for Barrett's, 5 due to poor prep, 4 for new IBD, 4 for polyp surveillance, 9 for other reasons. 2 cancers were detected.
Conclusions
COVID-19 compounded the issue of long endoscopy wait-times. Referrals to a private institution presented an avenue for us increase capacity to deal with urgent referrals. In some ways the process mimicked an NTPF approach as repeat procedures and follow up were referred back to the Mater Public. Whilst helpful, it was noted that the process generated a huge administrative burden and almost 50% of patients required referral back to MMUH for follow up after the procedure, further adding to MMUH clinic waiting lists. These data would suggest that outsourcing patients reduces procedure waiting list numbers (at a high cost), but generates further procedures or follow up for the parent institution in almost 50% of cases.

ABSTRACT 42 (20W152)

Does Living Remotely Impact Access to Care for Upper Gastrointestinal Malignancies?

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Introduction
There is robust data to support improved patient outcomes with centralisation of cancer care to high volume medical centres. It remains uncertain whether the increased travel times for patients residing remotely from the centres impedes their access to staging modalities and treatment.
Aims/Background
In our region, care for upper gastrointestinal (GI) cancers has been centralised to a select number of high-volume centres. Our centre caters to approximately 1 million people residing within a radius of approximately 100miles. This study aimed to determine whether patients' geographical location impacts negatively on access times for staging tests and subsequent treatment
Method
All patients presenting with oesophageal or gastric cancer between January 2013 and December 2018 were reviewed. Times from date of receipt of referral to date of: first outpatient appointment, first Multi-disciplinary team (MDT) discussion, staging CT, staging PET CT, laparoscopy (for gastric cancer), EUS (for oesophageal cancer), commencement of chemotherapy, and commencement of radiotherapy, were recorded; patients were categorised into four groups based on proximity of residence to the cancer centre, group A (<5 miles), group B (5-20 miles), group C (20 to 50 miles), group D (> 50 miles). Access times were compared for patient cohorts in each geographical group.
Results
In total, 624 patients with oesophageal (n=302), gastric (n=205), or gastro-oesophageal junction cancer (n=117) were treated between January 2013 and December 2018. Overall, there were: 263 patients in group A, 114 in group B, 142 in group C, 105 in group D.
Figure 1 illustrates the mean number of days to completion of the diagnostic and management end-points, showing no significant differences between patients geographically closest to the medical centre (Area A) vs those living in more remote areas (Areas B, C, and D).
Conclusions
Access times for staging modalities and cancer treatment were equivalent for patients regardless of distance from medical centre. Living remotely from the centre does not appear to delay testing nor treatment for patients with upper GI malignancies.

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Rheumatoid arthritis (RA), adults: In combination with methotrexate (MTX) for moderate to severe, active RA with inadequate response to disease-modifying anti-rheumatic drugs (DMARDs) including MTX. In combination with MTX for severe, active and progressive RA when not previously treated with MTX. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Reduces rate of progression of joint damage on X-ray and improves physical function, in combination with MTX. Dosage: 40 mg single dose every other week (EOW). Concomitant MTX should be continued. In monotherapy, patients may require 40 mg every week or 80mg EOW if they experience a decrease in clinical response. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Consider need for dose interruption, e.g. before surgery or if serious infection occurs. Reintroduction of Humira after discontinuation for 70 days or longer gave same magnitudes of clinical response and similar safety profile as before dose interruption.

Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above: In combination with MTX, for active pJIA, with inadequate response to one or more DMARDs. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Dosage: 10 kg to <30 kg: 20 mg EOW. If ≥ 30 kg: 40 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Enthesitis-related arthritis (ERA), paediatrics 6 years and above: For active ERA with inadequate response or intolerance to conventional therapy. Dosage: 15 kg to < 30 kg: 20 mg EOW. If ≥ 30 kg: 40 mg EOW.

Ankylosing spondylitis (AS), adults: For severe active AS with inadequate response to conventional therapy. Dosage: adults: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: For severe nr-axSpA with objective signs of inflammation (elevated CRP and / or MRI), and an inadequate response to, or intolerance to nonsteroidal anti-inflammatory drugs. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Psoriatic arthritis (PsA), adults: For active and progressive PsA with inadequate response to DMARDs. Reduces rate of progression of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Psoriasis (Ps), adults: For moderate to severe chronic plaque psoriasis in candidates for systemic therapy. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week
1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. Beyond 16 weeks, patients with inadequate response can increase dosage to 40 mg every week or 80mg EOW (refer to SmPC). If adequate response is achieved with 40mg every week or 80mg EOW, dosage may subsequently be reduced to 40 mg every other week.

Psoriasis, paediatrics 4 years and above: For severe chronic plaque psoriasis with inadequate response to or if topical therapy and phototherapies are inappropriate. Dosage: 15 kg to < 30 kg: 20 mg dose initially followed by 20 mg EOW starting one week after initial dose. If ≥ 30 kg: 40 mg dose initially followed by 40 mg EOW starting one week after initial dose. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time.

Hidradenitis suppurativa (HS), adults and adolescents from 12 years of age: For active moderate to severe HS (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Dosage: HS, adults: 160 mg dose initially at Day 1, followed by 80 mg two weeks later at Day 15. Two weeks later (Day 29) continue with a dose of 40 mg every week or 80mg EOW. Reintroduction after treatment interruption: 40 mg every week or 80 mg EOW.
Dosage: HS, adolescents from 12 years and ≥30 kg: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. If there is inadequate response to 40 mg EOW, an increase in dosage to 40 mg every week or 80mg EOW may be considered. Treatment interruption: Humira may be re-introduced as appropriate.
Adults and adolescents from 12 years of age: Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions is recommended to be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no improvement in that time. Evaluate periodically the benefit and risk of continued long-term treatment.

Crohn's disease (CD), adults: For moderately to severely active CD in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or are intolerant to or have medical contraindications for such therapies.
Dosage: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If decrease in clinical response, can increase dosage to 40 mg every week or 80mg EOW. Patients with no response by Week 4 may benefit from continued maintenance therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Paediatric Crohn's disease (CD), 6 years and above: For moderately to severely active CD with inadequate response to, intolerance to or contraindication for conventional therapy including primary nutrition therapy and a corticosteroid, and/or an immunomodulator.
Dosage: < 40 kg: Induction: 40 mg dose at Week 0, followed by 20 mg at Week 2. For a more rapid response: 80 mg at Week 0, followed by 40 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 20 mg dose EOW. If insufficient response, consider an increase in dosage to 20 mg every week. If ≥ 40 kg: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg dose at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. If insufficient response, consider an increase in dosage to 40 mg every week or 80 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.

Ulcerative colitis (UC), adults: For moderately to severely active UC with inadequate response to, intolerance to or contraindication for conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Dosage: Induction: 160 mg dose at Week 0, followed by 80 mg at Week 2. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If insufficient response, consider an increase in dosage to 40 mg every week or 80mg EOW. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time.

Uveitis, adults: For non-infectious intermediate, posterior and

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Further information is available upon request from AbbVie Limited,
14 Riverwalk, Citywest Business Campus, D24 XN32
Full prescribing information is available on www.medicines.ie
Legal Category: POM (S1A)

References

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

panuveitis with inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be tapered in accordance with clinical practice starting two weeks after initiating treatment with Humira. Evaluate on a yearly basis the benefit and risk of continued long-term treatment.

Paediatric Uveitis, 2 years and above: For chronic non-infectious anterior uveitis with inadequate response or intolerance to conventional therapy, or in whom conventional therapy is inappropriate. Dosage: < 30 kg: 20 mg dose EOW in combination with MTX. Optional 40 mg loading dose one week prior to start of maintenance therapy. No clinical data in use of loading dose < 6 years of age (see SmPC). If ≥ 30 kg: 40 mg dose EOW in combination with MTX. Optional 80 mg loading dose one week prior to start of maintenance therapy. Evaluate on a yearly basis the benefit and risk of continued long-term treatment.

Contraindications: Hypersensitivity to the active substance or any of the excipients (see SmPC). Active tuberculosis (TB) or other severe infections such as sepsis and opportunistic infections; Moderate to severe heart failure (NYHA class III/IV).

Warnings and precautions: Clearly record trade name and batch number of administered product to improve traceability of biological medicinal products. ***Infections:*** Patients taking Tumour Necrosis Factor (TNF)-antagonists are more susceptible to serious infections especially if impaired lung function. Monitor for infections, including TB, before, during and for 4 months after treatment. Do not initiate treatment with an active infection, until it is controlled. Consider risk/benefit prior to treatment in patients exposed to high risk of TB or who have travelled in areas of high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections, including the use of concomitant immunosuppressive medications. ***Serious infections:*** Serious infections, including those with hospitalisation or death reported in patients receiving treatment. ***TB:*** Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (disseminated) reported. Screen all patients before therapy initiation for active or latent TB. Appropriate screening tests (i.e. tuberculin skin test and chest X-ray) should be performed in all patients. If active TB is diagnosed Humira therapy must not be initiated. If latent TB is suspected, consult a physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Humira. Despite prophylaxis, TB reactivation has occurred on Humira. ***Other opportunistic infections:*** Opportunistic infections observed in patients receiving Humira. Stop treatment in patients with signs and symptoms of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients. ***Hepatitis B Reactivation:*** Reactivation of HBV has occurred in chronic carriers (surface antigen positive). Patients should be tested for HBV infection before initiating treatment. HBV carriers should consult with a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of Humira. If reactivation occurs stop treatment and initiate appropriate anti-viral and supportive treatment. ***Neurological events:*** Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. Discontinuation of treatment should be considered if any of these disorders develop. Neurological evaluation should be performed in patients with non-infectious intermediate uveitis before therapy initiation and regularly during treatment, to assess for pre-existing or developing central demyelinating disorders. ***Allergic reactions:*** Reports of serious allergic reactions including anaphylaxis received. For serious allergic or anaphylactic reaction, stop Humira immediately and initiate appropriate therapy. ***Malignancies and lymphoproliferative disorders:*** A possible risk of malignancy, including lymphoma and leukaemia, in all patients including paediatric patients, treated with TNF antagonists. Examine all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment for nonmelanoma skin cancer prior to and during treatment, caution in COPD patients, and in patients with increased risk of malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Humira (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk of developing dysplasia or colon cancer is unknown. Patients with UC, history of dysplasia or colon carcinoma to be screened for dysplasia before and during treatment. ***Haematologic reactions:*** Adverse events of the haematologic system reported with Humira. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias develop while on treatment. ***Vaccinations:*** Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to Humira treatment ***Congestive heart failure:*** See contraindications. Caution is advised in mild heart failure (NYHA class I/II). Discontinue treatment for new or worsening symptoms of congestive heart failure. ***Autoimmune processes:*** Autoimmune antibodies may form with Humira. Stop treatment if development of a lupus-like syndrome with positive antibodies against double-stranded DNA. ***Surgery:*** Consider the long half-life of Humira for planned surgical procedures. Closely monitor for infections. ***Small bowel obstruction:*** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture requiring surgical treatment. ***Elderly:*** Serious infections were higher in patients over 65 years of age, some of which had a fatal outcome. Consider risk of infections in these patients.

Interactions: Antibody formation was lower when Humira was given together with MTX in comparison with use as monotherapy. Combination of Humira with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended.

Fertility, pregnancy and lactation: Humira should only be used during pregnancy if needed. Women of childbearing potential should consider the use of adequate contraception and continue its use for at least five months after the last Humira treatment. No administration of live vaccines (e.g. BCG) to infants exposed to Humira in utero for 5 months following mother's last Humira treatment during pregnancy. Humira can be used during breast-feeding.

Adverse Reactions: *Very common ≥ 1/10:* Respiratory tract Infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leukopenia (including neutropenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema).

Serious, including fatal, adverse reactions have been reported. including infections/sepsis, TB, opportunistic infections, allergic reactions (including anaphylaxis), HBV reactivation and malignancies (including leukaemia, lymphoma and hepatosplenic T-cell lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia, aplastic anaemia, central and peripheral demyelinating events and reports of lupus, lupus-related conditions and Stevens-Johnson syndrome.

Prescribers should consult the SmPC for the complete list of reported side effects.

Legal Category: POM (S1A).

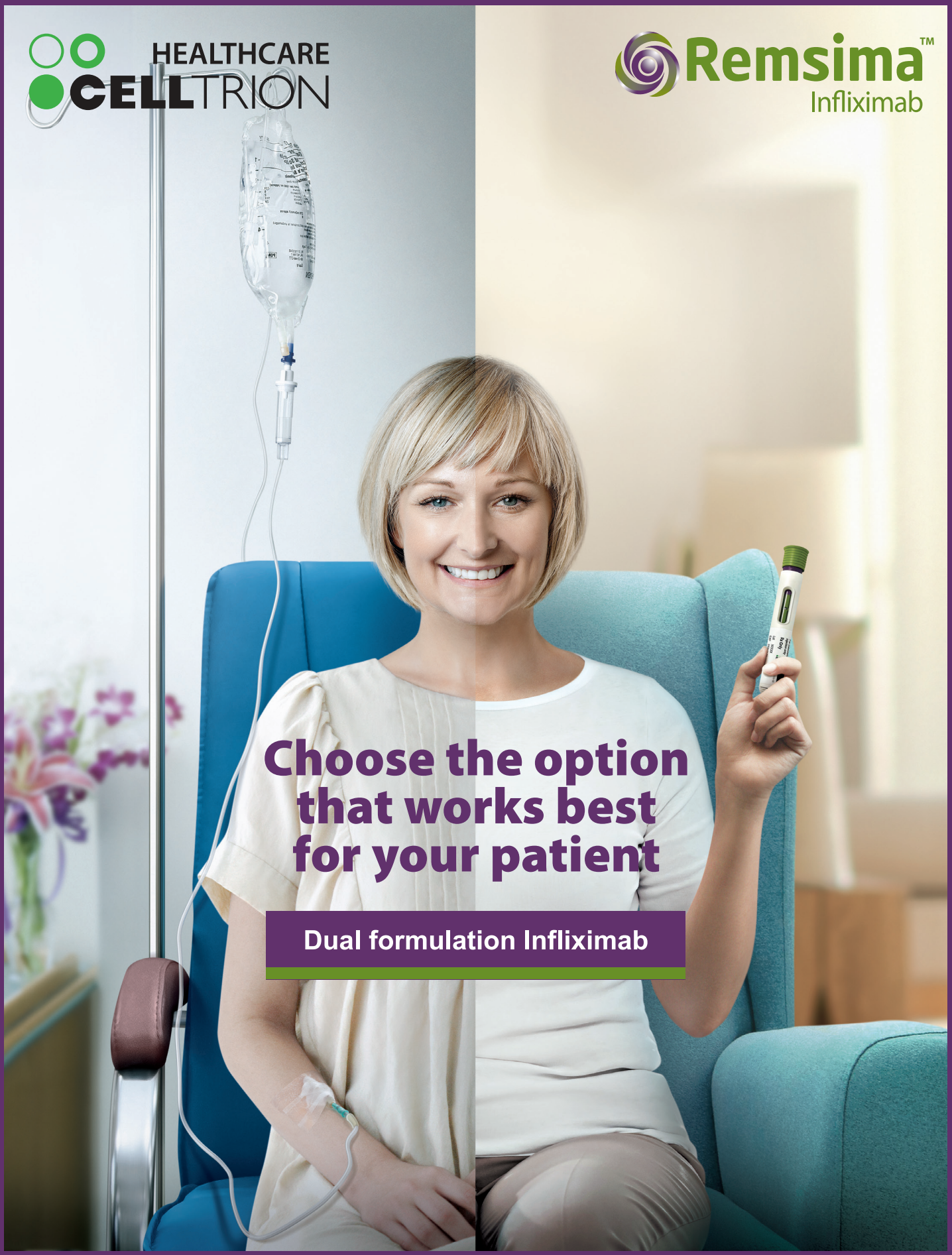
Marketing Authorisation Numbers: EU/1/03/256/022, EU/1/03/256/013, EU/1/03/256/017, EU/1/03/256/021.

Further information: available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24.

HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie.

Date of revision of PI: October 2018, PI/256/024

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



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RA : with MTX when response to previous DMARD therapy has been inadequate, or, severe active and progressive disease not previously treated with MTX or other DMARDS.
CD/UC : patients with moderate to severe disease who have not responded to conventional therapy.
AS : patients with severe disease who have not responded to conventional therapy.
PsA : In combination with MTX, or alone in patients with intolerances or contraindications to MTX.
PsO : patients with moderate to severe plaque psoriasis who have failed to respond to previous treatment.

Legal Category : POM. EU product number : EMEA/H/C/002576. Further information available on request. Date of item : October 2020
Marketing Authorisation Holder : Celltrion Healthcare Hungary Kft, 1062 Budapest, Váci út 1-3. WestEnd Office Building B torony. Hungary.
Marketed by : Celltrion Healthcare Ireland Ltd, 26, Arrow Building,Old Belgard Road, Tallaght, Dublin D24 ND70, Ireland.

Winter Meeting 2019

Nikki ONeill, Neil Power & Siobhan Goff - Abbvie

Dr Ilona Csizmadia

Dr Neasa McGettigan

ABSTRACT 43 (20W153)

An Evaluation of Outcomes following Endoscopic Balloon Dilatation of Strictures in Crohn's Disease Patients in a Tertiary Irish Hospital

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Introduction
Endoscopic balloon dilatation (EBD) is an established treatment for Crohn's Disease (CD). Studies suggest dilatation of anastomotic strictures, shorter stricture length, and bigger dilatation diameters are associated with technical success. Similarly, dilatation accompanied by subsequent escalation of medical therapy is associated with better outcomes.
Aims/Background
Evaluate outcomes after EBD in CD patients.
Method
A retrospective study of 45 EBDs on 23 patients. Details about the stricture and dilatation were obtained from endoscopy reports. Charts were reviewed for information about re-admission, escalation of medical therapy, repeat EBD, and surgery.
Results
98% of EBDs were successful without complications. One failed due to inability to pass the guidewire. Within 30 days of EBD, 9% were admitted, three for management of flares and one for C.difficile infection. Year 1: 68% needed no further intervention, 12% required repeat dilatation, and 20% underwent surgery. Year 3: 42% required no further intervention, 29% needed repeat dilatation, and 29% had surgery. Year 5: 28% needed no further intervention, 28% required repeat dilatation, and 44% underwent surgery. The range of diameter of dilatation was 8–20mm. In dilatations >15mm 50% required surgery, and <15mm 35% required surgery. Where EBD was applied to anastomotic strictures, 33% required surgery, compared to 45% in native strictures. Where medical therapy was escalated within 12 months of EBD, reflecting active disease, 50% avoided surgery.
Conclusions
EBD of strictures in CD is a safe treatment which can delay and reduce the need for surgery. Further determination of predictors of positive outcomes would allow for more selective application of EBD.

ABSTRACT 44 (20W154)

Social Media Analytics for Inflammatory Bowel Disease – What Are We Missing?

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Introduction
Increasingly, IBD patients are using social media to disseminate information, share experiences and address queries. Gastroenterologists can play an important role in IBD care by better understanding trends in patients' perception of their disease.
Aims/Background
To identify trending topics and misconceptions of disease for early targeted education based off patients' interactions and activity on social media.
Method
Utilising an established social media analytics program, we extracted social media posts relating to IBD over a 30-day period. The most common hashtags and frequently used words were retrieved from these posts, analysed and qualitatively coded. Additional analysis was performed to evaluate user mentions for specific key words identified from the ECCO consensus for Complementary and Alternative Medicine and psychotherapy (CAM).
Results
22,375 social media posts were reviewed. Twitter was the most common platform with 12,977 posts (58%). Most posts originated from North America and Europe (81%). Amongst common hashtags and words, patients most frequently referenced community groups (n=8094) for example "#crohnswarrior", followed by terms related to treatment (n=3256), and lifestyle (n=2446). Symptom-related terms were less frequently referenced (n=2031). Analysis of CAM mentions highlighted patients' interest in "exercise" as a manipulative and body-based intervention (2015/2088, 96.5%), "cannabinoids" as a herbal and dietary intervention (816/2144, 38.1%) and "yoga" as a mind-body intervention (175/415, 42.2%). 3435 mentions were generated from our psychological key word search. These included terms such as fatigue (28.2%), anxiety (20.1%), depression (13.8%) and suicide (2.2%).
Conclusions
Our study identified areas where patients' needs may be unmet by current clinical practices. Further development of our analytical model can aid gastroenterologists in bridging this gap and providing more holistic patient care.

ABSTRACT 45 (20W155)

A systematic review, metabo-meta-analysis and cohort validation of the prognostic value of metabolomics with genomic SNP cross-talk for colorectal cancer recurrence and five year overall survival

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Introduction
Metabolomic analysis in colorectal cancer(CRC)is an emerging research area.
Aims/Background
To identify prognostic metabolomic signatures for CRC recurrence and overall survival and cross-reference this data with prognostic genomic single nucleotide polymorphisms(SNPs).
Method
A systematic review of studies utilising metabolomics to identify patients at risk of cancer recurrence and poor survival outcomes in CRC was performed in keeping with PRISMA guidelines. The QUADOMICS tool was used to assess study quality. MetaboAnalyst software, version 4.0 was used to perform metabolic pathway

enrichment and identify genomic SNPs associated with colorectal cancer prognosis, referencing the following databases: Human Metabolome Database(HMDB), the Small Molecule Pathway Database(SMPDB), PubChem and Kyoto Encyclopaedia of Genes and Genomes(KEGG)Pathway Database. Metabolomic findings were validated in a population of Irish colon cancer patients.

Results

Nine studies met the inclusion criteria, reporting on 1117 patients and validation performed in 24 colon cancer patients with five-year follow-up. Increased metabolic activity in the urea cycle(p=0.002,FDR-0.198) ammonia recycling(p=0.004,FDR=0.359)and glycine and serine metabolism(p=0.004,FDR=0.374)were prognostic of CRC recurrence. Increased activity in aspartate metabolism(p=8.13E-04,FDR=0.079)and ammonia recycling(p=0.004,FDR=0.345) were prognostic of survival. Eight resulting SNPs were prognostic for CRC recurrence(Rs2194980, Rs1392880, Rs2567397, Rs715, Rs169712, Rs2300701, Rs313408, Rs7018169) and three for survival(Rs2194980, Rs169712, RS12106698) of which two overlapped with recurrence(Rs2194980, Rs169712).

Conclusions

Specific metabolites and metabolic pathways are dysregulated in the setting of poor prognostic colorectal cancers and such metabolic signatures are associated with specific genomic SNPs. These findings provide a platform for prognostic biomarker discovery and development in colorectal cancer as well as identify potential for therapeutic targeting.

ABSTRACT 46 (20W156)

Risk Factors Associated with Post Endoscopic Band Ligation Ulceration

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Introduction

Oesophageal varices have the potential to be the most devastating consequence of portal hypertension. The optimal management of oesophageal varices is multi-modal; namely beta blockade and endoscopic band ligation (EBL). Although these interventions are considered safe - adverse events are present. One such adverse event is Post Endoscopic Band Ligation Ulceration (PEBLU). MELD score, reflux oesophagitis and acute variceal haemorrhage have been identified as risk factors in the development of PEBLU – however, concordance among studies is not demonstrated.

Aims/Background

This study aims to delineate risk factors associated with the development of PEBLU.

Method

Data was collected prospectively on 68 patients who underwent 238 sessions of EBL in CUH between 2015 and 2019.The severity of cirrhosis was established for patients using their initial Child Pugh Turcot (CPT) score and Model for End-stage Liver Disease – Sodium (MELD-Na) score.

Results

238 episodes of EBL were performed in 68 patients. The patients included 40 (58.8%) men and 28 (41.2%) women. The aetiology of cirrhosis was predominately ALD (57.4%). 15 patients (22.7%) had a CPT score of C. The incidence of PEBLU was 10.9%. We evaluated potential risk factors for PEBLU. In univariate analysis, MELD-NA score > 15 (p=.018, OR: 2.133, 95% confidence interval [CI]: 1.10–4.117), CPT C (p=.045,OR: 1.91, [CI]: 1.07–3.41), Bleeding first presentation (p=.01, OR: 2.254, [CI]: 1.18–4.33) were associated with banding induced ulceration.

Conclusions

PEBLU is not a rare complication of EBL. MELD-Na score >15, CPT C and bleeding first presentation are the predictive risk factors for PEBLU.

ABSTRACT 47 (20W157)

Improving Adherence to Endoscopy Guidelines for Triage and Surveillance in a Single Endoscopy Unit

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Introduction

Numerous guidelines exist for endoscopy surveillance, fewer for endoscopy triage, and there is considerable variability in their application. Encouraging adherence to agreed guidelines is one facet of endoscopy waiting list management, particularly in the current climate of COVID-19.

Aims/Background

To determine if the use of locally developed flowsheets, created using existing guidelines, could aid in standardisation of endoscopy triage and follow up in a single endoscopy unit.

Method

Existing BSG, NICE, NCSS and HIQA guidelines were reviewed. Simple flowsheets were devised to address upper and lower GI endoscopy triage, polyp and Barretts surveillance, family history of CRC. A baseline survey of clinical scenarios was devised and endoscopy users were invited to participate. The survey was then retaken with access to the flowsheets.

Results

20 endoscopy users took part. In the initial survey, 45% of questions were answered in keeping with current guidelines. This improved to 71% when flowsheets were used. The improvement was noted across both the triage and surveillance sections of the survey, and across nursing (24%) and medical staff (26%).

Conclusions

Endoscopy waiting lists continue to grow, exacerbated by recent COVID restrictions. It is essential that endoscopy services strive for standardisation in triage and follow up, based on current national and international guidelines, to optimise patient care. We have demonstrated that the use of clear, accessible methods of guideline application can improve adherence to them. Triage of endoscopy within our unit is currently performed by senior medical staff, however this data may support a nurse-led process going forward.

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Avoid areas with psoriasis. Self-injecting patients or caregivers ensure appropriate training. Physicians are required to follow-up and monitor patients. **Plaque psoriasis, adults & elderly:** Patients up to and including 100kg, 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Patients greater than 100 kg, 90 mg at week 0 followed by a 90 mg dose at week 4, then every 12 weeks (45 mg was less effective in these patients). **Plaque psoriasis paediatrics (6 years and older):** Patients under 60 kg, 0.75 mg/kg at week 0, followed by 0.75 mg/kg at week 4 then every 12 weeks thereafter. Patients 60 - 100kg, 45 mg at week 0 followed by 45 mg at week 4, then every 12 weeks. Patients greater than 100 kg, 90mg at week 0, followed by 90mg at week 4, then every 12 weeks. **Psoriatic arthritis, adults & elderly:** 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Alternatively, 90 mg may be used in patients with a body weight greater than 100 kg. Consider discontinuation if no response after 28 weeks. **Crohn's disease and ulcerative colitis.** Initial single intravenous infusion dose based on body weight (260 mg or 390 mg or 520 mg) diluted in sodium chloride solution and given over at least one hour. At week 8 after intravenous dose, 90 mg s.c. dose is given; followed by every 12 weeks (or 8 weeks based on clinical judgement). Consider discontinuation if no response 16 weeks after the IV induction dose or 16 weeks after switching to the 8-weekly maintenance dose. Immunomodulators and/or corticosteroids may be continued but consider reducing/discontinuing corticosteroids if responding to Stelara. In Crohn's disease, if therapy interrupted, resume s.c. every 8 weeks if safe/effective. ***Children under 6 years*** - Not recommended for psoriasis. ***Under 18 years*** - Not recommended for psoriatic arthritis, Crohn's disease and ulcerative colitis. ***Renal & Hepatic impairment:*** Not studied. **CONTRAINDICATIONS:** Hypersensitivity to product; clinically important, active infection. **SPECIAL WARNINGS & PRECAUTIONS:** ***Infections:*** Potential to increase risk of infections and reactivate latent infections. Caution in patients with a chronic infection or history of recurrent infection, particularly TB. Patients should be evaluated for tuberculosis prior to initiation of STELARA. Consider anti-tuberculosis therapy prior to initiation of STELARA in patients with history of latent or active tuberculosis. Patients should seek medical advice if signs or symptoms suggestive of an infection occur. If a serious infection develops, closely monitor and STELARA should not be administered until infection resolves. ***Malignancies:*** Potential to increase risk of malignancy. No studies in patients with history of malignancy or in patients who develop malignancy while receiving STELARA. Monitor all patients, in particular those older than 60, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment for non-melanoma skin cancer. ***Concomitant immunosuppressive therapy:*** Caution, including when changing immunosuppressive biologic agents. ***Hypersensitivity reactions:*** Serious hypersensitivity reactions (anaphylaxis and angioedema) reported, in some cases several days after treatment. If these occur appropriate therapy should be instituted and STELARA discontinued. ***Latex sensitivity:*** Needle cover contains natural rubber (latex), may cause allergic reactions. ***Immunotherapy:*** Not known whether STELARA affects allergy immunotherapy. ***Serious skin conditions:*** Exfoliative dermatitis reported following treatment. Discontinue STELARA if drug reaction is suspected. **SIDE EFFECTS:** ***Common:*** upper respiratory tract infection, nasopharyngitis, sinusitis, dizziness, headache, oropharyngeal pain, diarrhoea, nausea, vomiting, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, injection site pain. ***Other side effects:*** cellulitis, serious hypersensitivity reactions (including anaphylaxis, angioedema), skin exfoliation, exfoliative dermatitis, lower respiratory tract infection. Studies show adverse events reported in children 12 years and over with plaque psoriasis were similar to those seen in previous studies in adults with plaque psoriasis. **Refer to SmPC for other side effects. LEGAL CATEGORY:** Prescription Only Medicine (POM). **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S):** 45 mg, 1 x vial, EU/1/08/494/001; 45 mg, 1 x 0.5 ml pre-filled syringe, EU/1/08/494/003; 90 mg, 1 x 1.0 ml pre-filled syringe, EU/1/08/494/004; 130 mg, 1 x vial, EU/1/08/494/005. **MARKETING AUTHORISATION HOLDER:** Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen Sciences Ireland UC, Barnahely, Ringaskiddy, IRL - Co. Cork, P43 FA46. **Prescribing information last revised:** 12/2019 (CHMP Opinion).

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events via: HPRA Pharmacovigilance Website: www.hpra.ie. Adverse events should also be reported to Janssen-Cilag Limited on +44 1494 567447 or at dsafety@its.jnj.com.

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

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CP-135801 | Date of preparation: February 2020

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ABSTRACT 48 (20W158)

Does Possession Of The Z Or S Allele For Alpha 1 Antitrypsin Deficiency Influence Survival In BCLC Stage A/B Hepatocellular Carcinoma?

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Introduction
Alpha 1 antitrypsin (AAT) Z allele heterozygosity has been shown to increase the likelihood of developing hepatocellular carcinoma (HCC). In both alcoholic liver disease (ALD) and non-alcoholic fatty liver disease (NAFLD) it has been found to predispose to cirrhosis. The S allele too increases the risk in ALD. Given these cofactor roles, we questioned whether survival in HCC is affected by the presence of AAT deficient alleles.
Aims/Background
We sought to determine if the presence of Z (Pi*Z) or S (Pi*S) alleles for AAT impacted survival in patients with HCC when compared to those with the normal genotype (PiMM).
Method
Patients were recruited from a prospectively maintained HCC database in St Vincent's University Hospital. We included patients with Barcelona Clinic Liver Cancer (BCLC) stage A or B HCC. The survival of patients with Pi*Z/Pi*S was compared to the control group (PiMM) by generating a Kaplan Meier survival curve using SPSS®.
Results
122 patients were identified from the database: 14 in the Pi*Z/Pi*S group, 108 in the PiMM group. The groups' demographics were similar and statistically insignificant from one another with regards to sex, age at diagnosis, rate of curative therapies, BCLC stages, and levels of ALD/NAFLD. Survival analysis showed no significant difference between the groups.
Conclusions
While the development of cirrhosis and HCC has been shown to be influenced by the presence of AAT deficiency alleles, our results do not show an impact on survival in BCLC stages A/B patients with HCC.

ABSTRACT 49 (20W159)

Ustekinumab use in Belfast Health and Social Care Trust – real world data

Author(s)
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Belfast Health and Social Care Trust

Introduction
Ustekinumab (UST) is a monoclonal antibody targeting interleukins-12 and -23. It is licensed for use in moderate to severe active Crohn's disease in patients who have had an inadequate response with, lost response to, are intolerant to, or have contra-indications to either conventional therapy or a tumour necrosis factor alpha inhibitor.
Aims/Background
We examined the demographics of patients who had been commenced on UST within the Belfast Health and Social Care Trust (BHSCT) between September 2016 and December 2018 and recorded their outcomes.
Method
This was a retrospective study of all patients commenced on UST in the BHSCT from September 2016 to December 2018 for Crohn's disease. We analysed patient data in December 2019; including follow up clinic appointments, faecal calprotectin samples, endoscopy findings and cross sectional imaging studies. We reviewed multiple patient factors including; age, duration of illness, previous drug and surgical therapies. Our aim was to determine the effectiveness of UST in treating patients with Crohn's disease. Emphasis was placed on steroid free remission and hospital stays.
Results
52 patients were included in the study. The average age was 36.7 years old and disease duration of 12.1 years. 65% of patients identified had one previous surgery; with 27% having multiple previous resections. 52% patients had failed 2 anti-tumour necrosis factor (anti-TNF) agents. 21% had failed 2 anti-TNF agents and an alpha4-beta7 integrin inhibitor. 54% of patients have demonstrated good clinical response to UST whilst remaining out of hospital and steroid free for over 12months. The group who did demonstrate a good response have been on UST for a median duration of 22 months. 30% of patients went on to have further surgery over the review period. We found that the side effect profile was similar to previously reported data.
Conclusions
UST is a viable treatment option for Crohn's disease. The patients we have initiated on UST have demonstrated multiple high risk features; with 65% having had previous surgery and 52% having failed 2 anti-TNF agents. UST is a safe drug and there could be an argument for commencing UST at an earlier stage in the patient treatment journey to try and optimise outcomes.

ABSTRACT 50 (20W160)

Is abnormal radiology a good predictor for endoscopic findings

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Introduction
Imaging modalities are increasingly being utilized to aid the diagnostic process for patients presenting with GI symptoms, increasing the likelihood of detecting abnormalities in the gastrointestinal tract (GIT). A common indication for gastrointestinal endoscopy is abnormal radiology. Given limited resources, solutions need found to reduce the burden on endoscopy services.
Aims/Background
The aims of this study were to assess the correlation between abnormal imaging and endoscopic findings.
Method
All patients who underwent a colonoscopy or sigmoidoscopy in Louth County Hospital (LCH) for abnormal imaging findings from the inception of EndoRaad in LCH (2013) to August 2020 were included. Data, including; patient demographics, modality of

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imaging, results of imaging, indication for endoscopy, and results of endoscopy were collected.

Results

A total of 234 lower GI endoscopies (196 colonoscopies and 38 sigmoidoscopies) were performed in LCH between 2013 and August 2020 for the indication of abnormal radiology. 52% (n=123) were male. The median interval from imaging to colonoscopy was 85 days (range 1 day to 527 days). 83% (n=163) of imaging modalities employed were CT scans. 41% (n=81) of findings on endoscopy correlated with radiological imaging. The median interval from imaging to sigmoidoscopy was 74 days (range 11 days to 823 days). CT Colon accounted for 52% (n=20) of the imaging modalities employed. 23% (n=15) of findings on sigmoidoscopy correlated with radiological imaging.

Conclusions

41% of the total cohort of patients had endoscopic findings correlating with abnormalities identified in radiology. Further assessment is recommended to identify specific imaging abnormalities that would benefit from endoscopy.

ABSTRACT 51 (20W161)

The use of a COVID-minimised pathway to restart outpatient endoscopy during Covid-19 pandemic – Is it safe for patients and staff? The Oxford Experience.

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Introduction

COVID-19 has had a significant impact worldwide on GI endoscopy with a substantial reduction in the delivery of service. During the deceleration and early recovery phase of the pandemic there was a need to restart endoscopy service while keeping patients and staff safe. The British Society of Gastroenterology published guidance based on consensus opinion and limited data available and proposed a 'Covid-minimised' endoscopy pathway.

Aims/Background

We sought to evaluate the risk of COVID-19 transmission in this COVID-minimised environment.

Method

The BSG guidelines were implemented in Oxford in May 2019.Three endoscopy units were designated 'COVID-minimised' sites and one large endoscopy unit was designated a 'hot' location. All patients underwent telephone screening with SCOTs criteria comprising of questions about symptoms, infectious contacts and shielding status. Patients had nasopharyngeal swabbing 48-72 hours prior to their endoscopy procedure. Lower GI endoscopy was performed on patients with negative swabs with level 1 PPE and all upper GI endoscopy was performed in level 2 PPE. All patients were followed up at 7 and 14 days to check for symptoms. All data was entered prospectively into an anonymised database.

Results

363 patients underwent pre-screening with SCOTS criteria between 30 April and 30 June 2020 and 334 patients underwent endoscopy in a 'COVID-minimised' site. The mean±SD age was 57.4±16.3 and 50.1% were male. 82.6% (n=275) underwent a lower GI endoscopy, 14.9% (n=50) underwent an upper GI endoscopy and 2.4% (n=8) had a combined procedure. The majority 60% (n=200) were urgent procedures. Preprocedure nasopharyngeal swab testing for SARS-CoV-2 was performed in 301 patients and all patients were negative. No cases of COVID-19 were detected post endoscopy in any patient or staff during this study.

Conclusions

A COVID-minimised pathway using screening questionnaires, pre-procedure swabbing and appropriate PPE is safe for both patients and staff in the deceleration/recovery phases of the Covid-19 pandemic.

ABSTRACT 52 (20W162)

An Audit on the Interval Cancer Rates in Louth County Hospital

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Introduction

Key performance indicators ensure endoscopy units deliver good quality endoscopy and maintain an appropriate standard of care. The interval cancer rate is an important indicator of the quality of colorectal cancer (CRC) screening in an endoscopy unit. A post colonoscopy or interval CRC is defined as a CRC diagnosed 'within three years of a negative screening colonoscopy'.

Aims/Background

The aim of this audit was to assess the interval colorectal cancer rate for Louth County Hospital(LCH).

Method

Using EndoRaad, colonoscopies and sigmoidoscopies (screening/symptomatic) performed in LCH, a JAG accredited site, from 2017 to 2019 on which a 'tumour' was identified were included. Histology records were reviewed to confirm malignancy. Electronic records were used to identify lower GI endoscopies performed in our unit within three years of the cancer diagnosis. Insertion point of prior endoscopies was taken into account.

Results

A 'tumour' was identified on 96 colonoscopies/sigmoidoscopies in LCH. 69 of these procedures were associated with a diagnosis of CRC. 4.35%(n=3) of patients had undergone a lower GI endoscopy in LCH within 3years of their cancer diagnosis. The average interval between negative endoscopy and cancer diagnosis was 24.67months. In all three cases, the point of insertion on the initial scope was proximal to the site of subsequent malignancy. CT Colon was performed in 2 of the 3 cases; occurring 21 and 72 days after negative endoscopy. Both CT Colon studies were negative; identifying no colonic mucosal lesion >6mm.

Conclusions

The interval cancer rate for LCH is in keeping with rates published internationally and by the national GI endoscopy working group.

ABSTRACT 53 (20W163)

Germline mutation testing in Serrated Polyposis Syndrome

Author(s)

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Introduction

Serrated Polyposis Syndrome (SPS) is now known to be the commonest polyposis syndrome. Previous analyses for germline mutations have shown no consistent positive findings. To exclude other polyposis syndromes, new 2019 BSG guidelines advise gene panel testing if: the patient is under 50 years of age, there are multiple affected individuals within a family, or if there is dysplasia within any of the polyps.

Aims/Background

The aim in this study was to determine find the yield of genetic mutations in the Oxford SPS cohort and to determine whether current BSG recommendations would have identified patients with a mutation.

Method

A database of patients with SPS according to the WHO 2019 criteria was established at the Oxford University Hospitals NHS Trust. Data collection began in 2010 and in total there were 173 SPS patients. The results of any patients sent for genetic testing were analysed.

Results

Out of 173 patients, 73 underwent genetic testing. The majority were tested for a hereditary colorectal cancer panel including MUTYH, APC, PTEN, SMAD4, BMPR1A, STK11 and Lynch syndrome mismatch repair genes. Of these, 15 had a positive genetic test result.

Conclusions

9% (15/173) of SPS patients were affected by heterozygous germline mutations, higher than in previous series, including previously unreported associations with CHEK2 and POLD1. This led to a change in management for patients or their families in 7 cases (4%). Only 60% (9/15) of these patients would have been recommended for gene panel testing according to the current BSG guidelines. Detection of germline mutations could have significant impact on risk assessment and clinical management, including advice on extra-colonic surveillance in patients and their family members.

ABSTRACT 54 (20W164)

Iron deficiency Anaemia – Are we on the right path?

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Introduction

Iron Deficiency Anaemia is a common reason for referral to Gastroenterology. It can be driven by insufficient intake, malabsorption, excessive loss, chronic inflammation, renal disease or malignancy. Establishing the diagnosis requires measurement of indices including HB, MCV, and haematinics. Serum Ferritin can be misleading in co-existing inflammatory conditions, and correlation with inflammatory markers is useful.

Aims/Background

Pathways for the investigation of anaemia (Hb<13 in men, <12 in women) are well established. This audit was undertaken to investigate adherence to the guidelines in SMH.

Method

A retrospective observational study was conducted on patients admitted to SMH, from 1/07/19-31/12/19. Data for 130 patients with Iron deficiency anaemia was collected from HIPE and their corresponding investigations including Hb, MCV, Iron profile, Coeliac screen, IgA levels, Endoscopy and CT colonography/ abdomen were documented to check compliance with local guidelines for anaemia work-up pathway (Anaemia Pathway Guideline PPGC-ENDO-14 SVUH).

Results

78 were female with a median age of 77.5, 52 male with median age of 71.5. Of the males, 44 (85%) had complete iron studies, 17 (31%) had a Coeliac screen and 10 (19%) had IgA levels checked. 49 (94%) had endoscopy performed and 2 of the 3 not endoscoped had radiological imaging performed. Of 78 females , 67 (86%) had complete iron studies, 23 (32%) had a coeliac screen, 9 (12%) had IgA levels. 62 (79.5%) had endoscopy performed. 9 of the 16 **remaining (56%) had radiological imaging performed.**

Conclusions

Overall there was a good adherence to the guidelines. Screening for Coeliac disease could be improved by Including these values on the Endoscopy Referral Form.

ABSTRACT 55 (20W165)

Validation of the Inflammatory Bowel Disease Disability Index in an English Speaking Patient Population

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Introduction

Inflammatory bowel disease (IBD) activity scales are valuable for assessing inflammation and the need for disease modifying medications, but do not assess physical, social, work-related or psychological disability. These patient reported outcome measures are important endpoints for clinicians and researchers, while helping assess patient's disease related concerns. The IBD disability index (IBD-DI) was developed in in 2012 and subsequently refined, condensed and validated in 200 French patients in 2017. The index has not been tested in other European populations.

Aims/Background

Our aim was to assess the IBD-DI validity in a European English speaking, hospital-based population.

Method

The study included 330 subjects who completed the IBD-DI, consisting of 14 questions regarding general health, sleep, fatigue, depression, anxiety, body image, pain, toilet issues, health/diet, personal relationships, community relationships, work/school activities, bowel motions and joint pain. Data were also collected on demographic, clinical, social and treatment variables, and subjects completed disease activity and quality of life scales along with an array of psychological survey tools.

Results

IBD-DI scores ranged from 0 to 79 (range 0-100). Internal consistency was demonstrated with a Cronbach's α of 0.86. Factor analysis resulted in a two-factor solution explaining 59% of the variance. IBD-DI scores correlated with disease activity (rs, 0.59; p<.001), quality of life (rs, 0.56; p<.001), time missed at work (rs, 0.46; p<.001), depression (rs, 0.79; p<.001), anxiety (rs, 0.66; p<.001) and body image dissatisfaction (rs, 0.56; p<.001). Linear

regression analysis showed that disability was independently related to disease activity (p<.001), quality of life (p<.001), depression (p<.001), anxiety (p<.001) and body image (p<.001).

Conclusions

The IBD-DI shows high internal consistency and construct validity and may be suitable for use as a core patient reported outcome measure for clinical and research practice in English speaking IBD patients.

ABSTRACT 56 (20W166)

Identification of Target Ustekinumab Levels in Maintenance Therapy in Inflammatory Bowel Disease

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Introduction

Ustekinumab is licensed for induction and maintenance therapy of moderate-severe inflammatory bowel disease (IBD). However, there are few data on the association between ustekinumab trough concentrations and mucosal healing.

Aims/Background

To identify maintenance target ustekinumab trough concentrations associated with mucosal healing in IBD.

Method

Trough ustekinumab levels and antibody titres were analysed in patients on maintenance drug using a drug-tolerant assay. Mucosal response was determined using combination of faecal calprotectin, endoscopy and radiology. Median trough levels were analysed using Kruskal-Wallis test and logistic regression was used to determine sensitivity and specificity of levels predicting mucosal response.

Results

26 patients on maintenance ustekinumab have been included to date (n = 25 CD, n = 1 UC). 22 (85%) patients had previously failed TNF treatment. Clinical remission was recorded in 46% of patients (n=12) and a further 31% of patients (n=8) achieved mucosal response. After calculating a receiver operating characteristic (ROC) curve for mucosal response vs non-response, a trough level of 2.75 µg/mL was associated with mucosal response with 83% sensitivity and 80% specificity, with a likelihood ratio of 4.167, P = 0.019.

Conclusions

A target trough ustekinumab level of 2.75 µg/mL associated with mucosal response. Limitations of the study included study size as well as variability in dose and time from assay to mucosal assessment. Prospective studies on target ustekinumab levels should be carried out to facilitate patient-centred dosing targets.

ABSTRACT 57 (20W167)

Post Liver Transplant Anastomotic Biliary Strictures – Experience from The National Liver Transplant Unit

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Introduction

Anastomotic biliary strictures (ABS) are a common complication following orthoptic liver transplant (OLT) occurring in 4.5-15% after deceased donor LT. ERCP and stent placement has become the preferred initial treatment although it is unclear whether fully covered self-expanding metal stents (FC-SEMS) are superior to plastic stents (PS).

Aims/Background

We aimed to assess outcomes and identify the optimal treatment strategy for ERCP and stent placement in cases of ABS.

Method

All OLTs performed from 1/1/2012 to 1/2/2020 were correlated with ERCPs performed in the same unit to identify patients who developed ABS requiring endoscopic intervention. Type of intervention and long-term outcomes were analysed retrospectively.

Results

459 OLTs, including 28 re-transplants, were performed during the study period. 16 patients (3.5%) were referred for ERCP due to ABS after a median of 93 days (IQR 17.5-148) post OLT. At initial ERCP, 15/16 procedures (94%) were technically successful (1 dilatation, 3 FC-SEMS, 11 PS) while 1/16 failed and required PTC and later hepaticojejunostomy. 2/15 subsequently died prior to stent removal due to chronic rejection and recurrent cholangiopathy. In the remaining 13 patients who had successful ERCP and had follow-up data available, 7/13 (53%) had stricture resolution and stent removal after a median of 3 procedures (IQR 3-5). All 7 successful cases had FC-SEMS insertion, 1 at index ERCP and 6 following initial PS insertion. 2 procedure-related complications were observed, 1 biliary perforation and 1 proximally migrated plastic stent requiring PTC.

Conclusions

ERCP and stenting resulted in stricture resolution in just over half of patients with anastomotic biliary stricture, and only in cases where FC-SEMS was placed.

ABSTRACT 58 (20W168)

Research in Inflammatory Bowel Disease – The Patient's Perspective

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Introduction

Although research plays a critical role in advancing the management and care of patients with IBD, little is known about patient's views relating to IBD-related research.

Aims/Background

This study aimed to assess patients' views on study participation, research areas of importance, and use of personal data.

Method

Patients attending an IBD educational event were asked to complete a 2-page questionnaire on IBD-related research, including rating the importance of 10 proposed research topics from 1 to 10.

Results

52 patients completed the questionnaire, mostly females (54%) with Crohn's disease (54%) with 50% aged less than 20. All 10 proposed research topics were rated of high importance, with least priority given to research into endoscopy (mean score 8.1) while developing safe and more effective drugs was rated most important (mean score

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▼ Hulio (adalimumab) 40 mg solution for injection

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Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above: In combination with MTX for active pJIA with inadequate response to one or more DMARDs. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate.
Enthesitis-related arthritis (ERA), paediatrics 6 years and above: For active ERA with inadequate response to or intolerance to conventional therapy.
Ankylosing spondylitis (AS), adults: For severe active AS with inadequate response to conventional therapy.
Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: For severe nr-axSpA with objective signs of inflammation (elevated CRP and/or MRI), and an inadequate response to or intolerance to nonsteroidal anti-inflammatory drugs.
Psoriatic arthritis (PsA), adults: For active and progressive PsA with inadequate response to DMARDs. Reduces the rate of progression, of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function.
Psoriasis, adults: For moderate to severe chronic plaque psoriasis in candidates for systemic therapy.
Paediatric Plaque Psoriasis, 4 years and above: For severe chronic plaque psoriasis with inadequate response to or if topical therapy and phototherapies are inappropriate.
Hidradenitis suppurativa (HS), adults and adolescents from 12 years and above: For active moderate to severe HS (acne inversa) with inadequate response to conventional systemic HS therapy.
Crohn's disease (CD), adults: For moderately to severely active CD with no response despite a full and adequate course of, intolerance to or contraindication for a corticosteroid and/or an immunosuppressant therapy.
Paediatric Crohn's disease (CD), 6 years and above: For moderately to severely active CD with inadequate response to, intolerance to or contraindication for conventional therapy including primary nutrition therapy and a corticosteroid and/or an immunomodulator.
Ulcerative colitis (UC), adults: For moderately to severely active UC with inadequate response to, intolerance to or contraindication for conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA).
Uveitis, adults: For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate.
Paediatric Uveitis, 2 years and above: For chronic non-infectious anterior uveitis with inadequate response to or intolerance to conventional therapy, or in whom conventional therapy is inappropriate.

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Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above: Dosage: 10 kg to < 30 kg 20 mg single dose EOW. If ≥ 30 kg: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Enthesitis-related arthritis (ERA), paediatrics 6 years and above: Dosage: 15 kg to < 30 kg: 20 mg single dose EOW. If ≥ 30 kg: 40 mg single dose EOW.
Ankylosing spondylitis (AS), adults: Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Psoriatic arthritis (PsA), adults: Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Psoriasis, adults: Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time (refer to SmPC).
Paediatric Plaque Psoriasis, 4 to 17 years: Dosage: 15 kg to < 30 kg: 20 mg dose initially followed by 20 mg EOW starting one week after initial dose. If ≥ 30 kg: 40 mg dose initially followed by 40 mg EOW starting one week after initial dose Treatment beyond 16 weeks should be reconsidered if no clinical response in that time.
Hidradenitis suppurativa (HS), adults and adolescents from 12 years and above: Dosage: HS, adults: 160 mg dose initially at Day 1, followed by 80 mg two weeks later at Day 15. Two weeks later (Day 29) continue with a dose of 40 mg every week or 80 mg every other week.
HS, from 12 years, weighing at least 30kg: 80 mg dose initially at week 0, followed by 40 mg EOW starting at week 1. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions is recommended to be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no improvement in that time. Reintroduction of treatment after interruption: 40 mg every week or 80 mg EOW. Evaluate periodically the benefit and risk of continued long-term treatment.
Crohn's disease (CD), adults: Dosage: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If decrease in clinical response, can increase dosing frequency to 40 mg every week or 80 mg EOW. Patients with no response by Week 4 may benefit from continued maintenance therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Paediatric Crohn's disease (CD), 6 to 17 years: Dosage: < 40 kg: Induction: 40 mg dose at Week 0, followed by 20 mg at Week 2. For a more rapid response: 80 mg at Week 0, followed by 40 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 20 mg dose EOW. If insufficient response, consider an increase in dosing frequency to 20 mg every week. If ≥ 40 kg: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg dose at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. If insufficient response, consider an increase in dosing frequency to 40 mg every week or 80 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time.
Ulcerative colitis (UC), adults: Dosage: Induction: 160 mg dose at Week 0, followed by 80 mg at Week 2. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If insufficient response, consider an increase in dosing frequency to 40 mg every week or 80 mg EOW. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time.
Uveitis, adults: Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be tapered in accordance with clinical practice starting two weeks after initiating treatment with Hulio. Evaluate on a yearly basis the benefit and risk of continued long-term treatment.
Paediatric Uveitis, 2 years and above: Dosage: < 30 kg: 20 mg dose EOW in combination with MTX. Optional 40 mg loading dose one week prior to

References:
1. Medicines Management Programme Best – Value Biological Medicines: Review of submissions for Hulio & Idacio February 2020
2. Hulio® SmPC

Legal Category
Medicinal product subject to restricted medical prescription. Supply through pharmacies only.
Marketing Authorisation Number:
EU/1/18/1319/002 (pre-filled syringe). EU/1/18/1319/005 (pre-filled pen). EU/1/18/1319/007 (vial)

Marketing Authorisation Holder:
Mylan S.A.S. 117 allée des Parcs, 69800 Saint-Priest, France
Full Prescribing Information available on request from:
Mylan Dublin, Dublin 17. Phone 01 8322250
Date of Revision of Abbreviated Prescribing Information:
26 April 2019
Job Code: ADA-2020-0038. **Date of preparation:** April 2020
Mylan Ireland, Newenham Court, Northern Cross, Malahide Road, Dublin 17, Ireland. www.mylan.ie

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CITRATE-FREE[2]

- ✓ **29 gauge needle** in both pre-filled pen & pre-filled syringe[2]
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start of maintenance therapy. No clinical data in use of loading dose < 6 years of age (see SmPC). If ≥ 30 kg: 40 mg dose EOW in combination with MTX. Optional 80 mg loading dose one week prior to start of maintenance therapy.

Contraindications: Hypersensitivity to the active substance or to any excipients (see SmPC); Active tuberculosis (TB) or other severe infections such as sepsis and opportunistic infections; Moderate to severe heart failure (NYHA class IIIV).

Warnings and precautions: Clearly record the name and batch number of administered product to improve traceability of biological products.

Infections: Patients taking TNF-antagonists are more susceptible to serious infections, especially if impaired lung function. Monitor for infections, including Tuberculosis (TB), before, during and for 4 months after treatment. Do not initiate treatment during an active infection, until infection is controlled. Consider risk/benefit prior to treatment in patients exposed to TB or who have travelled in areas of high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections, including the use of concomitant immunosuppressive medications.

Serious infections: Serious infections, including sepsis, due to bacterial, mycobacterial, invasive fungal, parasitic, viral, or other opportunistic infections such as listeriosis, legionellosis and pneumocystis have been reported.

Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septicaemia.

Serious infections, including those associated with hospitalisation or death, were reported in patients receiving treatment.

Tuberculosis (TB): Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (i.e. disseminated), were reported. Screen all patients before therapy initiation for active or inactive (latent) TB. Appropriate screening tests (i.e. tuberculin skin test and chest X-ray) should be performed in all patients. If latent TB is suspected, consult physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Hulio. Despite prophylaxis, TB reactivation has occurred on Hulio. If active TB is diagnosed, do not initiate Hulio treatment.

Other opportunistic infections: Opportunistic infections were observed in patients receiving Hulio. Stop treatment in patients with signs and symptoms (i.e. fever, malaise, weight loss, sweats, cough, dyspnoea, and/or pulmonary infiltrates or other serious systemic illness with or without concomitant shock) of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients.

Hepatitis B reactivation: Reactivation of HBV has occurred in chronic carriers (surface antigen positive). Patients should be tested for HBV infection before initiating treatment. HBV carriers should consult a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of treatment. If reactivation occurs, stop treatment and initiate appropriate antiviral and supportive treatment.

Neurological events: Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. Discontinuation of treatment should be considered if any of these disorders develop. Neurologic evaluation should be performed in patients with non-infectious intermediate uveitis prior to initiation of treatment and regularly during treatment, to assess for pre-existing or developing central demyelinating disorders.

Allergic reactions: Reports of serious allergic reactions including anaphylaxis were received. For serious allergic or anaphylactic reaction, stop Hulio immediately and initiate appropriate therapy.

Malignancies and lymphoproliferative disorders: A possible risk has been reported of malignancy, including lymphomas and leukaemia, in all patients, including paediatric patients, treated with Tumour Necrosis Factor (TNF) antagonists. Examine all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment, for non-melanoma skin cancer prior to and during treatment; caution in COPD patients, and in patients with increased risk for malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Hulio (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk of developing dysplasia or colon cancer is unknown. Patients with UC, history of dysplasia or colon carcinoma, to be screened for dysplasia before and during treatment.

Haematologic reactions: Adverse events of the haematologic system reported with Hulio. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias develop while on treatment.

Vaccinations: Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to initiating Hulio treatment.

Congestive heart failure: See contraindications. Caution is advised with mild heart failure (NYHA class I/II). Discontinue treatment if new or worsening symptoms of congestive heart failure.

Autoimmune processes: Autoimmune antibodies may form with Hulio. Stop treatment if development of a lupus-like syndrome with positive antibodies against double-stranded DNA.

Surgery: Consider the long half-life of Hulio for planned surgical procedures. Monitor closely for infections.

Small bowel obstruction: Hulio does not worsen or cause strictures however failure to respond to treatment for Crohn's disease may indicate the presence of fixed fibrotic stricture that may require surgical treatment.

Elderly patients: Serious infections were higher in patients over 65 years of age, some of which had a fatal outcome. Consider risk of infections in these patients.

Interactions with other medicinal products and other forms of interactions: Antibody formation was lower when Hulio was given together with MTX in comparison with use as monotherapy. Combination of Hulio with other biologic DMARDs (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended.

Fertility, pregnancy and lactation: Hulio should only be used during pregnancy if clearly needed. Women of childbearing age should consider the use of adequate contraception, and continue its use for at least 5 months after the last treatment. No administration of live vaccines (e.g. BCG) to infants exposed to Hulio in utero for 5 months following mother's last Hulio treatment during pregnancy. Hulio can be used during breast-feeding.

Effects on ability to drive and use machines: Hulio may have a minor influence on the ability to drive and use machines. Vertigo and visual impairment may occur following administration of Hulio (see section 4.8).

Undesirable effects: *Very common ≥ 1/10:* Respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leukopenia (including neutropenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema). *Common ≥ 1/100 to < 1/10:* Systemic infections (including sepsis, candidiasis and influenza), intestinal infections (including gastroenteritis viral), skin and soft tissue infections (including paronychia, cellulitis, impetigo, necrotising fasciitis and herpes zoster), ear 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, skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma), benign neoplasm, leucocytosis, thrombocytopenia, hypersensitivity, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphatemia, dehydration, mood alterations (including depression), anxiety, insomnia, paraesthesias (including hypoesthesia), migraine, nerve root compression, visual impairment, conjunctivitis, blepharitis, eye swelling, vertigo, tachycardia, hypertension, flushing, haematoma, asthma, dyspnoea, cough, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, worsening or new onset of psoriasis (including palmoplantar pustular psoriasis), urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasis, hyperhidrosis, alopecia, pruritus, muscle spasms (including blood creatine phosphokinase increased), renal impairment, haematuria, chest pain, oedema, pyrexia, coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), autoantibody test positive (including double stranded DNA antibody), blood lactate dehydrogenase increased, impaired healing. *Uncommon ≥ 1/1000 to < 1/100:* Neurological infections (including viral meningitis), opportunistic infections and tuberculosis (including coccidioidomycosis, histoplasmosis and mycobacterium avium complex infection), bacterial infections, eye infections, diverticulitis, lymphoma, solid organ neoplasm (including breast cancer, lung neoplasm and thyroid neoplasm), melanoma, idiopathic thrombocytopenic purpura, sarcoidosis, vasculitis, cerebrovascular accident, tremor, neuropathy, diplopia, deafness, tinnitus, myocardial infarction, arrhythmia, congestive heart failure, aortic aneurysm, vascular arterial occlusion, thrombophlebitis, pulmonary embolism, interstitial lung disease, chronic obstructive pulmonary disease, pneumonitis, pleural effusion, pancreatitis, dysphagia, face oedema, cholecystitis and cholelithiasis, hepatic steatosis, bilirubin increased, night sweats, scar, rhabdomyolysis, systemic lupus erythematosus, nocturia, erectile dysfunction, inflammation.

Serious, including fatal, adverse reactions have been reported including infections/sepsis, TB, opportunistic infections, allergic reactions (including anaphylaxis), HBV reactivation and malignancies (including leukaemia, lymphoma and hepatosplenic T-cell lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia, aplastic anaemia, central and peripheral demyelinating events and reports of lupus, lupus-related conditions and Stevens-Johnson syndrome.

For details of rare and very rarely reported adverse events see SmPC.

Reporting of suspected adverse reactions:

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL – Dublin 2; Tel: +353 1 6764971; Fax: + 353 1 6762517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie.

Adverse events should also be reported to Pharmacovigilance, Mylan, Building 4 – Trident Place, Hatfield Business Park, Mosquito Way, Hatfield, Hertfordshire, AL10 9BW, phone no: +44 (0) 800 121 8267, Email: UKPharmacovigilance@mylan.com.

ADA-2020-0038

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

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9.4). 60% had previously participated in research while 77% were interested in taking part in a future study. Travel distance and time commitment were the main barriers to participating in research. 94.2% were happy for their blood and biopsy samples to be used for research with 90% happy for their medical records to be used. However, 67% wished to be contacted for permission each time their medical records were used.

Conclusions

Patients living with IBD feel the development of more effective drugs is the most important research area. The majority have previously participated in research while over three-quarters would do so in the future. Most are also happy for their samples and medical records to be used, but wish to be contacted for permission.

ABSTRACT 59 (20W169)

PillCam ESO Capsule, An Alternative Diagnostic Tool During the Covid-19 Pandemic. First Irish Experience.

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Department of Gastroenterology and GI Function Lab. Mercy University Hospital, Cork.

Introduction

The Covid-19 pandemic has led to an unprecedented change in our endoscopy practice. At the peak of the pandemic in Ireland, all routine and surveillance endoscopies were cancelled, with only urgent scopes being performed. With increasing numbers on the waiting list, it is imperative that a safe and effective alternative is considered. The HSE has provided a guidance document for safe endoscopy unit operations in pandemic conditions, and it recommends that an alternative non-invasive investigation be considered where available for all non-urgent referrals for endoscopy. This includes capsule endoscopy. The PillCam ESO® (Given Imaging Ltd., Yoqneam, Israel) offers views of the UGI tract. During the pandemic the Mercy University Hospital offered a PillCam ESO service to selected patients as an alternative to gastroscopy. We conducted a prospective study to assess its utilization during the Covid-19 pandemic at our unit.

Aims/Background

The primary aim of this study is to assess if the PillCam Eso can identify important anatomical landmarks as stated in the British Society of Gastroenterology quality standards for upper gastrointestinal endoscopy and secondly if it can effectively identify pathology in the Upper GI Tract.

Method

Patients who fitted our inclusion criteria were prospectively invited to participate in our trial. The three main indications were 1; patients with dyspepsia less than 40 years of age with no red flag symptoms, 2; known cirrhosis to screen for varices, 3; UGI bleeds with a low Blatchford score (≤2). A local protocol for ingestion and series of positional guidelines was developed for the procedure. Ethical approval was granted for this study. Capsule transit time, important landmarks, and pathology detection was evaluated by two independent endoscopists.

Results

23 exams have been successfully performed in the GI Lab to date with no complications. The two frequent indications were dyspepsia and abdominal pain at 61% and 22% respectively. Metoclopramide was administered in 65% of cases. Complete visualisation of the following major anatomical landmarks was achieved in 100% of cases: Oesophagus, oesophageal-gastro junction, greater curve, antrum, pylorus, first and second part of duodenum. A full view of the cardia, fundus, lesser curve, and incisura angularis was obtained in 96%, 87%, 91%, and 96% of cases, respectively. The mean capsule transit times was 54 mins. A normal exam was reported in 30% of cases. Reflux oesophagitis and gastritis were the most common pathology detected. Adenocarcinoma of the OG junction was detected in 1 case.

Conclusions

The PillCam Eso3 achieved excellent views of the upper GI tract. In highly selective patients it is an alternative to gastroscopy and would allow reduction of growing gastroscopy waiting lists.

ABSTRACT 60 (20W170)

Does distance from tertiary referral centre impact access to treatment for rectal cancer?

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Gastroenterology Department, Beaumont Hospital

Introduction

The HSE initiated a programme of centralisation of cancer services following a recommendation in The National Cancer Strategy for Ireland published in 2006 to a smaller number of high-volume, specialist centres with the aim of optimising treatment and improving survival outcomes.

Aims/Background

The practical impact of patients being required to travel long distances for cancer care remains uncertain. This study aimed to assess the impact of this on the time to provision of care.

Method

A retrospective analysis of all patients with Rectal Cancer discussion at Beaumont colorectal cancer MDT between January 2012 and July 2019 was performed. Patients were categorized into three groups based on proximity to treatment centre. Time interval between initial diagnosis and first discussion at the colorectal cancer multidisciplinary team (MDT) meeting, time from MDT discussion to commencement of recommended neoadjuvant radiotherapy and neoadjuvant chemotherapy were compared. Data analysis was performed using GraphPad.

Results

In total, 669 patients with rectal cancer were included. 368 from Area A (50miles). Average time from diagnosis to discussion at MDT was 15 days; 14 days in Area A, 13 days in Area B (p=0.568) and 18 days in Area C (p=0.289). 293 patients received neoadjuvant chemotherapy. Average time from MDT to commencement was 28 days in Area A compared to 31 days in Area B (p=0.009) and 33 days in Area C (p=0.006) 277 patients received neoadjuvant radiotherapy. Average time from MDT to commencement was 28 days in Area A, 31 days in Area B (p=0.064) and 32 days in Area C (p=0.068).

Conclusions

Centralisation of rectal cancer care hasn't disadvantage patients travelling further distances in regard to time to discussion and time to neoadjuvant therapies.

ABSTRACT 61 (20W171)

IBD delivery of care during COVID-19 response: a review of telephone clinics for IBD patients in a large teaching hospital

Author(s)
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Introduction
In keeping with local guidelines for COVID-19, the COVID-19 ECCO Taskforce advised IBD patients should not come to clinical settings for appointments, where possible. IBD clinics were therefore rapidly restructured with a shift toward telephone consultations.
Aims/Background
Our study attempted to identify whether these changes would impact patient care and which patients would be appropriate to follow in telephone clinics going forward.
Method
We created a survey to be filled in following each telephone appointment. It included demographics of the patient, medication use, physician's global assessment, and investigations requested. Patient's were asked whether they found the telephone option acceptable/preferable. We retrospectively looked at appointments during a similar period in 2019 to gather to create a comparator cohort of patients seen face to face.
Results
Of 214 patients reviewed during a four week period this year, the PGA was moderate/severe in 9%. Investigations were requested for surveillance in 62% and de-escalation of therapy in 4%. 20% had investigations ordered in anticipation of escalation of treatment. These findings were similar to 2019. Of 69 patients asked, 74% were happy with telephone consultations. Many commented that when unwell they would prefer to be seen face to face. After 125 telephone consultations, doctors documented that a face to face consultation would not have altered care in 88%.
Conclusions
This review has demonstrated comparable care was provided to the same amount of patients both years, and that non face to face clinics are preferable to a majority of our IBD patients, both from a patient and medical perspective.

ABSTRACT 62 (20W172)

FIB4-based triage system reduces referrals for Fibroscan by more than 60% in MAFLD patients.

Author(s)
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Introduction
The most common cause of chronic liver disease in Ireland is metabolic-associated fatty liver disease (MAFLD), affecting 1 in 4 Irish adults >50years. The determination of liver fibrosis stage is critical to guide management. Transient elastography (Fibroscan®) can reliably exclude advanced liver disease, and is available at specialist liver centres throughout Ireland. However, given the volume of patients with MAFLD, access to Fibroscan cannot be accommodated in a timely manner. In contrast, the blood-based FIB4 score (age, platelet count, AST and ALT) has been validated as a predictor of advanced liver fibrosis. In order to reduce the demand for Fibroscan at our Institution, a triage referral pathway including FIB4 was implemented to limit Fibroscans to those with intermediate/high risk of advanced fibrosis.
Aims/Background
This study aimed to assess the effectiveness of a new Fibroscan referral pathway.
Method
The pathway was introduced in May 2019. Referrals from other centres were reviewed for 9months pre-and post-implementation.
Results
114 external referrals were assessed. Of these, 47 were for MAFLD (41%). 72% (34/47) of MAFLD referrals were received pre-implementation versus 28% (13/47) using the new pathway. The ratio of new referrals to old referrals was approximately 1:2.6.
Conclusions
By implementing a referral pathway using a validated predictor for advanced liver fibrosis in MAFLD, the volume of referrals for Fibroscan assessments at our centre decreased by >60%. Implementation of such a system nationwide could be a cost effective way to optimise Fibroscan access, and help tackle the burden associated with MAFLD.

ABSTRACT 63 (20W173)

Capsule Endoscopy: Is It Rightly Used? A Tertiary Referral Experience.

Author(s)
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Introduction
Small bowel video endoscopy (SBE) is a method of endoluminal exam looking into the small bowel. According to the European Society of Gastrointestinal Endoscopy (ESGE) clinical guidelines when investigating iron deficiency anaemia, a gastroscopy (OGD) with duodenal and gastric biopsies and an ileocolonoscopy is recommended prior to SBE. At the Mercy University Hospital 58 SBE were performed in the year 2019 to investigate anaemia.
Aims/Background
To evaluate our utilisation of SBE to investigate anaemia, and GI bleeding and to assess if it adhered to the 2015 ESGE clinical guidelines for small-bowel capsule endoscopy.
Method
A retrospective review was conducted on all SBE performed between Jan 2019 and Dec 2019. Their index referral, previous endoscopy where available, haemoglobin, age, SBE findings and intervention were obtained by a chart review and reviewing the unit's small bowel endoscopy database.
Results
56 eligible SBE were identified. The mean age was 62 years (SD 16.8). Median haemoglobin at referral was 8g/dl (IQR 7-10). A normal OGD and colonoscopy was reported in 45% and 54% of cases respectively before SBE and 12.5% of referrals did not include any OGD findings. 22% of cases were found to have pathology in the

stomach with an otherwise normal small bowel examination. 9% of these cases had gastric findings which were not mentioned on their initial OGD report. A diagnosis of GAVE was made in 5% of cases at SBE, which was not diagnosed at their initial OGD. Repeat OGD for endoscopic intervention was recommended in such cases.

Conclusions

This audit highlights a mismatch in findings reported in the referring OGD and SBE findings at our unit. For cases where GAVE was identified as the source of anaemia, SBE could have been avoided, resulting in savings on cost and time. To improve the diagnostic yield of SBE, it is important the right test is done for the right patient and at the right time.

ABSTRACT 64 (20W174)

A single-centre study of IBD patient's experience during the COVID-19 pandemic

Author(s)

Dr. Gerard Forde, Dr. Katie Gough, Dr. Louise Rabbitt, Ms. Linda Duane, Ms. Áine Keogh, Dr. Eoin Slattery

Department(s)/Institutions

Department of Gastroenterology, Galway University Hospital

Introduction

The COVID-19 Pandemic (C-19) has likely had a significant impact on the lives of patients with chronic health problems

Aims/Background

We wanted to determine the impact of C-19 on both physical and mental health of patients with Inflammatory Bowel Disease on biologic agents (deemed to be at the highest risk). We also aimed to ascertain if patients adhered to public health measures.

Method

We contacted IBD patients via standardised telephone interview and also e-mailed or mailed patients anonymous questionnaires

Results

113 patients (57 male) were contacted, including patients on Infliximab, Adalimumab and Vedolizumab. 79% (N=90) patients felt their IBD was much the same when compared to prior to the pandemic. On average, patients rated their health at 85/100 over the previous 2 weeks. Only 5% of patients missed a dose of their biologic agent, of whom 40% were unable to get their prescription renewed. 81.5% of patients were aware of recommendations around cocooning and social distancing and 79% of participants cocooned. Over 80% of participants stopped working or changed work practices. Less than 10% of patients continued to see family and friends as normal. 24 (21%) described themselves as being either slightly, moderately, severely/extremely anxious or depressed.

Conclusions

IBD patients on biologics did not note significant difference in their disease activity and only a minority of patients missed/omitted their medication. A majority of patients complied with public health guidance but with a consequent significant knock-on impact upon their daily lives as evidenced by changes in work and social practices.

ABSTRACT 65 (20W178)

Co Design of young person's multidisciplinary Inflammatory Bowel Disease (IBD) clinic, 16-24year olds

Author(s)

Mary Hamzawi, Susan Brannick, Yvonne Hickey, Fiona Jones, Prof Hugh Mulcahy, Prof Glen Doherty, Dr Juliette Sheridan, Dr Garret Cullen

Department(s)/Institutions

Department of Gastroenterology St Vincent's University Hospital

Introduction

Young people with IBD diagnosed in a paediatric hospital transition to adult services at 16years of age. Transition is an essential milestone for adolescents with IBD as critical functioning skills necessary for self-management are not fully developed and adolescents often find it difficult to engage. To date no ideal transition model has been defined in the literature.

Aims/Background

289 patients aged between 16-25 years currently attend SVUH IBD service, 31 of these (11%) are under 18 years of age. A nurse led project, seeking to design and evaluate a multidisciplinary team (MDT) transition pathway in collaboration with young adults was developed.

Method

During 2019, 8 patients transitioning into SVUH IBD service were assigned to the pilot structured MDT pathway for 12 months. This involved meeting with Consultant, CNS, psychologist and dietitian at clinic appointments. Patient experience measures were given after each visit and on completion of the pathway to steer service development. Participants rated experience on Likert scales and free text responses.

Results

At the end of 1 year excellent satisfaction rates were reported by those attending. Nonetheless 50% preferred consultant only clinics. 37.5% opted for full MDT review and 12.5% requested psychology input plus consultant at clinic.

Conclusions

The project highlights the importance of patient focused studies when designing young patient's transition clinics. 50% of young IBD patients did not request full MDT on a regular basis. This study is being expanded to review patient experiences from a larger cohort aged 18-24years and a RCT will be conducted to guide future care.

ABSTRACT 66 (20W179)

Is Sarcopenia an independent predictor of the need for colectomy in Acute Severe Ulcerative Colitis? – A pilot study

Author(s)

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Gastroenterology Department, Galway University Hospital

Introduction

Inflammatory bowel disease is classically associated with significant nutritional deficiencies and metabolic derangement. It is increasingly recognized that sarcopenia may impact the clinical course of IBD.

Aims/Background

To assess the role of sarcopenia in predicting the need for rescue therapy and surgical intervention in patients with acute severe ulcerative colitis.

Method
We conducted a retrospective study of patients hospitalized with acute flare of ulcerative colitis over last 2 years (2018-2019) who underwent CT imaging during hospitalization. Sarcopenia was defined as a SMI <38.5 cm2 /m2 in women, <52.4 cm2 /m2 in men. We reviewed the electronic data record of our patients regarding rescue therapy and surgical intervention.
Results
28 patients were admitted with flare of acute severe ulcerative colitis. 80% had inpatient CT imaging (n=20). Of those, 45% had sarcopenia confirmed on the CT. 67% of the sarcopenia cohort needed colectomy vs. 35% in the non-sarcopenia cohort. LOS was also longer (20 vs. 16 day). No correlation was seen with respect to sarcopenia and BMI (r2= 0.2) All patients with sarcopenia had BMI >18.5. A modest correlation was seen between albumin and sarcopenia (r2=0.4) as well as previous biologic and subsequent need for surgery (r2=0.4). The need for rescue therapy was comparable in both subsets
Conclusions
In this pilot study 90% of patients with Sarcopenia ended up with either rescue therapy (22%) or surgery (67%) or both. Early detection of Sarcopenia in patients with IBD may be important to prevent surgery and may potentially be a modifiable risk factor.

ABSTRACT 67 (20W180)

A 2020 Vision Of Blood Borne Viruses And Risk Behavior In Male Irish Prisoners- A Single Centre Experience

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1. Hepatology Unit, St James's University Hospital, Dublin 2. Midlands Prison, Portlaoise, Co. Laois
Introduction
There is a high prevalence of blood borne viruses (BBVs) in the prison population. Knowledge of the prevalence of BBVs and risk factors guides future strategies and responses. A 2017 study in Mountjoy Prison showed an estimated untreated chronic hepatitis C virus (HCV) seroprevalence of 13.7%, rising to 79.7% in those with a history of intravenous drug use (IDU).
Aims/Background
To establish the prevalence and risk factors for BBVs in the Midlands Prison, a medium security prison for adult males, and committal prison for counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath.
Method
We conducted a single-centre study using a patient self-administered questionnaire and serological testing for HCV, hepatitis B (HBV) and HIV.
Results
320 prisoners participated, mean age 40.48 years. 3.75% were HCV antibody positive. 1 (0.3%) prisoner was positive for HIV, with no HBV or cases of co-infection. The seroprevalence of HCV was greatest among IDU and those with a history of tattoos done in prison at 31% and 15% respectively. 12.5% of inmates with a family history of hepatitis tested positive for HCV. Among prisoners having unprotected sex and dental surgery abroad the seroprevalences of HCV were respectively 4.89% and 3.85%.
Conclusions
The prevalence of HCV in our study is much lower than previously reported. This is likely a reflection of the prison population and geographic location. The main risk is IDU echoing previous studies. Of the BBVs, HCV is the most frequent infection isolated and therefore needs to be treatment prioritization.

ABSTRACT 68 (20W181)

Adherence to Recommendations of Anticoagulation Management Guidelines in Endoscopy Procedures at Tallaght University Hospital (TUH).

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Introduction
Anticoagulants agents are widely prescribed. These drugs confer an increased bleeding risk when undertaking therapeutic endoscopic procedures, and also risks of thromboembolic sequelae if discontinued1, 2. European Society of Gastrointestinal Endoscopy, along with other societies have published guidelines on anticoagulation management pre- endoscopic procedures3,4,5
Aims/Background
To assess Oral Anticoagulant (OAC) and Direct Oral Anticoagulants (DOACs) management in endoscopy procedures.
Method
Retrospective analysis of endoscopic procedures in patients on OAC (Warfarin), and DOACs from January to December 2019, which were pre-assessed. OAC/DOACs management were based on the underlying Thrombotic Risk (TR) and the Initial Endoscopy Bleeding Risk (IEBR). Bleeding Risk during Endoscopy (BRDE) were assessed from final report.
Results
251 procedures were reviewed for 230 patients, 15/251 (6%) were cancelled (DNA), despite the pre-assessment. Therapeutic endoscopy was not performed in 33/236 (14%) due to anticoagulants use and needed to be repeated in 23 (9.7%). Colonoscopy was the most common procedure 78/236 (33.1%) and Apixaban was the most common DOAC in use 63/251 (33.5%). The TR, IEBR and the BRDE were high in 14.2%, 26.5% and 29.6% of cases, respectively. In procedures with high IEBR, DOACs were held in 34/42 (81%) and Warfarin was held in 14/19 (73.7%).
Conclusions
AOC/DOACs were held in the majority of patients with high IEBR and the pre-assessment in 2019 was beneficial and performed as per guidelines. The data of pre-assessment in 2018 were collected and analysis in process.

ABSTRACT 69 (20W182)

Trends in Baseline Screening and Vaccination for Hepatitis B in an Immunosuppressed Cohort of IBD Patients

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Introduction
Vaccination against Hepatitis B in Ireland was introduced to the vaccination programme in 2008. As per the second European consensus on prevention of opportunistic infections in inflammatory bowel disease (IBD) hepatitis B vaccination is recommended in all IBD patients who are HBV anti-HBcAb seronegative. Prior to commencing biologic therapy, it is standard practice to screen patients for hepatitis B. Compared with the general population, immunogenicity to Hepatitis B vaccination is less in IBD patients' with one study showing a response rate of 61%.
Aims/Background
To determine rates of immunity to Hepatitis B infection in a vulnerable cohort of IBD patients who are immunosuppressed.
Method
We performed a retrospective audit of all patients at our centre receiving Infliximab and vedolizumab infusions regularly. Patients biologic screen results taken prior to commencing treatment were reviewed to determine if patients were susceptible to hepatitis B and if vaccination was given.
Results
223 patients were identified for inclusion. 51 patients were excluded due to incomplete data. 171 patients in total were included (147 IFX, 24 vedolizumab). 115 (67%) were male. Median age 38years (range 17–82). 42.1% had Crohn's disease. Median time on infusions was 26 months(1–101 months). 169 (98.3%) patients had a negative Hepatitis B Surface Ag. 88 (51.5%) patients had a Hepatitis B anti-core Ab (anti-HBc) checked. Of the 90 patients who did not have an anti-HBc checked only 6 (6.5%) were performed after 2018 after introduction of standard biologic screen set at our centre. All patients who had an anti-HBc checked results were negative. Only one patient had confirmed vaccination to Hepatitis B. Similar results were seen in both patients treated with infliximab and vedolizumab.
Conclusions
Overall our audit highlights in a vulnerable cohort screening for Hepatitis B infection is adequate at our centre since introduction of a standard biologic screening set however vaccination against Hepatitis B in this immunocompromised cohort of patients is inadequate. As per ECCO guidelines all IBD patients should be vaccinated against Hepatitis B and we plan to implement a protocol to improve uptake of this vaccination at our centre.

ABSTRACT 70 (20W183)

Longterm Durability of Response to Ustekinumab in Refractory Crohns Disease patients

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Introduction
Ustekinumab is a fully human IgG1 monoclonal antibody that binds to the p40 subunit shared by the pro-inflammatory interleukins 12 and 23. ECCO guidelines recommend ustekinumab for the induction of remission in patients with moderate to severe crohns disease (CD) with inadequate response to conventional therapy and/or to anti-TNF therapy.
Aims/Background
To describe the outcome of CD patients at a single institution receiving Ustekinumab therapy. The primary endpoint was the characterisation of long term therapy outcome and durability of response to Ustekinumab and whether mode of ustekinumab induction (IV compared with subcutaneous) effected these outcomes.
Method
A chart review was carried out of all patients prescribed ustekinumab in St James's Hospital between July 2016 and July 2020. Patient demographics, baseline characteristics and disease behaviour were characterised. Medication history and duration of Ustekinumab therapy was documented.
Results
72 patients with CD were commenced on Ustekinumab during the study period, all had previously received at least 1 anti-TNF therapy. 11 (15%) patients underwent surgery during the follow up period. The median duration of ustekinumab treatment was 445 days. 44 patients remained on ustekinumab at the time of their last review (61%). 43 patients were in remission at 1 year (60%). 17 patients received IV induction and 55 patients received subcutaneous induction. There was no statistically significant difference in the duration of ustekinumab therapy comparing those who received IV and SC induction regimens.
Conclusions
Ustekinumab is an effective therapy in patients with refractory CD. Mode of delivery of induction therapy did not impact on the long term outcome of ustekinumab therapy.

ABSTRACT 71 (20W184)

Malignancy Surveillance in Primary Sclerosing Cholangitis

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Introduction
Primary Sclerosing Cholangitis (PSC) is associated with a high risk for both hepatobiliary and colorectal carcinomas. Patients with PSC have a 10-20% lifetime risk of cholangiocarcinoma. Annual gallbladder surveillance is recommended. Approximately 60-80% of patients with PSC have concomitant inflammatory bowel disease (IBD). This cohort requires annual colonoscopies for colorectal cancer surveillance.
Aims/Background
The aim of the audit was to assess our compliance with international guidelines on malignancy surveillance in our PSC cohort.
Method
A retrospective database of patients with PSC attending MMUH was created prior to commencing the audit. Data collected included; the presence/absence of concomitant inflammatory bowel disease, dates of colonoscopies and dates of biliary imaging. The time interval between consecutive colonoscopies/biliary imaging was calculated.
Results
43 patients with PSC attend outpatient clinics in MMUH. 33 patients (76.7%) have concomitant IBD. Taking scheduling factors into account, an investigation was deemed overdue if not performed within 14 months of the previous scan/endoscopy. The median interval time for surveillance colonoscopies in the IBD cohort was 13 months. 10 patients (32.25%) are overdue surveillance colonoscopy (median time of 21.5 months). In the non-IBD cohort 60% are compliant with surveillance guidelines. The median interval for gallbladder imaging was 8 months. At present, 25.58% of patients (n=11) are overdue

surveillance imaging.

Conclusions

Our compliance with malignancy surveillance in PSC can be improved. The creation of a database will also allow us to follow surveillance in this high-risk population more closely to ensure compliance with international standards and improved patient care.

ABSTRACT 72 (20W185)

Malnutrition In Hospitalised Patients – Readily Addressed But Poorly Recognised?

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Introduction

Malnutrition has a significant impact on length of stay, cost of hospitalization, re- admission and mortality. Despite this it remains poorly recognised by many physicians as a significant contributor to morbidity.

Aims/Background

The objective was to determine how frequently malnutrition was included in a discharge diagnosis (as a surrogate of physician-deemed importance) when an in-hospital diagnosis of malnutrition was made.

Method

A retrospective review was performed using the hospital electronic medical record. Medical patients with an in-hospital diagnosis of malnutrition over a 4 month period attending a university teaching hospital were identified and their records were reviewed.

Results

34 patients were diagnosed with malnutrition; of these no patient had malnutrition recorded as primary or secondary diagnosis in their discharge summaries. Average LOS was 11.85 days (compared to hospital mean of 5.5). Fourteen (41%) of the discharge summaries mentioned that dietetics has been consulted as inpatient, despite the fact they all were reviewed by dietetics. All patients received some form of nutritional support whilst an inpatient but only 15 received supplementation on discharge prescription. Dietetic follow-up was limited to 2 patients referred to community services.

Conclusions

Malnutrition is widely recognised as a (potentially reversible) contributor to ill-health. Failure to recognise and address malnutrition has implications for both the patient (with respect to clinical outcomes) and to the institution (documenting a diagnosis of malnutrition would help contribute further to financial case-mix). When diagnosed; malnutrition should be recorded and a comprehensive management plan should be developed to address.

ABSTRACT 73 (20W186)

Lynch Syndrome – Can We Reduce the Endoscopy Burden?

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Introduction

Individuals with Lynch Syndrome(LS) have a lifetime risk of 12-57% of developing colorectal cancer depending on the gene involved. Endoscopic surveillance has been shown to significantly reduce mortality. The European Society of Gastrointestinal Endoscopy(ESGE) guidelines have recommended surveillance colonoscopy every 2 years for asymptomatic individuals with LS. Routine gastric surveillance is not recommended.

Aims/Background

To determine the number of endoscopic procedures performed for LS surveillance from 2015 to 2019. To determine the number of procedures, for the same cohort, from 2020 to 2024 if surveillance intervals remained unchanged compared to if ESGE guidelines were applied.

Method

The Family Screening Clinic database was used to identify those with confirmed LS who undergo surveillance in MMUH. The number, type and surveillance interval of endoscopic procedure for each individual was recorded for a five-year period (2015-2019). This data was then used to predict the number of procedures for the next five years and compared to the estimated number of procedures for the same period, applying the ESGE guidelines.

Results

89 patients were identified as having confirmed LS and undergoing endoscopic surveillance in MMUH. From 2015 to 2019 this cohort accounted for 176 OGDs and 290 colonoscopies. With current surveillance intervals an estimated 209 OGDs and 379 colonoscopies would be performed between 2020 and 2024 for the same cohort. If ESGE guidelines were applied no routine OGDs and 197 colonoscopies would be expected in the same time period.

Conclusions

There is potential to significantly reduce the number of endoscopies performed in individuals with LS in MMUH by ensuring ESGE guidelines are adhered to. This is important both for service provision, given the ever increasing endoscopy waiting list, and to ensure that patients are not having unnecessarily frequent endoscopies which are not without risk.

ABSTRACT 74 (20W188)

The evaluation of inflammatory bowel disease detected at Bowelscreen colonoscopy

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Introduction

The National Colorectal Cancer Screening Program invites those aged 60-69 to undergo a FIT test to assess for human haemoglobin present in stool. Those with a positive FIT are invited for colonoscopy. IBD can give rise to a positive FIT. Those with persistent inflammation are likely to have a positive FIT in future rounds of screening unrelated to the presence of advanced neoplasia.

Aims/Background

To identify the proportion of patients with IBD detected at Bowelscreen, to evaluate their follow up and to examine the incidence of colorectal cancer among these patients.

Method

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Dr Brooke Layard & Dr Hannah McCaughan

Prof. Diarmuid O'Donoghue, Mr Adrian Ireland, Dr Martin Buckley, Prof Richard Farrell
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Dr Hilary Kerr, Dr Alan Marrinan, Dr Stephanie Ryan

Dr Mary Hussey & Dr Grainne Holleran

This was a retrospective study examining SVUH Bowelscreen data from 2013 to February 2020. Patients with IBD were identified based on the presence of biopsy reports.

Results

49 patients had changes consistent with IBD on biopsies; 29 with UC, 13 with CD and 7 with IBDU. 55% of those had a known IBD diagnosis, 45% received an initial IBD diagnosis at screening. 26.5% were symptomatic at screening. Those with known IBD were less likely to be symptomatic. 2% of those with IBD had colorectal cancer compared with an overall incidence of 4.7% among all NCSS patients. 59% with IBD were discharged from Bowelscreen. 34.7% were referred back to FIT, 6.1% were booked for surveillance colonoscopy and 85% were referred to IBD clinic. 14.3% progressed to need either immunosuppression or surgery.

Conclusions

IBD incidence is increasing among older patients. There are currently no national guidelines regarding the inclusion of patients with IBD into Bowelscreen. The incidence of CRC among IBD patients who underwent screening is significantly less than the overall incidence of CRC in Bowelscreen. Assessment of Bowelscreen data at a national level would allow us to study this further and examine the clinical course and disease outcome of screen detected cases of IBD.

ABSTRACT 75 (20W189)

To Anticoagulate Or Not Anticoagulate Portal Vein Thrombosis In Hepatocellular Carcinoma? That Is The Question

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Introduction

Portal vein thrombosis (PVT) occurs in up to 40% of patients with hepatocellular carcinoma (HCC). There is no consensus on whether anti-coagulation improves outcomes and use varies between individual physicians. Anticoagulation is considered on a case-by-case basis and evidence is lacking on its survival benefit.

Aims/Background

We aimed to determine whether anticoagulation impacts on the survival of patients with HCC and PVT.

Method

A retrospective study was carried out at the National Liver Transplant Centre including all patients who had died with underlying HCC and PVT. Data was collected from the electronic HCC data-base. The date of PVT diagnosis was taken as the time it was first diagnosed on imaging. Baseline demographics, treatments (anticoagulation or no anticoagulation) and survival times in months for each treatment group were recorded.

Results

60 patients who died with an underlying diagnosis of HCC and PVT were included. 80% (n=48) male, 88.3% (n=53) were cirrhotic with an average age of 64. 31.6% (n=19) were anticoagulated and mean survival was 6.42 months. 68.3% (n=41) were not anti-coagulated and the mean survival was 5.73 months. The p- value was 0.689. 87% (n=52) were Barcelona clinic liver cancer staging (BCLC) C or D.

Conclusions

There was no significance observed between those receiving anticoagulation or not. HCC is usually diagnosed late and PVT carries a very poor prognosis. The majority of our patients were BCLC stage C and D. The timing of anticoagulation, duration of illness, etiologies of cirrhosis and co-morbidities may influence survival and this needs to be further explored.

ABSTRACT 76 (20W190)

Alcohol-related Emergency Department presentations during the COVID-19 pandemic

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Introduction

More than 50% of Irish adults who drink alcohol, do so in a harmful manner. During the COVID19 lockdown period, more than 30% of Irish adults increased their alcohol consumption. The impact of this on alcohol-related (AR) presentations to hospital Emergency Departments (ED) has not been reported to date.

Aims/Background

To assess the number and type of AR presentations to the ED of a major Dublin hospital over a one week period during the COVID-19 pandemic, compared with a similar period one year previous.

Method

Retrospective review of all ED presentations during the weeks ending 19/04/2020 and 21/04/2019.

Results

There were 1853 presentations during the 2 time periods, with 1111 in 2019 and 742 in 2020. Of the presentations in 2020, 139 were COVID19-related. Despite a 33% reduction in ED attendances, AR presentations increased from 8.2% of total in 2019 to 11.3% of non-COVID19 related presentations in the 2020 study period. More women presented in 2020 than 2019 with AR harm (42% vs. 34% of total). There was a doubling of AR presentations related to psychiatric issues (such as deliberate self-harm/mood disorders/overdose/suicidality) in 2020 compared to 2019, reflecting an increase from 13% to 27% of all AR presentations. More mid-week presentations occurred during COVID19, when compared with 2019.

Conclusions

AR presentations represent a significant burden on ED services in Ireland, which was exacerbated by the COVID-19 pandemic. Moreover, a significant increase in psychiatric morbidity was seen. The implementation of measures to reduce alcohol-related harm is urgently needed.

ABSTRACT 77 (20W191)

Changing lanes-switching between Biologics, an Observational Study

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Introduction

Switching between biologics in the treatment of IBD is common

and a paucity of data exists regarding the optimal switching strategy. Failure of biologic therapy regularly occurs prompting the need for a treatment switch.

Aims/Background

To review trends amongst our patients who switched biologics to identify high risk features and to look for predictor variables which may reduce the need to switch biologic in the future.

Method

A 4 year review of patients who underwent biologic switch.

Results

39 patients are included, 53.9% (n=21) with CD, mean age 42.8 years. The mean duration of disease to switch was 78 months. 14/17 UC patients had pancolitis. 9/21 CD patients underwent previous surgery. The most common initial biologic was Adalimumab (n=18), with the most common switch to IFX (n=14). Primary LOR occurred in 28% (n=11) and secondary LOR in 44% (n=17). Mean CRP was 13.7 ug/ml (95%CI: 7.28, 20.09), mean endoscopic Mayo score was 1.88 (95%CI: 1.37, 2.39), mean SES-CD score was 5.79 (95%CI: 3.24, 8.33). 39% (n=15) were on an immunomodulator, no association was found between combination therapy and primary/secondary LOR (p-value= 0.67, p-value= 0.63). 28% (n=11) were admitted in the year post switch, 13% (n=5) underwent surgery and 26% (n=10) experienced LOR to the second biologic.

Conclusions

The most common biologic switch was within Anti-TNF class, CRP was raised at the time of switch and patients trended toward a more severe disease phenotype.

ABSTRACT 78 (20W192)

Establishing an Integrated Clinical Psychology Service for People with IBD in St Vincent's University Hospital Gastroenterology Department

Author(s)

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Introduction

SVUH Gastroentrology is the only IBD service in Ireland with fulltime Clinical Psychology input. Psychology service development was informed by stakeholder views in line with BSG consensus guidelines on IBD management, and BPS psychology service design recommendations. Development was supported by an audit of initial referrals and pilot of psychological outcome measures to evaluate baseline symptom severity of those referred

Aims/Background

Develop clinical psychology service

Method

Service development involved four phases. Phase 1: IBD staff (n=11) completed a survey regarding priorities for psychology. Phase 2: IBD team colleagues collaborated on developing a psychology referral form. Phase 3: Standardised distress measures were piloted with an audit of referral reason. Phase 4: Patients (n=52) completed a survey about psychology input.

Results

Phase 1: IBD staff identified the following 3 priorities: Individual therapy, transition support and group interventions. Phase 2: A referral pathway opened, accepting 107 referrals in the first 12 months. Phase 3: The Depression Stress and Anxiety questionnaire was piloted to measure psychological distress. 60% of depression, 68% of anxiety and 70% of stress scores fell within clinical range. Stress was the most common referral reason. Phase 4: The majority of patients (75%) surveyed were unaware of the service although would access it if needed. The following were ranked by patients as priorities for help. 1) Newly diagnosed, 2) managing flares, 3) admission and surgery support.

Conclusions

There is a high level of psychological need in this cohort. Developing interventions for those newly diagnosed and increasing knowledge of the service will guide next development phases.

ABSTRACT 79 (20W193)

The Effect of SARS-CoV-2 on Endoscopy Training in a Tertiary Referral Centre

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Introduction

In Spring 2020, guidelines for the safe practice of endoscopy during the SARS-CoV-2 pandemic were introduced. Endoscopy units transformed to comply with guidelines in order to prevent the spread of COVID-19 and to protect patients and staff. Many units experienced a marked decrease in case volume.

Aims/Background

The aim of this study was to assess the effect of the pandemic on the colonoscopy performance in our endoscopy unit; focusing primarily on case volume, pathology identified and training.

Method

This was a single centre, retrospective, observational study comparing colonoscopies performed at a high-volume endoscopy centre during the SARS-CoV-2 pandemic with colonoscopies performed during a similar time frame pre-pandemic (March-June 2020 versus 2019).

Results

During the reference period (March to June 2019), 981 colonoscopies were performed in our unit. In the same period in 2020, there was a 4.5-fold reduction in colonoscopies performed (n=217). There was an 8-fold reduction in the number of colonoscopies performed by GI trainees (2019, n=367; 2020, n=44). Although the number of polyps identified reduced greatly (2019, n=331; 2020, n=62), the polyp detection rate for GI trainees remained acceptable (2019=40.6%; 2020=54.5%). The average number of polyps detected per procedure was equal in 2019 to 2020. Caecal intubation rates (91.0% vs 90.9%) and withdrawal times (15.9 vs 17.3 minutes) were comparable for 2019 versus 2020.

Conclusions

The SARS-CoV-2 pandemic impacted greatly on endoscopy training in our unit. A second wave of the virus is predicted. Strategies will need to be created to safeguard endoscopy training for our trainees.


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Abbreviation: NHCTP = National Hepatitis C Treatment Programme.
Reference: 1. The Medical Independent. Hepatitis C in Ireland in 2019 and finding the 'missing millions' by Michelle Tait. Available from: www.medicalindependent.ie/hepatitis-c-in-ireland-in-2019-and-finding-the-missing-millions/. Accessed February 2020.
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Dr Shiobhan Weston & Dr Mary Shuhaibar

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Prof Richard Wong, Speaker

Prof JJ Bergman, Speaker

ABSTRACT 80 (20W194)

Association between baseline serum albumin and mortality in 310 admitted patients with COVID-19.

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Introduction
Coronavirus disease 2019 (COVID-19) has led to significant morbidity and mortality worldwide. The identification of readily accessible and reliable markers of disease outcomes is crucial to effective management. Deranged liver blood tests (LBTs) have been reported with severe disease, and in >50% of patients dying or requiring ICU admission.
Aims/Background
To examine LBTs in a cohort of admitted patients with COVID-19, and to investigate for an association with clinical outcome.
Method
Demographics, biochemistry and clinical outcomes were reviewed in patients admitted to Beaumont Hospital. Data was analysed using Stata statistical software.
Results
310 admitted patients who were diagnosed with COVID19 were included. Of these, 96.5% were caucasian, 39.4% were female, mean age was 69.5(+/-15) years, and mean BMI was 27(+/-6.7) kg/m2. 83/310 (26.7%) patients died during the admission. With regards to LBTs on admission, albumin was <35g/L in 23%, ALT >40IU/L in 20%, AST >40IU/L in 28%, bilirubin >20umol/L in 5.2%, alkaline phosphatase >130IU/L in 17.4%, and gGT >40IU/L in 48.4%. Basline albumin, alkaline phosphatase, and bilirubin were significantly different in survivors vs. non-survivors ($p<0.05$). Multivariate regression analysis showed a significant association between mortality and serum albumin (OR 0.90, 0.85-0.96; p=0.002) along with age, gender, and MULBSTA score (an indicator of viral pneumonia severity); other LBTs were not associated.
Conclusions
In this study, abnormal liver blood tests were common on admission in patients with COVID19. Serum albumin was independently associated with mortality. Research into the underlying mechanisms and potential therapeutic targets are warranted.

ABSTRACT 81 (20W195)

Identification of Anaemia in Inflammatory Bowel Disease while on Biologic treatment.

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Introduction
Anaemia is the most common extraintestinal manifestation of Inflammatory Bowel Disease (IBD). Patients most commonly have Iron Deficiency Anaemia secondary to chronic blood loss and impaired GI absorption. Over 1/3 of IBD patients suffer recurrent anaemia, which has been shown to impact on patient quality of life, and increase healthcare costs.
Aims/Background
To assess the prevalence of Anaemia (Hb <12g/dL in women, <13.5g/dL in men) in IBD patients receiving Biologic Infusions.
Method
A cross-sectional analysis was conducted of 122 patients receiving biologic infusions for IBD in a Model 2 hospital in Tipperary. Data collection included chart, medication and biochemistry review.
Results
A total of 122 patients with IBD diagnoses were reviewed. 53 patients (43%) were female. The mean age was 40.6 years. 77 (63%) patients were receiving Infliximab, and 45 (37%) receiving Vedolizumab. Overall prevalence of anaemia was 28 patients (23%). 32% of the Anaemia group displayed either microcytosis or hypochromia, while a further 36% displayed both. 21.5% had normocytic anaemia, and 10.5% had macrocytosis. Fisher Exact Test analysis of our data showed a positive correlation between features typical for iron deficiency and thrombocytosis, ($p<0.01$).
Conclusions
Overall we showed a significant proportion of IBD patients display anaemia, >65% with features of Iron deficiency. ECCO guidelines recommend IV Iron as first line replacement in IBD, and screening all patients 3-6 monthly with Iron Studies, Ferritin, Haemoglobin, and CRP. This project underlines the importance of ongoing compliance with these guidelines, and urges consideration of using platelet count as an indicator of active disease and iron deficiency.

ABSTRACT 82 (20W196)

Endoscopy nurse triage significantly reduces urgent, non-urgent and surveillance endoscopies with significant inter-rater agreement with consultant gastroenterologists after 1 year

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Introduction
Despite established referral guidelines many patients are referred inappropriately for symptomatic and surveillance endoscopy. Triage of endoscopy referrals is essential to reducing waiting lists. Limited data exists assessing the impact of endoscopy nurse triage and the inter-rater agreement between consultant gastroenterologists and triage nurses.
Aims/Background
We prospectively compared the effect of our triage nurse (appointed January 2019) on endoscopy referrals and inter-rater agreement between triage nurse and consultant gastroenterologists.
Method
All endoscopy referrals including health-link between January 2019 and July 2020 were stratified into urgent/(P1), non-urgent/(P2) and surveillance groups prior to nurse triage based on established HIQA/BSG guidelines. Missing referral data including prior endoscopy/histology and alarm symptoms were validated by telephone before being vetted by 4 consultant gastroenterologists. Inter-rater agreement between nurse triage and consultant gastroenterologists

were compared for the periods Jan-Mar 2019 and May-July 2020.

Results

Of 2273 patients referred for endoscopy, 1231 patients were urgent/P1, 615 were non-urgent/P2 and 427 were surveillance. Nurse triage reduced urgent referrals by 56% ($p<0.001$), non-urgent referrals by 27% ($p<0.001$) and surveillance referrals by 36% ($p<0.001$) with a large proportion redirected back to GP, OPD, HP testing, FIT, CT colonography or discharged from surveillance lists. Substantial agreement between triage nurse and consultant gastroenterologists in early 2019 ($K=0.645$) increased to almost perfect agreement by mid 2020 ($K=0.94$), $P<0.001$).

Conclusions

Endoscopy nurse triage can achieve significant reductions and cost savings in P1, P2 and surveillance endoscopy referrals. After 1 year, endoscopy nurse triage using established endoscopy referral guidelines can approximate decision making by experienced gastroenterologists.

ABSTRACT 83 (20W197)

The effect of exercise on gastrointestinal permeability: acute and chronic measures

Author(s)

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Introduction

The important role of intestinal barrier function and intestinal permeability is increasingly appreciated in health and disease. Alterations in barrier function may also impact the central nervous system via the gut-brain axis. Evidence of an association between stress-related psychiatric disorders (i.e. depression) and increased intestinal permeability levels is accumulating. Exercise exerts beneficial effects in depression although the mechanisms are unclear. The physiological impact of exercise may manifest as hormetic effects on gastrointestinal permeability, acting initially as an acute stressor that subsequently stimulates positive adaptation rather than deleterious consequences.

Aims/Background

This study aims to assess the impact of exercise training intensity (low, moderate, or high) on gastrointestinal permeability in sedentary healthy controls, both acutely and chronically over a 12-week duration.

Method

Monthly fitness and psychometric assessments were performed throughout a 12-week exercise program (3-sessions/week). Intestinal permeability was assessed in plasma samples, pre-exercise and one-hour post-exercise, for each monthly visit using LPS-binding protein and sCD14 as biological markers.

Results

Preliminary analyses show significant increases in fitness ($p<0.05$) and performance ($p<0.001$), with modest reductions in stress ($p=.08$) and depression ($p=.06$) levels after 12-weeks exercise. Acutely, intestinal permeability markers (LBP; sCD14) were unchanged one-hour post the monthly fitness assessment. Chronically, we observe a significant effect of training ($p=<0.05$) and significant training x exercise group interaction ($p<0.05$) in LBP concentration levels, which were increased in the high-intensity group only.

Conclusions

Preliminary data shows that 12-weeks exercise training has a modest impact on intestinal permeability. Further research is needed to understand exercise-induced alterations in gastrointestinal physiology and gut-brain axis signaling, and the beneficial effects of exercise in modulating stress and depression.

ABSTRACT 84 (20W198)

Repeat Endoscopy For Gastric Ulcers Within 12 Weeks

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Introduction

JAG (Joint Advisory Group on GI Endoscopy) requires services to repeat all gastroscopies for gastric ulcers within 12 weeks. As per BSG (British Society of Gastroenterology) guidelines, gastric ulcers should be biopsied and re-evaluated after appropriate treatment (including Helicobacter pylori (H. pylori) where indicated) within 6 to 8 weeks, 90% of the time.

Aims/Background

The aim of this audit was to validate the level of compliance regarding current practice in Cork University Hospital against the JAG recommendations on repeat endoscopy for all gastric ulcers within 12 weeks.

Method

All patients with at least 1 ulcer found during gastroscopy between 1st of January 2020 and 18th of August 2020 were included in this audit. The data was collected through Unisoft.

Results

Of the total 22 patients, 13 (59%) did not have a repeat gastroscopy within 12 weeks. Of these 13 patients, 4 had a repeat OGD beyond the recommended 12 week timeframe (between 14 and 22 weeks). Review of the Unisoft recorded data highlighted that although most patients had a Urease test for H. pylori done, only 2 had the result recorded in the system. Furthermore, no data was available with regards to eradication therapy prescribed.

Conclusions

41% of the patients with gastric ulcers had a repeat endoscopy within 12 week timeframe. Additionally, 18% had a repeat OGD beyond 12 weeks. As the data/audit was conducted in the first half of 2020 it is possible that the low level of compliance with the JAG recommendation could be explained in the context of the COVID-19 pandemic. Further data collection/analysis using patients notes regarding Urease test results +/- triple therapy prescribed and histopathology results, will allow a better representation of this cohort and possibly explain the delay in follow-up investigations.

ABSTRACT 85 (20W199)

How frequently does COVID-19 infection mimic an IBD flare when community transmission of SARS-CoV2 is active?

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Introduction
Gastrointestinal symptoms are frequently reported in patients who test positive for COVID-19. Diarrhoea is common with a reported incidence as high as 49%. Angiotensin converting enzyme 2 (ACE-2), the entry receptor for COVID-19, and virus nucleocapsid protein have been detected in gastrointestinal epithelial cells, suggesting GI symptoms may be caused by direct viral insult. Faecal PCR testing has been shown to be as accurate as respiratory PCR testing. Many diseases, including acute self-limiting infectious colitis, may mimic the presentation of an acute flare of inflammatory bowel disease (IBD).

Aims/Background
To determine if COVID-19 infection in IBD patients mimics a disease flare.

Method
Prospective single centre study. IBD patients who reported symptoms suggestive of disease flare during the first peak of the SARS-CoV-2 pandemic (March-June 2020) were requested to provide a stool sample to measure faecal calprotectin as part of clinical care. If patients agreed to participate, a second stool sample for SARS-CoV-2 testing was obtained. Patient and disease characteristics were recorded. Faecal calprotectin (FC) levels >150g/dL were considered positive for an IBD flare, and 50-150g/dL indeterminate.

Results
A total of 249 patients reported flares of disease during the study period. Of these, 158 (63.5%) provided a stool sample for FC testing. 38 patients were invited to provide a second stool sample for SARS-CoV-2 testing, of which 21 (55%) complied. Of those providing 2 stool samples, there was a male preponderance (n=14, 66%) with a median age of 35.5 years (IQR 22-47). Crohn's disease (CD) and Ulcerative Colitis (UC) accounted for 57% (n=12) and 43% (n=9) respectively with a median duration of disease of 10.4 years (IQR 7-11). No upper respiratory symptoms were reported. In terms of treatment, 7 patients were treated with biologic therapy alone, 6 with combination therapy, 3 with 5-ASA and immunomodulator, 2 with 5-ASA alone, and 3 with no therapy. Faecal calprotectin was positive in 8/21 (38%) and indeterminate in 4/21 (19%). SARS-CoV-2 RNA was not detected in any of the stool samples. Of the patients with suspected flares/positive FC (n=8), 1 had cryptosporidium, 2 were non-compliant with treatment, 1 was given a steroid enema, 1 commenced an immunomodulator, and 3 had no change in their therapy.

Conclusions
Disease flares are frequently described during the SARS-CoV-2 pandemic. SARS-CoV-2 RNA was not detected in stool samples submitted, whether FC levels were elevated or normal. This limited data suggests that COVID-19 infection does not mimic an IBD flare when community transmission of the virus is active.

ABSTRACT 86 (20W201)

Intravenous Iron Induced Hypophosphataemia: A single center experience

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Introduction
Intravenous(IV) iron is popular for the treatment of IDA due to its favourable efficacy and safety profile compared with oral iron. Recent studies have demonstrated that Ferric carboxymaltose(FCM) is associated with significant decreases in serum phosphate (S-Phosphate). For many, this may be asymptomatic and transient, however the true clinical impact is unknown. Patients with pre-existing disorder influencing phosphate homeostasis and those receiving multiple IV-iron are at high risk of prolonged and symptomatic hypophosphatemia.

Aims/Background
We aimed to review our departmental experience regarding S-Phosphate monitoring, pre-and post-IV-Iron administration.

Method
Medical records of patients (n=39) attending our gastroenterology infusion unit for IV-iron administration between Mar-19 and Aug-19 were examined. Data on patient demographics and phosphate monitoring were collected.

Results
Seventy-four percentage of patients were female; the mean(SD) age was 43 (18)yrs ranging between 19-81yrs; 66% received FCM and 34% received Iron Isomaltose(IIM). Only 5% (n=2) patients had S-Phosphate measured on day of IV-Iron infusion; 36% (n=14) had S-Phosphate measurements within one month prior to IV-Iron infusion and 18% (n=7) had S-phosphate measured within 1 month post-IV-Iron regardless of the reason. Of these, 57% of patients had recorded hypophosphatemia which was more common with FCM. Only 2.56% (n=1) had S-Phosphate measured on both the day of infusion and within one month post-IV iron.

Conclusions
This study emphasizes the lack of awareness regarding IV-Iron induced hypophosphatemia and the need for S-Phosphate monitoring pre-and post-IV Iron, particularly in high risk patients, to avoid potential side effects and long-term complications. Several studies have reported high rates of hypophosphatemia following FCM administration caused by an acute increase in circulating, biologically active, FGF-23 promoting renal phosphate wasting.

ABSTRACT 87 (20W202)

Implementation of new British Society of Gastroenterology (BSG) 2020 post-polypectomy surveillance guideline is associated with cost savings and capacity improvements.

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Introduction
Patients with low-risk adenomas (LRAs) are not at increased risk of colorectal cancer compared to patients with no adenomas nor the unexamined general population., recently published BSG post-polypectomy surveillance guidelines recommend patients with LRAs participate in Bowel Cancer Screening programmes when eligible rather than colonoscopic surveillance. Furthermore, no surveillance is recommended in patients over 75 years or with <50% 5-year survival.
Aims/Background
Assess diagnostic yield of post-polypectomy surveillance colonoscopies at our unit. Impact of implementation of updated guidelines with regards to cost and capacity.
Method
Retrospective study analysing electronic endoscopy database records from an academic teaching hospital from January 1st, 2018 to January 1st 2020. Life expectancy was estimated as < 10 years where Charlson comorbidity index (CCI) was ≥3. Need for repeat/surveillance colonoscopy rates was calculated by application of 2010 and 2020 BSG guideline. Cost savings were calculated using the NHS 2018/2019 tariff for diagnostic colonoscopy and an estimate of histology costs (assuming 30% adenoma detection rate (ADR)).
Results
1561 procedures were analyzed, accounting for 1495 patients . Caecal intubation, adequate bowel preparation rate and premalignant polyp detection rate were 98.1%, 86% and 60.5%, respectively. 10.8% were ≥75 years. 21.3% had a limited life expectancy. Advanced colorectal polyps and large non pedunculated colorectal polyp (LNPCP) detection rates were 10.4% and 0.7% respectively. A single T1 colorectal cancer was identified. The need for repeat/surveillance colonoscopy rate was reduced from 66% to 33.3% with an annual cost saving of €117,045.
Conclusions
Implementation of the new BSG guideline generates cost savings and additional capacity, at no additional cost. This is particularly helpful where endoscopy unit capacity has been effected by COVID-19 pandemic

ABSTRACT 88 (20W204)

Pancreatic Cystic Lesions Under Surveillance, A Growing Population

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Introduction
Pancreatic cystic lesions(PCLs) are a diverse group of lesions arising within the pancreas. The incidence is increasing worldwide with improved imaging. The major risk of PCLs is progression to pancreatic ductal adenocarcinoma. Current guidelines advise annual radiological and clinical surveillance.
Aims/Background
We reviewed patients under surveillance to assess the rate of progression to cancer or surgery.
Method
Patients with PCL under surveillance between 2000 and 2020 were identified via MDT and radiology databases. Endpoints were cancer, surgery, or discontinuation of surveillance.
Results
549 patients were identified, 301 female(54.8%), median age 71. Mean cyst size at first diagnosis was 14.09mm, (SD 12.39mm). 112 (20.04%) patients had worrisome features at first scan. Median follow up was 28 months, (range 0-139). No lesions transformed during surveillance. At 1 year surveillance we found a mean 4.2Δ% change in our patient cyst sizes. At 5 years this had risen to 37.5Δ% across our group. 32(5.8%) patients underwent surgery for pancreatic cystic lesion. Median time to surgery was 4 months, 23(71.8%) had surgery within one year, 28 (87.5%) had surgery within two years. Mean cyst size for surgical patients was 32.9mm at diagnosis (SD20.65), significantly bigger that than the cohort ($P < 0.0001$). 22 patients (69%) had worrisome features at first scan, 3 further patients developed worrisome features within the first year.
Conclusions
We have a large cohort of patients requiring annual surveillance. The majority of our patients progress to surgery within two years raising the question of widening surveillance intervals beyond this point.

ABSTRACT 89 (20W205)

The Impact of SARS-Cov2 on Bowel Cancer Screening in a High-Volume Endoscopy Centre

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Introduction
The Bowel Screen programme paused activities in March 2020 to prioritise the emergency response to the SARS-CoV-2 pandemic. As a result, patients with positive faecal immunochemical test (FIT) results that had already been returned, experienced significant delays in time to colonoscopy.
Aims/Background
To examine the impact of this delay on index FIT positive cases in a high-volume tertiary endoscopy unit. In particular, we examined the time from date deemed suitable for colonoscopy to colonoscopy, which should be within 20 working days.
Method
Screening cases affected by the pause in activity and subsequently completed (up to July 2020) were analysed in comparison to the same period in 2019.
Results
Sixty-eight colonoscopies were performed in 2020. Thirty-eight (56%) were male, median age 67. In 2019 for the same period 122 screening colonoscopies were completed. Median time from date deemed suitable for colonoscopy to colonoscopy was 60 days in 2020. Fifty-two polyps were detected in the 2020 group. This included 16 advanced adenomas (defined as adenoma ≥ 10mm) in 14 patients. The 2019 group had 27 advanced adenomas in 23 patients. There were three cancers detected in 2020 and five in 2019.
Conclusions
This audit demonstrates the significant impact of the pandemic on cancer screening in Ireland and is likely to have been mirrored in other centres. Despite the significant challenges during this period, it should be possible to maintain activity of our cancer screening services with expected and proven benefit on key cancer treatment outcomes.

ABSTRACT 90 (20W206)

An Audit Of Magnetic Resonance Enterography In The Diagnosis of Crohn's Disease In St. Vincent's University Hospital

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Introduction
BSG/ECCO/ESGAR guidelines recommend Magnetic Resonance Enterography (MRE) as the first line radiological investigation for work-up of suspected Crohn's Disease (CD), in conjunction with biochemical and endoscopic investigations.
Aims/Background
To audit if MREs performed in St Vincent's University Hospital from July 2019 to July 2020 for suspected CD are performed in conjunction with appropriate biochemical and endoscopic investigations.
Method
Retrospective review of MREs performed. Correlation of findings with patients' biochemical (FCP) and colonoscopy findings in previous 2 years.
Results
In total 200 MREs were performed during the study period, of which 91 were performed as work-up for suspected CD. 44/91 (48%) had a FCP and 64/91 (70%) had ileo-colonoscopy. 23/91 (25%) of the suspected new cases demonstrated radiological small bowel pathology consistent with Crohn's Disease. FCP was underutilized as a screening test with only 10/23 (43%) of new CD diagnosis having prior FCP and 8/10 (80%) of this group had a positive FCP. All 12 of patients with new radiological CD diagnosis who had ileo-colonoscopy prior to MRE had endoscopic CD.
Conclusions
As MRE is a very limited resource at our institution all suspected cases should undergo FCP and Ileo-colonsocopy prior to MRE. FCP may help us more appropriately select patient to undergo MR due to the low positive yield from MREs performed, and ensuring ileo-colonscopy may expedite time-to-diagnosis.

ABSTRACT 91 (20W207)

Evolution of Barrett's Assessment In a Tertiary Referral Centre Over Time

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Introduction
Barrett's oesophagus is a precancerous condition associated with a 24 fold increase in risk of Oesophageal cancer. Seattle biopsy protocol is the gold standard in Barrett's surveillance. Adherence to Seattle protocol increases dysplasia detection rate (DDR). In addition, the inclusion of chromoendoscopy with Narrow band imaging (NBI) and Acetic Acid spray (AA) is also associated with improved dysplasia detection rate.
Aims/Background
To review, over time, how our assessment of Barrett's oesophagus with regards to the use of chromoendoscopy, adherence to Seattle Protocol and documentation of Prague classification has evolved.
Method
The first 50 patients with Barrett's oesophagus at 3 different time points (2013, 2016, 2019) were retrospectively reviewed. Data of consecutive 50 patients from each year was retrieved through electronic database. Patients with known dysplasia, prior treatment for dysplasia and contraindication for biopsy were excluded.
Results
A total of 150 patients were included in the study. Mean age 65 (66% males). Documentation of Prague classification increased from 50% (2013) to 94% (2019) while Seattle protocol adherence increased from 56% (2013) to 86% (2019). Seattle Protocol adherence in short segment Barrett's(SSBE) improved from 50% (2013) to 94.7%(2019) and in long segment Barrett's (LSBE)from 62.5%(2013) to 86.2% (2019). Dysplasia detection rate increased from 8% (2013) to 18% (2019) and was higher in long segment (16%) than short segment (2%). Also use of chromoendoscopy increased from 0% AA, & 4% NBI (2013) to 62% & 86% (2019).
Conclusions
Our study showed increased documentation of Prague classification, better adherence to Seattle protocol, greater use of chromoendoscopy with improvement in dysplasia detection rates over this 7 year period.

ABSTRACT 92 (20W208)

Is It Time To Rationalise Barrett's Surveillance Intervals

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Introduction
Barrett's oesophagus (BE) is a pre-cancerous condition .The annual incidence of Oesophageal adenocarcinoma(EAC) amongst BE patients varies from 0.3% to 0.6.Several studies suggest a modest effect of surveillance programs on EAC mortality .So there is a need to develop a more cost effective approach for BE surveillance .The new European Society of Gastroenterology (ESGE) guidelines published in 2017 have extended the surveillance intervals for non-dysplastic short segment (SSBE) to 5years and long segment BE(LSBE) to 3 years.
Aims/Background
To assess the impact of new 2017 ESGE Guidelines on Barrett's surveillance work load. To evaluate the past practice to see how many Oesophagoastroscopy(OGD) slots can be saved by adopting ESGE 2017 guidelines.
Method
All patients who underwent gastroscopy for Barrett's Surveillance in 2013 in Beaumont Hospital for non-dysplastic BE (NDBE) were reviewed for this study. Data was retrieved from electronic data base and was recorded prospectively from time of diagnosis of BE. Cumulative Patient years (PY) follow up and total OGDs performed were recorded. Patients with known Dysplasia at index endoscopy were excluded. If incident dysplasia was diagnosed during surveillance subsequent OGDs were excluded from the analysis. Actual procedure numbers performed were compared to hypothetical numbers if ESGE guidelines had been followed to determine unnecessary procedure utilizatio
Results
In total, 70 patients (Male n=51, Mean age74) with NDBE underwent surveillance OGD in 2013. In SSBE cohort, cumulative Follow up

was 398 Patient years (Mean follow up 9.2 y), total OGDs =236 with mean annual number of OGDs at 1.68 per patient, a three-fold increase based on ESGE guidelines. No incident dysplasia was detected in the SSBE cohort. In LSBE cohort, cumulative Follow up was 258 Patient years (Mean follow up 9.8 y), total OGDs =177 with mean annual number of OGDs at 1.5 per patient, a two-fold increase based on ESGE guidelines. Five cases of incident dysplasia (2 LGD, 1 HGD, 2 CA) were detected in the LSBE cohort.

Conclusions

By adopting and adhering to new ESGE 2017 guidelines we can reduce our surveillance workload by half to a third on average in a similar cohort over 9 years.

ABSTRACT 93 (20W209)

Potential Impact of New Adenoma Surveillance Guidelines

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Introduction

Colorectal cancer is a major cause of morbidity and mortality in Ireland. Surveillance colonoscopy after adenoma removal or cancer resection is based on existing guidelines, and constitutes a large volume of endoscopy throughout the country. Recently, the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (BSG/ACPGBI) published updated guidelines on post-polypectomy and post colorectal cancer surveillance.

Aims/Background

The aim of this study was to assess whether scheduled colonoscopy procedures for adenoma surveillance in our department are still indicated based on updated guidelines.

Method

The study was conducted in a single tertiary referral centre in Ireland. 300 surveillance requests for adenoma surveillance scheduled for 2021 and 2022 were reviewed. Electronic records were used to review endoscopy and pathology details of the index procedure from which surveillance was deemed necessary. We then applied updated surveillance guidelines to each request to determine if the follow up procedure was still indicated.

Results

204/300 (68%) of those procedures were not indicated based on the BSG/ACPGBI guidelines.

Conclusions

A large number of surveillance endoscopic procedures were no longer indicated based on the updated guidelines. Implementation of the new guidelines would result in reduced waiting lists and cost related to surveillance colonoscopy.

ABSTRACT 94 (20W210)

Quality of Upper Gastrointestinal Bleeding Risk Stratification and Pre-endoscopic Management at an Irish University Teaching Hospital

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Introduction:

Upper Gastrointestinal bleeding (GI) is a common presentation to hospital with significant associated mortality. Pre-endoscopic assessment and treatment plays an important role in patient outcome.

Aim/Background:

To audit of admission risk stratification and quality of pre-endoscopic management using the 2015 European Society of Gastrointestinal Endoscopy (ESGE) Upper GI Non-Variceal Bleeding guideline as a standard.

Methods:

Retrospective study analysing electronic endoscopy database from an academic teaching hospital over a 10-month period. All OGDs performed due to the indication of haematemesis, melaena and anaemia analysed. Patients were excluded if procedure was performed as an outpatient. Clinical data was obtained from Electronic Patient Records.

Results:

107 upper GI endoscopies were identified. Glasgow Blatchford score (GBS) was documented on patient notes in 24 patients (22%). Retrospective calculation of GBS revealed 9 patients had a GBS of 0 or 1 (8%) with a cumulative inpatient stay of 64 days. No endoscopic intervention was performed in patients with a GBS of 0 or 1. 10 patients (9.3%) received blood transfusion prior to endoscopy despite a haemoglobin >9g/dL. The median time to endoscopy was 37 hours. 85.7% of patients with high risk GBS (≥12) received early endoscopy (<24hours)

Conclusion:

GBS is a clinically useful and validated risk assessment score in correctly identifying very low-risk patients suitable for outpatient management and subsequent saving in hospital bed days. It is underutilised at point of admission/referral.Consideration of restrictive transfusion strategy should be given as it is associated with improved early survival rates.

ABSTRACT 95 (20W211)

Clinicopathological features and oncological outcomes of patients with early age onset rectal cancer

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Introduction

The incidence of rectal cancer among adults under the age of 50 is rising. Survival data are limited and conflicting, and the oncological benefit of standard neoadjuvant and adjuvant therapies is unclear.

Aims/Background

The aim of this study was to analyse the clinicopathological features and oncological outcomes among patients diagnosed with rectal cancer aged less than 50 years and to compare cancer-specific outcomes to patients aged 50 years and older.

Method

Disease-specific outcomes of patients diagnosed with rectal cancer undergoing surgical resection with curative intent between 2006 and 2016 were analysed.

Results

A total of 797 patients with rectal cancer were identified of whom

685 underwent surgery with curative intent. Seventy were aged under 50 years and 615 were aged 50 years or over. Clinical stage did not differ between the two age groups. Under 50's were more likely to have microsatellite instability (9% vs. 2%, p =0.003) and Lynch Syndrome (7% vs. 0%, p = <.001). Overall 5-year survival was better in the under 50's (80% and 72%; p = 0.013). Disease-free 5-year survival was 81% in both age groups (p = 0.711). There were no significant differences in the development of locoregional recurrence or distant metastases. Younger patients were more likely to receive neoadjuvant chemoradiotherapy (67% vs. 53%, p = 0.003) and adjuvant chemotherapy (41% vs. 24%, p = 0.006).

Conclusions

Despite accessing more treatment, young patients have comparable disease-specific outcomes to older counterparts.

ABSTRACT 96 (20W212)

Serological Exclusion Of Coeliac Disease: An Audit Of Anti-Tissue Transglutaminase and Immunoglobulin A Testing

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Introduction

Coeliac disease is a hereditary autoimmune malabsorptive disease affecting approximately 1% of the Irish population. To serologically exclude the diagnosis both the HSE Laboratory Handbook and the British Society of Gastroenterology guidelines on coeliac disease recommend excluding Immunoglobulin A (IgA) deficiency in any patient who has a negative anti-tissue transglutaminase (TTG). 2-3% of patients with coeliac disease are IgA deficient. Given that commonly measured anti-TTG is IgA dependent, false negatives need be out-ruled. We set about to determine if these guidelines were being adhered to within the catchment of University Hospital Waterford (UHW).

Aims/Background

To determine adherence to the above named guidelines on the serological exclusion of coeliac disease in the patient cohort at UHW.

Method

A random sample of 500 patients with a negative anti-TTG tested in the first 6 months of 2019 at UHW was evaluated. Anyone with another high or equivocal result was not included. Their laboratory record was interrogated to determine if they had ever had their IgA level checked.

Results

Of the 500 patients evaluated, 89 had ever had an IgA level assessed. This corresponds to 17.8% of the studied sample.

Conclusions

Coeliac disease is mostly not being appropriately serologically excluded in this population. Anti-TTG levels are being requested without consideration for the appropriate interpretation of the results. Such a practice may lead to missed diagnoses of coeliac disease. Clinicians within the UHW catchment need to reminded of the requirement for IgA level testing in the context of a negative anti-TTG result.

ABSTRACT 97 (20W213)

Unnecessary oesophagogastroduodenoscopy (OGD) of patients with dyspepsia and no alarming signs in Endoscopy unit of University Hospital Waterford

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Introduction

Dyspepsia management is a challenge for clinicians as underlying pathology varies from life threatening to benign. According to NICE guidelines UGI endoscopic examination is recommended when patients with dyspepsia present with alarming signs. There is a Rapid Access Dyspepsia Clinic at University Hospital Waterford for assessment of patients with dyspepsia and no alarming signs.

Aims/Background

Dyspepsia without any alarming signs is a frequent referral for OGD in Endoscopy unit at University Hospital Waterford, our aim is to see the appropriateness of referrals with NICE guidelines in order the reduce the number of OGDs in this group of patients.

Method

A retrospective data of OGDS performed during one-year 2018 was obtained, it included all patients of dyspepsia and no alarming signs, age less than 45 years, sex, and OGD results

Results

A total number of 120 patients of dyspepsia and alarming signs had OGD done in our endoscopy unit in one-year 2018. There were 44 men and 76 women, and their ages ranged between 20 to 45 years (median age=35). Out of 120 patients 30 patients (25%) of patient had normal OGD ,64(54%) had gastritis,27 (23%) had duodenitis,24 (20%) has esophagitis,21 (18%) had Hiatus hernia,2 (2%) had gastric polyp,4(3%) had ulcer,4 (3%) had CLO positive,1 (1%) had Barret's oesophagus. None of these patients were referred to Rapid Access Dyspepsia Clinic for assessment before getting OGD.

Conclusions

It is evident that patients went through invasive procedure without any indication and it could be prevented by referring these patients to the Rapid Access Dyspepsia Clinic at University Hospital Waterford. Endoscopy unit dealt with inappropriate referrals subsequently delaying the OGDS for patient who really needed it.In order to improve the quality of Endoscopy Unit, an audit report will be shared with the manager of the facility ,clinical lead and will be presented at Grand round/clinical meeting.A re-audit will be done in six months time to complete the audit cycle.

ABSTRACT 98 (20W214)

Review of Nurse-Led Hepatitis B Inactive Carrier Clinic in Mater Misericordiae University Hospital

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Introduction
The inactive carrier state of HBV infection is characterised by eAb positivity, a low viral load and normal ALT. A nurse-led clinic was established in MMUH in 2012 to manage inactive carriers of HBV. In the absence of other risk factors for chronic liver disease, patients have an excellent prognosis and anti-viral therapy is usually not indicated. A proportion seroconvert to surface antigen (sAg) negativity.

Aims/Background
1. Characterise the cohort: demographics, ALT, viral load and liver stiffness measurement (LSM). 2. Characterise a subgroup that spontaneously seroconverted to sAg negativity and identify predictors of seroconversion.

Method
Patient information was extracted from the electronic patient record and paper charts.

Results
217 patients attend the nurse-led HBV inactive carrier clinic (117 female, 100 male; mean age 41 years (21-67 years); 33% Eastern European, 28.5% African, 24% Chinese, 11.5% non-Chinese Asian and 3% Western European). The mean ALT is 28 IU/L (8-356 IU/L). The mean DNA viral load is 5287 IU/ml (0-642195 IU/ml). The mean LSM is 5.2 kPa (2.9-9.7 kPa). 6 patients (0.4% per year) spontaneously seroconverted to surface antigen negativity (4 male, 2 female; mean age 50.33 years (37-59 years); mean ALT 21 IU/L (14-24 IU/L); mean LSM 4.8 kPa (2.9-7.0 kPa)). Initial ALT, VL and LSM were not associated with seroconversion to sAg negativity (P=0.9089; P=0.8207; P=0.7936).

Conclusions
A nurse-led approach to clinical care provides an opportunity to streamline management and reduce visits to doctor-led clinics. Seroconversion to sAg negativity is a rare, unpredictable but definite event.

Winter Meeting 2019


Prof Colm O'Morain

Dr Jonathan Hoare Speaker

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USG Spring Meeting 2021

Date to be confirmed
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Systemic corticosteroid effects may occur, including glaucoma. Monitor for visual disturbance caused by e.g. cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR).
Monitor for infections.
Caution in: patients with reduced liver function; patients with infections, hypertension, diabetes mellitus, osteoporosis, peptic ulcer, glaucoma or cataracts or family history of diabetes or glaucoma or any condition where glucocorticosteroids may have unwanted effects; patients with severe affective disorders (or family history), including depressive or manic-depressive illness and previous steroid psychosis; patients not immune to chicken pox and measles. If exposed, consider immunoglobulin therapy, or antiviral agents. Contains sucrose. Caution when transferring from another glucocorticosteroid to Entocort® CR Capsules, monitor adrenocortical function and unmasked allergies. During surgery or other stress situations, supplementary glucocorticoid treatment is recommended. On discontinuation, reduce dose over 2 to 4 weeks, monitor for withdrawal effects, adjust dose if necessary. Coadministration of CYP3A inhibitors is expected to increase side effects: avoid/monitor (see interactions). With chronic high doses, systemic glucocorticosteroid effects such as hypercorticism and adrenal suppression may occur, and very rarely psychiatric/behavioural effects. **Children:** not recommended. If used monitor child's growth, evaluate risk-benefit. Long-term studies have not been performed.
INTERACTIONS: CYP3A4 inhibitors (e.g. ketoconazole, itraconazole), HIV protease inhibitors and grapefruit juice can increase systemic budesonide, CYP3A4 inducers (e.g. carbamazepine) may reduce budesonide levels; adjust dose. Colestyramine may reduce Entocort uptake. Raised levels/effects of corticosteroids reported with oestrogens and contraceptive steroids. At recommended doses, omeprazole does not affect the pharmacokinetics of oral budesonide whereas cimetidine has a slight but clinically insignificant effect.
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LEGAL CATEGORY: POM. **MA No:** 2018/003/001.
MA HOLDER: TILLOTTS PHARMA GmbH, Warmbacher Strasse 80, 79618 Rheinfelden, Germany.
DATE OF PREPARATION: May 2020. **CODE:** 2020/21 Full prescribing information available on request from the Marketing Authorisation holder or from Tillotts Pharma Ltd., 25 Sandyford Office Park, Dublin 18. Tel:(00 353 1) 294 2015.

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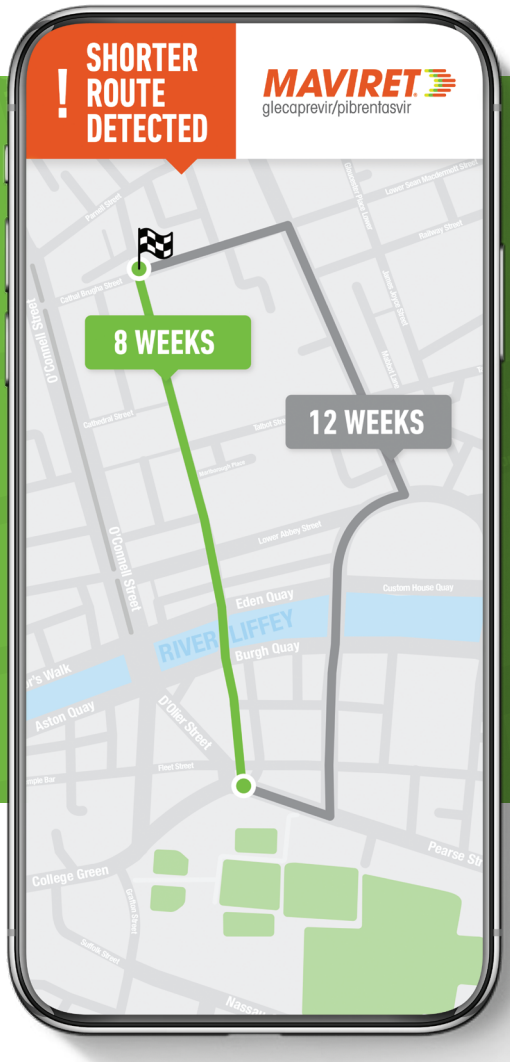

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for treatment-naïve patients[1]*

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†Cure=sustained virologic response (SVR12), defined as HCV RNA less than the lower limit of quantification at 12 weeks after the end of treatment and was the primary endpoint in all the studies.[1]

MAVIRET® is contraindicated in patients with severe hepatic impairment (Child-Pugh C) and not recommended in patients with moderate hepatic impairment (Child-Pugh B).[1]
***Refers to GT 1–6, excluding decompensated cirrhotic patients and liver or kidney transplant recipients. MAVIRET® is not indicated in decompensated cirrhosis.** The recommended duration of MAVIRET® is 12 weeks in liver or kidney transplant recipients, with or without cirrhosis.[1]
‡Tablets should be swallowed whole, taken at the same time with food and not chewed, crushed, or broken.[1]
ITT=intent-to-treat.

Maviret® ▼ 100mg/40mg film-coated tablets PRESCRIBING INFORMATION
PRESENTATION: Each film-coated tablet contains 100 mg glecaprevir and 40 mg pibrentasvir. Please refer to the Summary of Product Characteristics (SmPC) before prescribing. **INDICATION:** For treatment of Chronic Hepatitis C Virus (HCV) in adults and in adolescents aged 12 to <18 years. **DOSAGE AND ADMINISTRATION:** Oral. Treatment to be initiated and monitored by physician experienced in the management of patients with HCV infection. See SmPC for full posology. **Dosage:** *Adults and adolescents aged 12 to <18 years:* The recommended dose of Maviret is 300 mg/120 mg (three 100 mg/40 mg tablets), taken orally, once daily at the same time with food. **Treatment Duration:** Patients without prior HCV therapy (GT 1, 2, 3, 4, 5, 6): **No cirrhosis:** 8 weeks. **Cirrhosis:** 8 weeks. Patients who failed prior therapy with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin: GT 1, 2, 4-6: **No cirrhosis:** 8 weeks. **Cirrhosis:** 12 weeks. GT 3: **No cirrhosis:** 16 weeks. **Cirrhosis:** 16 weeks. **Special Populations:** HIV-1 Co-infection: Follow the dosing recommendations as above. For dosing recommendations with HIV antiviral agents, refer to SmPC for additional information. Elderly: No dose adjustment required. Renal impairment: No dose adjustment required. Hepatic impairment: No dose adjustment recommended in patients with mild hepatic impairment (Child-Pugh A). Maviret is not recommended in patients with moderate hepatic impairment (Child-Pugh B) and is contraindicated in patients with severe hepatic impairment (Child-Pugh C). Liver or kidney transplant patients: 12 weeks in liver or kidney transplant recipients with or without cirrhosis, with 16 week treatment duration to be considered for GT 3-infected patients who are treatment experienced with peg-IFN + ribavirin +/- sofosbuvir, or sofosbuvir + ribavirin. Paediatric Population: No dose adjustment required in adolescents aged 12 to <18 years. The safety and efficacy of Maviret in children aged less than 12 years have not yet been established. Diabetic Patients: Diabetics may experience improved glucose control, potentially resulting in symptomatic hypoglycaemia, after initiating HCV direct acting antiviral treatment. Glucose levels of diabetic patients initiating direct acting antiviral therapy should be closely monitored, particularly within the first 3 months, and their diabetic medication modified when necessary. **CONTRAINDICATIONS:** Hypersensitivity to the active substances or to any of the excipients. Patients with severe hepatic impairment (Child-Pugh C). Concomitant use with atazanavir containing products, atorvastatin, simvastatin, dabigatran etexilate, ethinyl oestradiol-containing products, strong P-gp and CYP3A inducers (e.g., rifampicin, carbamazepine, St. John's wort (Hypericum perforatum), phenobarbital, phenytoin, and primidone). **SPECIAL WARNINGS AND PRECAUTIONS:** Hepatitis B Virus reactivation: HBV screening should be performed in all patients before initiation of treatment. HBV/HCV co-infected patients are at risk of HBV reactivation, and should, therefore, be monitored and managed according to current clinical guidelines. Hepatic impairment: Maviret is not recommended in patients with moderate hepatic impairment (Child-Pugh B) and is contraindicated in patients with severe hepatic impairment (Child-Pugh C). Patients who failed a prior regimen containing an NS5A- and/or an NS3/4A-inhibitor: GT 1-infected (and a very limited number of GT 4-infected) patients with prior failure on regimens that may confer resistance to glecaprevir/pibrentasvir were studied in the MAGELLAN-1 study. The risk of failure was, as expected, highest for those exposed to both classes. A resistance algorithm predictive of the risk for failure by baseline resistance has not been established. Accumulating double class resistance was a general finding for patients who failed re-treatment with glecaprevir/pibrentasvir in MAGELLAN-1. No re-treatment data is available for patients infected with GT 2, 3, 5 or 6. Maviret is not recommended for the re-treatment of patients with prior exposure to NS3/4A- and/or NS5A-inhibitors. Lactose: Maviret contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **INTERACTIONS:** See SmPC for full details. Contraindicated: Dabigatran etexilate, carbamazepine, phenytoin, phenobarbital, primidone, rifampicin, ethinyloestradiolcontaining products, St. John's wort, atazanavir, atorvastatin, simvastatin. Not Recommended: darunavir, efavirenz, lopinavir/ritonavir, lovastatin, ciclosporin doses > 100 mg per day. Use Caution: digoxin, pravastatin, rosuvastatin, fluvastatin, pitavastatin, tacrolimus. Monitor Levels: Digoxin, Monitor INR with all vitamin K antagonists. No dose adjustment: Losartan, valsartan, sofosbuvir, raltegravir, elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide, levonorgestrel, norethidrone or norgestimate as contraceptive progestogen. **FERTILITY, PREGNANCY AND LACTATION:** Maviret is not recommended in pregnancy. It is not known whether Maviret and its metabolites are excreted in breast milk. No human data on the effect of glecaprevir and/or pibrentasvir on fertility are available. **SIDE EFFECTS:** See SmPC for full details. ***Very common side effects*** *(≥1/10):* headache, fatigue. ***Common side effects*** *(≥1/100 to <1/10):* diarrhoea, nausea, asthenia. Frequency not known (cannot be estimated from the available data): pruritus. **▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance; website: www.hpra.ie. Suspected adverse events should also be reported to AbbVie Limited on 01-4287900. LEGAL CATEGORY:** POM(S1A) **MARKETING AUTHORISATION NUMBER/ PRESENTATIONS:** EU/1/17/1213/001 – blister packs containing 84 (4 x 21) film-coated tablets. **MARKETING AUTHORISATION HOLDER:** AbbVie Deutschland GmbH & Co. KG, Knollstrasse, 67061 Ludwigshafen, Germany. Further information is available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24, Ireland. **DATE OF REVISION:** January 2020. PI/1213/008.

References: 1. Maviret Summary of Product Characteristics. AbbVie Ltd. Available at www.medicines.ie
2. Zuckerman E, Gutierrez JA, Dylla DE, et al. 8-Week Glecaprevir/Pibrentasvir Is Safe and Efficacious in Treatment-Naïve Hepatitis C Patients: An Integrated Analysis. Clinical Gastroenterology and Hepatology 2020.

IE-MAVI-200019 | Date of Preparation: June 2020

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