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Irish Society of Gastroenterology

Summer Meeting

18 June 2021

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Welcome Message

Dear Friends and Colleagues,

Welcome to our virtual Irish Society of Gastroenterology (ISG) meeting. We welcome our internationally renowned speakers from the USA, Portugal, UK and Ireland. We have an exciting program organised for you including themes on lower GI diseases such as how to use FIT for symptomatic patients, plus managing gastrointestinal consequences of pelvic radiation disease. We continue our liver theme on common conditions such as management of ascites and update on haemochromatosis. Our upper gastrointestinal theme includes endoscopic treatment of preneoplastic and early cancers and an update on what is new in surgery for gastric cancer. Our daily practice involves seeing patients with irritable bowel syndrome and with this in mind, we have a neurogastroenterology theme that deals with this condition including oesophageal dysmotility. Our IBD theme is on the prevention of post operative Crohn's. At this meeting, we are also recognising promising research by our young investigators and will have more emphasis on oral free papers and posters.

I would like to thank our industry colleagues and friends who have continued to support us during the pandemic. Without them, it would not be possible to hold this meeting. I would like to thank the outstanding effort of our Chief Executive, Michael Dineen and also Cora Gannon in organising this meeting. I would like to thank the ISG Board for their support and guidance as always.

Finally, I end this message with some mixed emotions as this will be my last President's message before I hand over to our incoming President, Professor Deirdre McNamara. I would like to thank you and the Society for giving me the honour and privilege to be your President for the last two years. It has truly been the highlight of my career. It has been a most challenging time with the pandemic but what we as a Society have learned is to be able to adapt to changes. I look back with pride with what the Society has achieved over the past two years with the E's: Engaging with other societies and clinical services, collaborating with Europe, and Educating our members.

I look forward to having a social drink with you whenever we are able to! (We, of course, endorse responsible drinking).

Yours sincerely,

Tony Tham
President, ISG

Irish Society of Gastroenterology Summer Meeting

Friday 18 June 2021

Virtual Meeting

09.30 **Commercial Video**

09.50 **Oral Free Papers 1- 4 (4 by 8 mins)**

10.30 ***Early gastric cancers and pre-cancer detection and management***
Prof. Mario Dinis-Ribeiro
Consultant Gastroenterologist,
Head of Gastroenterology Dept., Portuguese Oncology, Institute of Porto.

10.55 ***Gastric Surgery – The future***
Mr Paul Carroll
Oesophagogastric & General Surgeon, Galway University Hospital.

11.20 **Commercial Video**

11.30 ***Gastrointestinal Consequences of Pelvic radiation disease***
Prof. Jervoise Andreyev
Consultant Gastroenterologist and Hon Professor, University of Nottingham, UK

11.55 ***Preventing post operative recurrence of Crohn's***
Prof. David Kevans
Consultant Gastroenterologist, St James's Hospital, Dublin.

12.20 **Commercial Video**

12.30 Top 10 Posters (10 by 3 mins), followed by 15 min Q&A

13.55 Oral Free Papers 5 – 8 (4 by 8 mins)

14.30 ***Haemochromatosis – what's new?***
Prof. Suzanne Norris
Consultant Hepatologist, St James's Hospital, Dublin.

14.55 **Commercial Video**

15.05 ***Managing ascites in cirrhosis***
Prof. Guru Aithal
Professor of Hepatology & Head of Division for Digestive Diseases, University of Nottingham, UK

15.30 ***Oesophageal dysmotility***
Eamonn Quigley M.D.
Past President of WGO, Chief of Gastroenterology & Hepatology at Houston Methodist Hospital, Texas, USA.

15.55 **Commercial Video**

16.05 ***Using FIT in symptomatic disease***
Prof. Ramesh Arasaradnam
Consultant Gastroenterologist University of Warwick, UK

16.30 ***The latest approach to irritable bowel syndrome***
Kyle Staller M.D.
Director of Gasrointestinal Motility Laboratory,
Harvard University, USA

16.55 **Close of Meeting**
(Commercial Video)

Biographical Sketches

Prof. Mario Dinis-Ribeiro
Consultant Gastroenterologist,
Head of Gastroenterology Dept.,
Portuguese Oncology, Institute of Porto

Mário Dinis-Ribeiro, graduated in Medicine in 1996, earned his Doctorate Degree in 2005 and *Agregação* in 2009 from the Faculty of Medicine of the University of Porto (FMUP). He is Senior Consultant and Head of the Gastroenterology Department of the IPO-Porto and Guest Full Professor at FMUP (since 2014) and Group Leader in CINTESIS (iGO). His research interests focus on improving early diagnosis and noninvasive management of gastrointestinal tumors, leading several inter-institutional national and international projects with over 290 scientific articles published (HI=45). He is a member of the Scientific Committee of the PhD programme in Clinical and Health Services Research at FMUP. He is currently the Past-President of the European Society of Gastrointestinal Endoscopy and Co-Editor-in-Chief of the journal Endoscopy. He won the BIAL Award in Clinical Medicine in 2018 and co-authored the Pfizer Award in 2016.

Mr Paul Carroll
Consultant Upper GI and General Surgeon
Galway University Hospital
Honorary Senior Lecturer School of Medicine
National University Ireland Galway

Paul graduated from UCD in Medicine (MB, BCh, BAO) in 2005. After basic Surgical training, he was awarded an M.D. from Trinity College Dublin investigating adipocytokines in Breast Cancer. Higher Surgical Training culminated in 2017 with the award of FRCSI in General and Upper GI surgery. Paul subsequently travelled to Toronto General Hospital for fellowship in Thoracic and Foregut Surgery focusing on Minimally Invasive and endoscopic approaches to Foregut Disease.
Appointed as a Consultant Surgeon in Galway in 2019, His specialist interest include the treatment of Oesophageal and Gastric malignancies using minimally invasive approaches, and the treatment of Barrett's Oesophagus and early neoplasia utilising EMR, ESD and RFA.

Prof. Jervoise Andreyev
Consultant Gastroenterologist
and Hon Professor,
University of Nottingham, UK

Jervoise Andreyev's first degree was in Arabic Studies at Magdalene College, Cambridge. He qualified in Medicine in 1987 from The Royal London Medical College and completed a PhD in molecular biology in 1997. In 2000, he was appointed Senior Lecturer at Imperial College and in 2006, at the Royal Marsden Hospital became the first ever consultant gastroenterologist worldwide specifically appointed solely to treat the GI side effects of biological, chemotherapy, radiotherapy and surgical treatments for cancer.
In 2016, he was invited to be the Nimmo Visiting Professor at the Royal Adelaide Hospital, Australia. In 2017, he moved to Lincoln County Hospital. In 2019, he was appointed Honorary Professor, the School of Medicine, the University of Nottingham.
His research team has enrolled more than 1,500 patients into randomized trials and several thousand patients into interventional cohort studies. He has published approximately 150 papers.

Dr David Kevans
Consultant Gastroenterologist,
St James's Hospital, Dublin

David Kevans graduated from University College Dublin with an Honours Degree in Medicine. He obtained Membership of the Royal College of Physicians of Ireland (RCPI) and then entered the Irish Higher Medical Training Scheme in Gastroenterology. During this period of training he undertook a Medical Doctorate (MD) at the Centre for Colorectal Disease, University College Dublin, focusing on novel prognostic markers in stage II colorectal cancer. Having been awarded Specialist Registration in Gastroenterology he undertook a three year fellowship at Mount Sinai Hospital, Toronto / University of Toronto specialising in Inflammatory Bowel Disease. While in Toronto he was awarded a Canadian Institutes of Health Research Fellowship award to support Inflammatory Bowel Disease focused research. David returned to Ireland in 2014 to take up an appointment as Consultant Gastroenterologist at St James's Hospital, Dublin and Clinical Associate Professor at Trinity College Dublin. He has a special interest in Inflammatory Bowel Disease and leads a programme at St James's Hospital which provides both regional and tertiary level care for patients with these disorders. David has a significant number of peer-reviewed publications in the areas of Inflammatory Bowel Disease and Colorectal Cancer. He has an active research programme at St James's Hospital / Trinity College, Dublin. His main research interests include genetic, microbial and environmental

contributions to Inflammatory Bowel Disease susceptibility; pharmacokinetics of monoclonal antibodies; biomarkers of prognosis and therapy response; clinical trials of novel therapeutics for gastrointestinal disorders; and nutrition in gastrointestinal health.

Prof. Suzanne Norris
Consultant Hepatologist,
St James's Hospital, Dublin

Professor Suzanne Norris is a consultant hepatologist/gastroenterologist at St James's Hospital and is Professor in Gastroenterology & Hepatology at Trinity College Dublin. A graduate of University College Dublin 1989, she trained in hepatology at the National Liver Transplant Centre at St Vincent's University Hospital, Dublin, and the Institute of Liver Studies at King's College Hospital London completing CCST in 1999 and was appointed consultant in viral hepatitis and liver transplantation in 2000 at Kings' College Hospital. In 2002, Prof Norris returned as Consultant Hepatologist and Senior Lecturer at St James's Hospital/ Trinity College Dublin, and subsequently was appointed Professor in Gastroenterology & Hepatology in 2008 at Trinity College Dublin.
Prof Norris is a former member of the National Consultative Council for Hepatitis C, former member of the governing board of the European Association for the Study of the Liver (2007-2008), EASL Scientific Committee (2005-2008), and AASLD Education Committee (2007-2009). She was National Specialty Director for gastroenterology/hepatology registrar training in Ireland from 2007-2012 at the Royal College of Physicians in Ireland, and Vice-Dean of Postgraduate Specialist Training 2012-2016. Prof Norris was the inaugural Clinical Lead to the National Hepatitis C Treatment Programme in Ireland 2016-2017. A founding member and chair of the Irish Hepatitis C Outcomes Research Network (2012-2016), she has participated into several collaborative works on epidemiology and public health issues related to viral hepatitis. Her research interests include viral hepatitis, NAFLD, cirrhosis, haemochromatosis, and liver cancer. She has co-authored more than 100 published articles.

Prof. Guru Aithal
Professor of Hepatology & Head of Division for Digestive Diseases,
University of Nottingham, UK

Guruprasad P. Aithal is Professor of Hepatology and the Deputy Director of Translational Medical Sciences, School of Medicine, University of Nottingham. He is the Deputy Director and Gastrointestinal & Liver Theme lead of the NIHR Nottingham Biomedical Research Centre (BRC). He is the current President of the British Association for the Study of the Liver.
After being awarded PhD from the University of Newcastle in 2000, he completed Advanced Endoscopy Fellowship at the University of South Carolina, USA and returned to the UK in 2001 to establish Endoscopic ultrasound service in Nottingham. He has won NHS Innovation Award (2013), SAGE National Award (2015) and was BMJ Gastroenterology team finalist (2015). His has over 260 publications including original articles in Nature Genetics, Nature Medicine, Nature Communications, Lancet, BMJ, Gastroenterology, Gut, Hepatology, Journal of Hepatology, Gastrointestinal Endoscopy and Endoscopy. His H index of 64 currently.

Eamonn Quigley M.D.
Past President of WGO,
Chief of Gastroenterology & Hepatology at Houston Methodist Hospital, Texas, USA

Eamonn M M Quigley MD FRCP FACP MACG FRCPI MWGO is David M Underwood Chair of Medicine in Digestive Disorders and Chief of the Division of Gastroenterology and Hepatology at Houston Methodist Hospital. A native of Cork, he graduated in medicine from UCC, trained in internal medicine in Glasgow, completed a research fellowship at the Mayo Clinic and trained in gastroenterology in Manchester, UK. He joined the University of Nebraska Medical Center in 1986 where he rose to become Chief of Gastroenterology and Hepatology. Returning to Cork in 1998 he served as Dean of the Medical School and a PI at the Alimentary Pharmabiotic Center. He served as president of the American College of Gastroenterology and the WGO and as editor-in-chief of the American Journal of Gastroenterology. Married for over 40 years to Dr Una O'Sullivan they have 4 children and three grandchildren. Interests outside of medicine include literature, music and sport and rugby, in particular; he remains a passionate supporter of Munster and Irish rugby.

Prof. Ramesh Arasaradnam
Consultant Gastroenterologist University of Warwick, UK

Following graduation at Queen's, Ramesh pursued specialty training in Sheffield and PhD in Newcastle. Thereafter, he took up consultant position at Coventry with joint honorary academic appointments at Warwick, Leicester and Coventry Universities.
He is the regional specialty group lead for Gastroenterology in the West Midlands and currently chair of the Research Committee for the British Society of Gastroenterology. In 2020, as part of the Queen's birthday honours, he received an OBE for services to the NHS during COVID.
His research interest is varied but largely focused on diagnostic tools in cancer and inflammation to improve clinical pathways.

Kyle Staller M.D.
Director of Gasrointestinal Motility Laboratory,
Harvard University, USA

Kyle Staller, MD, MPH is the director of the Gastrointestinal Motility Laboratory at Mass General and an assistant professor of medicine at Harvard Medical School. His clinical practice is devoted to treating patients with GI motility disorders and disorders of brain-gut interaction.
Dr. Staller's research interests include clinical and epidemiologic research in neurogastroenterology and motility with particular interest in chronic constipation, irritable bowel syndrome (IBS), fecal incontinence, eating disorders, and women's health in functional GI diseases. His research is funded by the US National Institutes of Health (NIH).
Dr. Staller received his medical degree from Harvard Medical School and trained at Massachusetts General Hospital (MGH) for residency and gastroenterology (GI) fellowship. He also completed formal training in epidemiology culminating in a Masters of Public Health from the Harvard School of Public Health and subspecialty training in neurogastroenterology and motility at MGH before joining the faculty.

Winter Meeting 2020

Dr Diarmaid Houlihan, Bon Secours Hospital, Cork
& Dr Tony Tham, President, ISG

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 Karl Hazel
SpR Training Representative
Beaumont Hospital, Dublin

I am a fourth year trainee on the Higher Specialist Training in Gastroenterology. I am currently undertaking my MD in RCSI and Beaumont Hospital, investigating the role of bile acids in IBD. I have an interest in all areas of Gastroenterology, with a special interest in IBD and endoscopy. I am delighted to be the trainee representative on the Board of ISG and hope we can continue to provide events for trainees in the vein of our breakout session at the ISG Winter meeting 2020 which was an outstanding success for all involved.

Honorary Officers and Board Members

Dr Tony Tham,
President ISG
Consultant Gastroenterologist

Dr Garret Cullen, Hon Secretary ISG
Consultant Gastroenterologist

Dr Manus Moloney, Hon Treasurer ISG
Consultant Gastroenterologist

Dr Patrick Allen,
Consultant Gastroenterologist

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Consultant Gastroenterologist

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Mr Jurgen Mulsow
Consultant Surgeon

Dr Karl Hazel
SpR Training Representative
Beaumont Hospital, Dublin

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Admin Secretary
Ms Cora Gannon

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

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1964-1966	Professor Patrick Fitzgerald (R.I.P.)
1962-1964	Professor Oliver Fitzgerald (R.I.P.)

ISG Oral Presentations Friday 18 June 2021

Abstract No.	Title of Paper	First Author's Name	Time
21S144	Multicentre Review of Outcomes of EUS Guided Drainages in Three Irish Tertiary Referral Centres	Gregory Mellotte	9.50
21S135	Endoscopic Ultrasound guided Choledochoduodenostomy with Electrocautery enhance lumen apposing metal stents(LAMS)	Ciaran McDonald	9.59
21S120	Eosinophilic Esophagitis: Increasing Prevalence over Two Decades at an Irish Tertiary Referral Centre	Thomas James Matthews	10.08
21S106	Methylome wide sequencing in NAFLD to detect low versus high-risk disease	Marie Boyle	10.17
21S132	Morbidity And Mortality Of Refractory Coeliac Disease Type II: A 10-Year Experience From The West Of Ireland	Muhammad Umair Tayyub	13.55
21S145	Should biopsy still be a prerequisite for the diagnosis of coeliac disease in adults?	Charlene Deane	14.04
21S165	Time For A Change - Transition from paediatric to adult Inflammatory Bowel Disease services: 1 year and 5 year outcomes in a single Irish academic centre	Eabha Ring	14.13
21S129	The role of bile acids in mediating fibrosis in inflammatory bowel disease	Karl Hazel	14.22

ISG Summer Meeting 18 June 2021 - Premier Posters

12.30 to 13.15 (including Q&A)

Abstract No.	Title of Paper	First Author's Name
21S105	Health-related Quality of Life in Non-alcoholic Fatty Liver Disease Associates with Hepatic Inflammation	Marie Boyle.
21S131	TIPSS Review: A retrospective study of TIPSS in Northern Ireland from 2006 to 2019	Neil Bradley.
21S128	Rates of Hospital-Acquired Clostridioides difficile infection during the COVID-19 Pandemic in a Tertiary Healthcare Setting	Karl Hazel.
21S150	Virtual Versus Physical G.I. Clinics – What Does the Patient Prefer?	Eileen Shannon.
21S157	Cancer, Inflammatory Bowel Disease and Immunosuppression: A Decade of Experience at an Irish Tertiary Referral Centre	Thomas Matthews
21S113	Obliterative Portal Venopathy is the Predominant Pathway of Liver Disease in Adult Cystic Fibrosis: Retrospective Data from the Irish National Liver Transplant Unit	John O'Neill.
21S159	Challenges in clinical practice with Hepatocellular Carcinoma (HCC) screening in patients with Hepatitis C virus (HCV) related cirrhosis after antiviral treatment	Aoife Alvain.
21S163	Ustekinumab Therapy Outcome in a Refractory Crohn's Disease Patient Population	Roisin Corcoran.
21S142	Giant Polyps a Giant Leap Forward	Neasa Mc Gettigan.
21S166	Impact of the COVID-19 on colorectal cancer diagnosis in Dublin Midlands Hospital Group.	Karen Hartery.

ORAL PRESENTATIONS

ABSTRACT 1 (21S144)

Multicentre Review of Outcomes of EUS Guided Drainages in Three Irish Tertiary Referral Centres

Author(s)
GS Mellotte, J O'Grady, V Parihar, M Buckley, F MacCarthy, BM Ryan
Department(s)/Institutions
Tallaght University Hospital, Mercy University Hospital, St James's Hospital

Introduction
The step up approach to pancreatitis has led to increasing reliance on a endoscopic drainage of pancreatic collections prior to consideration for surgical intervention. Newer lumen apposing stents(LAMS) have been developed but there are increasing concern of adverse events and poorer outcomes compared with biliary double pigtail plastic stents(DPPS).

Aims/Background
To compare outcomes of EUS guided drainages.

Method
Patients were identified through endoscopic systems in Tallaght University Hospital, Mercy University Hospital, and St James's Hospital.

Results
120 patients, 80Male, were identified between 2009-2020. Mean age 53(13-86). 86 Lams procedures and 34 DPPS. There were no significant differences in patient demographics between centres. 114 drainages (95%) were technically successful, 2 failed DPPS and 4 failed LAMs procedures. 41 of 86 LAMS were day procedures, a further 13 required overnight admission. The median length of stay for LAMS was 0 and DPPS was 2, (p=0.612). Clinical success was resolution of the collection without need for surgical or percutaneous drainage. 25(73.5%) of DPPS stent placements and 73 of LAMS procedures(83.7%) were clinically successful. 5 Patients required surgical drainage. 1 patient required percutaneous drainage. Recurrence in 3 patients(2.5%). Median time to documented resolution was 68.5 days in the LAMS cohort and 50 days in DPPS, (p=0.804) The LAMS cohort had 15 minor complications, 5 complications requiring reintervention and 2 life threatening complications. In comparison there were 10 minor in DPPS patients and 1 moderate complication, and 1 life threatening. There was no significant statistical difference in outcome between stent choice or centre and complications.

Conclusions
There was no significant difference seen between DPPS and LAMS complications overall. LAMS allowed for more drainages as day cases.

ABSTRACT 2 (21S135)

Endoscopic Ultrasound Guided Choledochoduodenostomy With Electrocautery Enhanced Lumen Apposing Metal Stents (Lams) In Patients With Malignant Distal Biliary Obstruction: The First Multi-Centre Irish

Author(s)
Dr Ciaran McDonald Dr Ciaran Judge Dr Finbar MacCarthy Dr Danny Cheriyan
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, RCSI Hospital Group, Dublin 9 Department of Gastroenterology, St James's Hospital, Trinity Hospital Group, Dublin 8

Introduction
Endoscopic ultrasound guided choledochoduodenostomy (EUS-CDD) with an electrocautery enhanced lumen apposing metal stent (EC-LAMS) has gained increased recognition worldwide as a means of providing biliary drainage in patients with malignant distal biliary obstruction (MDBO).

Aims/Background
We aim to evaluate real world clinical data of patients undergoing EUS-CDD with EC-LAMS for the first time in Ireland with regards procedural efficacy and safety profiles along with post procedural follow- up data.

Method
A retrospective analysis of all patients who underwent EUS-CDD with EC-LAMS for MDBO at two tertiary institutions in Ireland between November 2018 and March 2021 was carried out. The primary endpoints included technical and clinical success rates. The secondary endpoints included adverse event rates, re-intervention rates and the duration of survival post stent insertion.

Results
25 patients (60% males) with a mean age of 72.8 years old (SD ± 13.25) were included. The median follow- up period for 17 patients was 58 days (range 7- 521 days) and 31.25% of patients were alive at follow-up. 9 patients were lost to follow- up. Technical success was achieved in 24 patients (96%) and clinical success (reduction in serum bilirubin ≤50% of original value after 7 days) was available for 17 patients and was achieved in 64.7% (n=11). The overall procedural adverse event (AE) rate was 16% (n=4) with only one of these events impacting the overall procedural technical success. Biliary re-intervention was required following technical success in 4% of patients (n=1). The overall mean survival post stent insertion for data available was 101.4 days (range 7- 484 days).

Conclusions
EUS-CDD with EC-LAMS at tertiary institutions within a regional network for treatment of MDBO following unsuccessful ERCP is effective, with an acceptable AE rate.

ABSTRACT 3 (21S120)

Eosinophilic Esophagitis: Increasing Prevalence over Two Decades at an Irish Tertiary Referral Centre

Author(s)
TJ Matthews, S O'Donnell, S Anwar, R Ballester, N Breslin, D McNamara, A O'Connor, B Ryan
Department(s)/Institutions
Department of Gastroenterology, Tallaght University Hospital, Dublin 24

Introduction
The prevalence of Eosinophilic Esophagitis, identified in the 1990s, has increased in a manner not explained through increased recognition alone.
Aims/Background
We audited treatment against UEG guidelines and assessed longitudinal epidemiological changes at our centre.
Method
32,346 OGDs were performed on 21,441 patients between 10/10/2011 and 01/04/2021. An interrogation of our outpatient letter database yielded a set of 61 patients in whom the treating gastroenterologist had reached a diagnosis of EE.
Results
Median age at diagnosis was 33.8y. 64% were male. 41% had a history of atopy. 60% of lab investigations sent for atopy were positive. 84% complained of dysphagia. 15% had prior experience of food bolus. 9.8% had developed a stricture. 85%, 79% and 10% were offered treatment with a PPI, topical budesonide or exclusion diet respectively. The current prevalence of EE in our catchment area is approximately 13.55 per 100,000. A 2011 study published in Gastroenterology and Hepatology identified a prevalence of approximately 3.25 per 100,000 at our centre for the decade prior. The correlation coefficient pertaining to macroscopic and histologic findings at endoscopy was 0.235.
Conclusions
EE is a rare disorder predominantly affecting young men with prior histories of atopy. Its prevalence has increased by 416% over a decade at our centre. Though empiric six-food elimination diet induces remission in 75% of cases, we offered it to only 10% of our cohort. This may be as a result of difficulties with compliance and of the need for an increased number of surveillance endoscopies. Macroscopic and histologic findings are imperfectly correlated.

ABSTRACT 4 (21S106)

Methylome wide sequencing in NAFLD to detect low versus high-risk disease

Author(s)
Marie Boyle. Quentin Anstee
Department(s)/Institutions
Freeman Hospital. Newcastle University

Introduction
Epigenetic regulatory pathways have been described in association with hepatic fibrosis progression in NAFLD, where alterations in DNA methylation can serve as biomarkers for progressive disease.
Aims/Background
To characterize a DNA methylation progression signature to define risk at presentation to facilitate improved approaches to care.
Method
8 well characterised NAFLD patients with paired biopsies were phenotyped into high and low risk groups. Portal to portal regions in FFPE index biopsies were isolated using laser capture microdissection (LCM). Genomic DNA was extracted and subject to whole genome bisulfide sequencing (WGBS) using the illumina HiSeq 2500 platform and in silico bioinformatics analysis to establish if DNA Methylation signatures in early disease can stratify patient risk.
Results
> 657 novel methylation signatures to distinguish low and high-risk disease were identified. Top hypermethylated DMRs included HM13, CGGBP1 and TET1. Top hypomethylated DMRs included BMP4, EPN1 and DPP9. Pathway analysis showed significant enrichment for genes involved in liver fibrosis and metabolic homeostasis. Low risk NAFLD can be broadly characterised by hypermethylation of DMRs primarily associated with fibrosis and hypomethylation of pathways largely associated with metabolic homeostasis.
Conclusions
This pilot study presents the first methylome map of low versus high-risk disease in NAFLD, using baseline F0/F1 biopsy specimens subject to LCM as a platform to define a methylation progression signature. The findings suggest that high and low risk NAFLD while interrelated, may be biologically distinct from disease onset. Identification of high risk and low risk NAFLD early from standard FFPE tissues has obvious clinical utility to both progress our understanding of the pathogenesis and to identify patients requiring tertiary level follow-up.

ABSTRACT 5 (21S132)

Morbidity And Mortality Of Refractory Coeliac Disease Type II: A 10-Year Experience From The West Of Ireland

Author(s)
M. Tayyub(1), F. Murray(2), A. Hayat(3), V. Byrnes(1).
Department(s)/Institutions
1.Department Of Gastroenterology, University Hospital Galway, Galway, Ireland 2.Department Of Pathology, University Hospital Galway, Galway, Ireland 3.Department Of Haematology, University Hospital Galway, Galway, Ireland

Introduction
RCD II, a rare complication of coeliac disease(CD) is characterised by the presence of aberrant IELs. It has a very variable presentation with a high degree of morbidity and mortality.
Aims/Background
To study the natural history of RCD II in a cohort of patients presenting over a 10 year period(2009-2019).
Method
Data on demographics, mode of presentation, treatment, and outcome of 10 consecutive RCD II patients attending our institution was recorded
Results

5 men(mean age 63yrs), and 5 women(mean age 58yrs). Median time between CD and RCD II diagnoses(8 years) Presentation included weight loss(60%), diarrhoea(70%), abdominal pain(30%), and ulcerative jejunitis(50%). 5 had extra GI manifestations, 3 neuro-coeliac (dysarthria, ataxia and myoclonus) and 2 cutaneous (mycosis fungoides and erythema induratum). All had loss of CD8 on immunohistochemistry, and clonal TCR-GR on molecular analysis. 7 had flow cytometry(mean aberrancy 77%). 9 patients received budesonide, of which 6 had clinical improvement albeit without significant histological improvement. 7 received chemotherapy and ASCT, the indications for which were intestinal failure(n=4), EATL(n=2), and progressive neuro-coeliac(n=1). Of these, 4 died, 3 of relapse of intestinal failure at 8, 8, and 1.5 years post ASCT and 1 at 6 weeks, secondary to complications of ASCT. 6 are alive and well(mean of 6 yrs post-diagnosis).

Conclusions

In our cohort, RCD II had a mortality of 40% on mean 6 yrs of follow up. While ASCT may delay decline in GI function other novel therapeutics are desperately required for this rare complication of CD.

ABSTRACT 6 (21S145)

Should biopsy still be a prerequisite for the diagnosis of coeliac disease in adults?

Author(s)

C Deane, E O'Connor, H O'Donovan, C McHale, A Alvain, E Shannon, S Hynes, V Byrnes

Department(s)/Institutions

Galway University Hospital, Gastroenterology Department, Galway, Ireland Galway University Hospital, Pathology Department, Galway, Ireland

Introduction

The paediatric guidelines support the use of the 'No Biopsy Approach' in the diagnosis of coeliac disease (CD). However, histological confirmation remains necessary in the adult cohort.

Aims/Background

We aimed to determine if adults with an IgA anti-TTG >10 times ULN with a positive EMA have an equivalent degree of diagnostic accuracy as that observed in the paediatric population.

Method

A retrospective study of newly diagnosed CD patients from 2013–2019 in a single centre. Patients were excluded if; 1) selective IgA deficiency, 2) initiation of a GFD prior to biopsy or serology confirmation, and 3) biopsies done elsewhere. All biopsies were reread and classified according to Marsh, by two independent pathologists, blinded to the anti-TTG titre.

Results

Over 800 referrals were screened, 210 patients were diagnosed with CD between 2014-2019. 165 patients (med age 40yrs, 62% female) had both serology and biopsy within 6 months and prior to starting a GFD. 68(33%) had an anti-TTG titre>10ULN, 100% of which had biopsies consistent with CD, (Marsh ≥ 3, 99%) and (Marsh 2, 1%). The PPV for CD if anti-TTG>10, >8 and>6ULN was also 100%. Analysis of a subset of gastroscopy reports showed no abnormal findings (54%), gastritis/duodenitis/oesophagitis (36%), HP positive (2%), and Barrett's (2%).

Conclusions

We found a high diagnostic accuracy of CD in those with an anti-TTG>10ULN and a +ve EMA. We propose omitting the need for histological confirmation in this cohort, thereby reducing unnecessary aerosolized procedures in this COVID era and beyond.

ABSTRACT 7 (21S165)

Time For A Change – Transition from paediatric to adult Inflammatory Bowel Disease services: 1 year and 5 year outcomes in a single Irish academic centre

Author(s)

Eabha Ring, Conor Palmer, Annika Gallagher, Fiona Jones, Mary Hamzawi, Garret Cullen, Glen Doherty, Hugh Mulcahy, Juliette Sheridan

Department(s)/Institutions

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

Introduction

Inflammatory bowel disease (IBD) presents in 25% of patients before the age of 20 with younger age of onset associated with aggressive disease. Transition to adult services comes at a complex developmental period with increased risk of adverse outcomes.

Aims/Background

Describe 1 and 5-year outcomes of patients transferring from paediatric to adult IBD services in an Irish academic centre.

Method

IBD patients (aged 16-18) referred from paediatric services to SVUH from 2010-2019 were identified from our IBD database. Demographic data, 1 year and 5-year disease related outcomes were reviewed using electronic records, endoscopy, laboratory and radiological reporting systems.

Results

180 patients were referred over a 10 year period. 141 were included in the final analysis following exclusion of incomplete records, with 81 patients having data up to 5 years. 1 year and 5 years outcomes were as follows, respectively: 54 patients (38%) and 48 patients (34%) had evidence of active disease. 33 (23%) and 52 (37%) required new/escalated medical therapy; 16 (11%) and 39 (28%) required steroids; 4 (3%) and 21 (15%) patients were referred for surgery; 12¬ (9%) and 32 (23%) had an IBD-related hospital admission; 11 (8%) and 33 (23%) had ≥1 non-attendance at clinic and 5 (4%) and 37 (26%) were lost to follow up.

Conclusions

Our data reflects the published literature, highlighting a high degree of disease activity in a transition cohort. The almost 60% of disease activity and 26% of patients lost to follow up over a five-year period reflect the unique challenges in treating this cohort. Further studies are required to guide management, service planning and improve outcomes for this group.

ABSTRACT 8 (21S129)

The role of bile acids in mediating fibrosis in inflammatory bowel disease

Author(s)
K. Hazel, N. McGinley, A. O'Toole, S. Keely
Department(s)/Institutions
Department of Molecular Medicine, Royal College of Surgeons in Ireland, Beaumont Hospital, Dublin Department of Gastroenterology, Beaumont Hospital, Dublin

Introduction
10% of Crohn's disease patients will develop fibrostenosing disease. There are currently no anti-fibrotic medications in use for the treatment of fibrostenosing CD. Bile acids (BAs) have previously been shown to have the capacity to regulate fibroblast activation and to exert protective effects against both hepatic fibrosis and intestinal inflammation. Therefore, altered mucosal fibroblast function in response to luminal BAs may be an important factor in the pathogenesis of fibrostenosing Crohn's disease.

Aims/Background
To determine if treatment of fibroblasts under pro-fibrotic conditions with naturally occurring BAs decreases markers associated with fibrosis.

Method
Murine NIH/3T3 fibroblasts were treated with TGF-B (5 ng/ml), inducing their activation and transition to myofibroblasts in the absence or presence of varying concentrations of the naturally-occurring BAs, deoxycholic acid (DCA) and ursodeoxycholic acid (UDCA) over 24 hours. qPCR was employed to determine expression of alpha-smooth muscle actin (aSMA), an important marker for ECM deposition and fibrosis.

Results
Treatment with DCA within the range of normal physiological concentrations (50 to 200 uM) induced significant inhibition of TGF-B-induced aSMA expression. At a concentration of 100 uM, DCA reduced TGF-B-induced responses by 50%, compared to cells treated with TGF-B-alone (RQ=2.17; RQ=4.58, respectively) (n=6) (p=0.0031). Similarly, treatment with UDCA at supraphysiological concentrations (500 uM) decreased aSMA expression following TGF-B stimulation (RQ=1.75; RQ=3.69, respectively) (n=5). Treatment with conjugated BAs TDCA and TUDCA suggest an intracellular mechanism of action by DCA and UDCA.

Conclusions
We have shown that treatment of fibroblasts under pro-fibrotic conditions with the BAs, DCA and UDCA, results in a significant decrease in aSMA expression. These data suggest that BAs represent a promising target for the development of new anti-fibrotic agents to treat/prevent fibrostenosing CD.

PREMIER POSTER PRESENTATIONS

ABSTRACT 9 (21S105)

Health-related Quality of Life in Non-alcoholic Fatty Liver Disease Associates with Hepatic Inflammation

Author(s)
Marie Boyle. Quentin Anstee
Department(s)/Institutions
Freeman Hospital. Newcastle University

Introduction
Chronic liver disease has negative effects on health-related quality of life (HRQL).

Aims/Background
We analyzed data from the European non-alcoholic fatty liver disease (NAFLD) registry to assess the effects of NAFLD on HRQL scores

Method
304 patients (mean age, 52.3 ± 12.9 years) in Germany, the United Kingdom, and Spain completed the CLDQ. 147 Patients enrolled prospectively into the UK arm of the NAFLD European registry completed the Beck's Inventory Version 2 (BIV2) and the Fatigue Impact Scale (FIS).

Results
Total CLDQ scores in the UK cohort (n=147) were significantly lower compared to Germany (5.27) and Spain (5.14) p=0.01 and lower than normative population data (p<0.0001). Male gender, BMI and NASH negatively correlated with total CLDQ scores (p<0.05). CLDQ scores were lower for females versus males (4.27 versus 5.1, p=<0.0001), obesity versus overweight/normal (4.66 versus 5.44, p=0.036) and for NASH versus NAFL (4.49 versus 4.9, p=0.038). Degree of lobular inflammation correlated significantly with total CLDQ scores (Rs = -0.200, p=0.015) In the UK arm (n=147). Mean CLDQ (4.72 +/-1.3), FIS (79.45+/- 34) and BIV2 (13.75 +/- 10.95). 100% had significant fatigue, 22% had hypersomnolence and 23% had moderate/severe depression. Grade of lobular inflammation influenced CLDQ scores (F=3.802, p=0.012) and FIS scores (F=4.908, p=0.012) only. Liver histology did not influence depression scores.

Conclusions
In an analysis of data from the European NAFLD registry, we observed a substantial burden of symptoms in patients. In addition to age, sex, and the presence of diabetes, detection of lobular inflammation in biopsies correlated with lower HRQL.

ABSTRACT 10 (21S131)

TIPSS Review: A retrospective study of TIPSS in Northern Ireland from 2006 to 2019

Author(s)
Neil Bradley, Conor Braniff
Department(s)/Institutions
Hepatology Department, Royal Victoria Hospital, Belfast, Northern Ireland

Introduction
TIPSS is a treatment used to decrease portal hypertension in patients with liver disease. A stent is inserted to create a channel between the portal vein and hepatic vein. Indications include variceal bleeds unresponsive to other treatments and intractable ascites.

Aims/Background
A review of TIPSS procedures in Northern Ireland from October 2006 to July 2019 in the regional Hepatology centre. It assessed patient demographics, procedural indications, transplant rate and mortality. The primary goal was to assess mortality relative to MELD score.

Method
TIPSS data from October 2006 to July 2019 was obtained from the Interventional Radiology team in Royal Victoria Hospital Belfast. Additional data, such as MELD score, transplant rate and mortality rate, was obtained via the Northern Ireland Electronic Care Record.

Results
119 TIPSS procedures took place for a total of 94 patients. 60% were male, 40% female. The most common aetiology was alcohol related liver disease (61%). The most common indication was variceal bleeding (66%). Ten percent of patients proceeded to transplant post TIPSS. Mortality rate at one month and five years was lower in a MELD score of 14 or under, compared to over 14 (6% and 38% versus 40% and 75% respectively).

Conclusions
TIPSS was mainly used in emergency variceal bleeding secondary to underlying alcohol related liver disease. It was used as a successful bridge to transplant in 10% of select patients. HIgher MELD scores correlate to higher mortality rates at 1 month and 5 years, and all cause mortality post TIPSS at 5 years is 50%.

ABSTRACT 11 (21S128)

Rates of Hospital-Acquired Clostridioides difficile infection during the COVID-19 Pandemic in a Tertiary Healthcare Setting

Author(s)
K Hazel, M Skally, E Glynn, M Foley, K Burns, A O'Toole, K Boland & F Fitzpatrick
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Dublin 9, Ireland Department of Microbiology, Beaumont Hospital, Dublin 9, Ireland

Introduction
Clostridioides difficile infection (CDI) is the leading cause of hospital-acquired infectious diarrhoea. High bed occupancy rates in acute hospitals are correlated with an increased incidence of healthcare-associated CDI. The COVID-19 pandemic led to changes within our healthcare system, with a cessation of elective procedures and reduced presentations for non-COVID-19-related illnesses.
Aims/Background
To determine if improved hand-hygiene, increased use of PPE, social distancing and reduced hospital occupancy resulted in a decrease in new cases of healthcare-associated C. difficile infection during the first wave of the COVID-19 pandemic.

Method
We defined the COVID-19 outbreak period as March to May 2020 and identified newly-acquired C. difficile cases during the same period from 2018 – 2020, using the hospital C. difficile database. Electronic records were used to assess patient demographics and biochemical markers. Statistical analysis was performed using STATA. Antimicrobial usage was provided by our Pharmacy Department. Hand-hygiene audit results were provided by the Infection Control Department

Results
50 patients with a new diagnosis of hospital-acquired CDI were identified. Chi-squared analysis with Yates correction demonstrated a decrease in newly-acquired healthcare associated CDI during the first wave of the COVID-19 pandemic period March to May 2020 when compared to the same period in 2018 and 2019 ($p=0.029$)

Conclusions
During the first wave of the COVID-19 pandemic, static antimicrobial use, reduced hospital occupancy, improved hand hygiene and the use of PPE resulted in a decline in rates of new cases of healthcare-associated CDI; demonstrating the importance of hospital overcrowding, social distancing and hand hygiene on the development of CDI during an inpatient stay.

ABSTRACT 12 (21S150)

Virtual Versus Physical G.I. Clinics – What Does the Patient Prefer?

Author(s)
Eileen Shannon, Ciarán McHale, Carol Goulding
Department(s)/Institutions
Department of Gastroenterology, University Hospital Galway

Introduction
Since the start of the COVID-19 pandemic, outpatient gastroenterology clinics have switched predominately to virtual consultations.

Aims/Background
Our aim was to determine patient preferences for the method of consultation in clinics, identify the reasons, and determine any relationship with patient demographics and their preference.

Method
We performed a cross-sectional analysis over a 3-week period at gastroenterology clinics in a model 4 hospital. A standardised questionnaire was used to record preferences. Statistical analysis was completed using Excel and MiniTab.

Results
125 patients participated in the study of whom 64/125 (51.2%) were female. The mean age was 52.8 years (17 – 89 years). In the current COVID-19 situation, 53.6% of patients favoured virtual clinics, 33.6% physical clinics, the remainder had no preference. There was

no significant difference in the ages of patients in these groups (p = 0.211). IBS was the only diagnosis that demonstrated significant difference, with 90.9% of patients preferring virtual clinic reviews (p = 0.048 Fisher's Exact). The most frequently cited reason for favouring virtual clinics was convenience (78.4%), with only 15% of patients (mean age 60.3 years) citing fear of COVID-19 as their primary reason. Regarding future appointments; 38.4% of patients reported a preference for virtual clinics, with 24% preferring to attend in person. 37.6% of patients would opt for a mixture of both depending on their disease activity.

Conclusions

Our study suggests that only a minority of patients would prefer to revert back fully to physical clinics. This has important implications for planning and streamlining future clinics in an era with considerable capacity and time constraints.

ABSTRACT 13 (21S157)

Cancer, Inflammatory Bowel Disease and Immunosuppression: A Decade of Experience at an Irish Tertiary Referral Centre

Author(s)

T.J. Matthews, A. Tawfik, A. O'Grady-Walshe, P. Mulryan, S. Phelan, A. O'Donnell, S. Quidwai, M. Ather, S. Anwar, R. Ballester, N. Breslin, A. O'Connor, S. O'Donnell, B. Ryan, D. McNamara

Department(s)/Institutions

Department of Gastroenterology, Tallaght University Hospital, Dublin 24 Trinity Academic Gastroenterology Group, Tallaght University Hospital, Dublin 24

Introduction

As demographics age, gastroenterologists increasingly immunosuppress IBD patients with histories of cancer.

Aims/Background

We compared our practice to standards suggested by Sebastian & Neilaj (2019) in Therapeutic Advances in Gastroenterology.

Method

2,033 return patients attended an IBD clinic over the period 1/10/2012 to 31/12/2020. A letters search yielded a subset of 78 with a history of cancer and IBD. 7 had a history of two malignancies.

Results

45% were male (n=35). Mean ages at IBD and cancer diagnosis were 45.4 and 54.5 years respectively. 46.2%, had a diagnosis of Crohn's (n=36). 25%, 55% and 20% of malignancies were, following Sebastian and Neilaj, categorised as having a high, medium and low risk of recurrence respectively (n=21, 47, 17). 24% of malignancies were diagnosed in excess of two years prior to IBD diagnosis (n=20) and in no case altered IBD therapy. 9% never required any medications to treat their IBD (n=7) and 38% never required therapy in excess of ASAs (n=30). Diagnosis of cancer precipitated a cessation of therapy in 20% and a switch to vedolizumab in 12% of cases (n= 17, 10). Estimation of a probit binary regression model failed to establish a significant relationship between cancer recurrence risk, gender, age or IBD type and alteration of IBD therapy as a result of a cancer diagnosis.

Conclusions

IBD patients diagnosed with cancer requiring immunosuppression have had typical therapy stopped and have been switched to vedolizumab where necessary. Remote diagnoses had a lesser impact on therapeutic choice consistent with comparable standards.

ABSTRACT 14 (21S113)

Obliterative Portal Venopathy is the Predominant Pathway of Liver Disease in Adult Cystic Fibrosis: Retrospective Data from the Irish National Liver Transplant Unit

Author(s)

John O'Neill, FRCPath (1), Cathal Clifford, MRCPI (2), Niamh Nolan, FRCPI, FRCPath (1), Aidan McCormick, FRCPI (2)

Department(s)/Institutions

Department of Histopathology (1) and the National Liver Unit (2), St Vincent's University Hospital, Dublin

Introduction

Two pathways are now proposed to lead to chronic liver disease in the CF patient (CFLD). The traditional pathway is obstructive biliary disease arising from inspissated bile, presenting with cholestatic biliary cirrhosis.

Aims/Background

The cohort of adult CF patients seen in our institution however tend to present initially with portal hypertension, rather than with jaundice. The second recently proposed mechanism of liver disease in CF patients is obliterative portal venopathy causing non-cirrhotic portal hypertension.

Method

Histology from 9 CFLD livers explanted since the Irish adult liver transplant program commenced in 1993 were examined. Control explants from 10 primary biliary disease patients were reviewed, 3 primary biliary cirrhosis (PBC) and 7 primary sclerosing cholangitis (PSC).

Results

The most striking feature was marked reduction in portal vein branches (PVB) in CF cases when compared to PBC and PSC controls. Mean PVB counts per 15mm2 in CF were 46 versus 82 for controls (p = 0.0015). Additionally all CF cases displayed portal hyalinised sclerotic nodules, not seen in control cases, and which we hypothesize to represent a marker of CFLD not previously described. These nodules are typically seen unaccompanied by PVBs, possibly representing scars of obliterated PVBs. Nodular regenerative hyperplasia was prominent in CFLD cases, in keeping with portal inflow obstruction. Cirrhosis was deemed "incomplete" in all CFLD cases while being present in 70% of controls.

Conclusions

These findings support the recent contention that CFLD is predominantly a condition of venous inflow obstruction leading to early portal hypertension without significant cirrhosis, benefiting from early shunting.

ABSTRACT 15 (21S159)

Challenges in clinical practice with Hepatocellular Carcinoma (HCC) screening in patients with Hepatitis C virus (HCV) related cirrhosis after antiviral treatment

Author(s)
A. Alvain, E. Shannon, J. Lee, M. Bohan-Keane, M. Scarry, JM. Lee
Department(s)/Institutions
University Hospital Galway

Introduction
While overall HCC risk significantly reduces after successful HCV treatment, it remains considerable in patients with pre-treatment advanced liver fibrosis or cirrhosis. International guidelines recommend HCC screening after treatment.

Aims/Background
This study evaluates the clinical practice challenges in meeting this recommended standard of care prior to Covid-19.

Method
Patients with cirrhosis prior to HCV treatment were identified through a prospectively maintained database. Further data was obtained from the electronic patient record and radiology system.

Results
Of 394 consecutive patients treated for HCV, 73 had cirrhosis diagnosed pre-treatment. 8 (11%) of patients developed HCC (1 recurrence) up to 3 years after successful anti-viral therapy. 7 (10%) patients died during the follow-up period (3 HCC-related, 3 decompensated cirrhosis-related). 58 (79%) of patients attended regularly for follow-up after treatment (49 at dedicated clinic, 9 at different centers). By 2019, 8 patients (11%) had stopped attending despite a proactive management practice - reasons are explored. Of the 49 patients attending the dedicated clinic during a 12 month period (prior to Covid-19), 36 (73.5%) had at least one form of imaging, 12 (24.5%) had >2 imaging studies. 3 patients (6.1%) did not attend for any scheduled imaging appointments. Overall, there was a 21.7% non-attendance rate for scheduled radiology appointments – reasons are explored.

Conclusions
The clinical practice burden of HCC after successful HCV treatment in cirrhotic patients is significant (11% in this cohort). Despite this, there are challenges in keeping cirrhotic patients engaged with scheduled medical care after anti-viral therapy. Some patients do not attend regularly for any follow-up care, while non-attendance for scheduled radiology appointments is common.

ABSTRACT 16 (21S163)

Ustekinumab Therapy Outcome in a Refractory Crohn's Disease Patient Population

Author(s)
RM Corcoran, N. Breslin, B. Ryan, S. McKiernan, F. MacCarthy, C. Dunne, K. Hartery, A. O'Connor, S. O'Donnell, D. McNamara, D Kevans.
Department(s)/Institutions
Department of Gastroenterology, St. James's Hospital Dublin 8, Ireland Department of Gastroenterology, Tallaght University Hospital, Dublin 24, Ireland Trinity Academic Gastroenterology Group (TAAG)

Introduction
Ustekinumab is a fully human IgG1 monoclonal antibody which binds the p40 subunit shared by the pro-inflammatory interleukins 12 and 23. Ustekinumab has been demonstrated to have efficacy for induction and maintenance of remission in patients with Crohn's disease (CD).

Aims/Background
To describe the outcomes of CD patients receiving ustekinumab therapy at two academic medical centres. The primary endpoint was ustekinumab therapy outcome assessed by drug persistence in the study cohort. Secondary endpoints included the requirement for and outcome of optimised ustekinumab dosing regimens and faecal calprotectin concentrations following therapy.

Method
Retrospective cohort study of Crohn's disease patients receiving ustekinumab at St James's and Tallaght University Hospitals between April 2012 and April 2021. Patient demographics, baseline characteristics, medication history and disease behaviour were characterised. Duration of ustekinumab therapy and ustekinumab dosing regimens were documented. Optimised dosing was defined as a dosing regimen of ustekinumab 90mg at less than an 8-weekly interval.

Results
134 patients with CD were commenced on Ustekinumab during the study period. 99% had received 1 previous anti-TNF therapy and 58% 2 anti-TNF agents. In a survival analysis the median (95% CI) duration of ustekinumab therapy was 137.2 weeks (95% CI 99.8-174.8). There was no significant difference in ustekinumab persistence between patients receiving standard (8-weekly) dosing regimen (n=67, 51%) and those requiring an optimised dosing regimen (n=65, 49%).

Conclusions
Ustekinumab is an effective treatment for Crohn's disease patients which significant prior biologic therapy exposure. Optimised dosing regimens are frequently required, however, a durable response can be achieved with high long term treatment persistence.

ABSTRACT 17 (21S142)

Giant Polyps a Giant Leap Forward

Author(s)
Neasa Mc Gettigan, Edric Leung, Aidan Harhen, James Bergin, Jane Burns, Ann Cooney, Nicky Kennedy, Syafiq Ismail, Margaret Walshe, John Keohane, Subhasish Sengupta
Department(s)/Institutions
Our Lady of Lourdes Hospital Drogheda

Introduction
Polyp size is an important factor to consider prior to polypectomy. Polyps > 3cm or so-called giant polyps represent a significant proportion of the most challenging polyps. As a general rule, 10-15% of polyps are considered difficult and 10-15% of larger polyps harbour invasive carcinoma.

Aims/Background
To review the practice of endoscopic removal of lesions > 3cm in a Bowel Screen JAG accredited endoscopy unit.
Method
A retrospective study from 2015-2020 of EMR of lesions > 3cm. Statistical analysis carried out using Minitab.
Results
A total of 39 patients were identified with lesions > 3cm from 191 patients who underwent polypectomy. The mean age was 69yrs, 59% were male (n=23). The mean size was 5.14cm (95%CI: 3.02, 7.26). TVAs were the most common histological subtype 92% (n=36). HGD was present in 15% (n=6) and invasive carcinoma in 10% (4). A significant difference was seen between polyps >3cm and those <3cm in respect to the presence of HGD (p-value= 0.05). Medical endoscopists carried out 62% (n=24) of cases vs surgeons 38% (n=15). Piecemeal resection was carried out in 69% (n=27), 1 case was incomplete. Flat lesions were most common 44% (n=17); pedunculated 33% (n=13); sessile 23% (n=9). Clear margins were confirmed in 54% (n=21). IPB occurred in 10% (n=4); no perforations were reported. A referral for surgical resection was made in 10% (n=4).
Conclusions
Polyps >3cm are more likely to demonstrate HGD and harbour invasive carcinoma. The majority of lesions are endoscopically resectable with relatively low severe complication rates.

ABSTRACT 18 (21S166)

Impact of the COVID-19 on colorectal cancer diagnosis in Dublin Midlands Hospital Group.

Author(s)
Asad Toor, Haroon UR Rashid, Farid Toor, Cara Dunne, Dermot O'Toole, Finbar Mac Carthy, Susan Mc Kiernan, Brian Mehigan, Paul Mc Cormick, David Kevans, John Larkin, Karen Hartery.
Department(s)/Institutions
Dept of Colorectal Surgery and Gastroenterology, St. James's Hospital, Dublin 8.
Introduction
Due to COVID-19 pandemic, the first national lockdown was introduced in Ireland in March 2020. Continuing surges in cases has resulted in rolling lockdowns requiring changes in current work practices to redeploy resources to critical areas. The national bowel screening programme was temporarily suspended. Routine diagnostic work was deferred. Only urgent symptomatic cases were prioritized for diagnostic intervention.
Aims/Background
To assess the impact of COVID-19 pandemic on diagnosis on colorectal cancer in Dublin Midlands Hospital Group.
Method
A retrospective study of patients with colorectal cancer diagnosis in Dublin Midlands Hospital Group over a 2 year period (year prior to pandemic (March 2019 – February 2020) and pandemic year (March 2020 - February 2021)). Patient details were obtaied from electronic patient records. Endoscopy and Radiology reports were reviewed for tumour location and TNM staging. Where patient had resection without neo-adjuvant treatment, histopathology report was used for definitive local staging.
Results
During the study period, 303 colorectal cancer diagnoses were made, 193 in pre-pandemic year and 110 in pandemic year with an overall reduction of 43%. Patients presenting with metastatic disease (Stage IV) increased from 24.4% (n=47) to 30% (n=33), while those with localised disease (Stage I) decreased from 25.9% (n=50) to 19.1% (n=21). There was increase in younger patients (0-<60 years old) diagnosed (21.6% to 32.7%) and decrease in middle aged patients (60-69 years old) diagnosed (30.9% to 23.6%).
Conclusions
Disruptions in healthcare related to COVID-19 burden has resulted in reduction in colorectal cancer diagnosis and increased in diagnosis of patients with advanced disease. This may lead to increase in colorectal cancer mortality and morbidity in years to come if unmitigated.

REGULAR POSTER PRESENTATIONS

ABSTRACT 19 (21S101)

An Audit of Mismatch Repair Protein Testing in Colorectal Carcinoma in The Mater Misericordiae University Hospital in 2020

Author(s)
S. McGrath JJ. Aird
Department(s)/Institutions
Department of Histopathology, Mater Misericordiae University Hospital, Dublin
Introduction
Mismatch repair deficiency (dMMR) leading to microsatellite instability occurs in approximately 15% of all colorectal cancers and can be due to germline mutations in MMR genes or epigenetic silencing of MLH1. MMR status has treatment implications for patients, and reflex testing with MMR IHC on all colorectal adenocarcinomas began in MMUH in November 2019.
Aims/Background
To assess the rate of MMR testing and follow up testing, as indicated by our algorithm, in MMUH in 2020. Figures from 2019 were also collected for comparison.
Method
All cases of colorectal adenocarcinoma in MMUH in 2019 and 2020 were reviewed to determine if MMR IHC was performed, and if appropriate molecular testing was performed in cases of dMMR.
Results
2/106 (1.9%) of cases of colorectal adenocarcinoma in 2020 did not have reflex MMR testing, a marked improvement from 34/110 (30.9%) of cases in 2019. MMR testing was subsequently performed, meaning that 100% of colorectal carcinoma specimens were tested for MMR IHC in 2020. Of the 106 cases in 2020, 15 (14.4%) were dMMR compared to 11/76 (14.5%) in 2019. Appropriate molecular testing was performed in 10/12 (83.3%) of the cases with PMS2/MLH1 loss in 2020, and 3/106 (2.8%) patients were referred for germline testing for Lynch syndrome
Conclusions
A marked improvement in rates of MMR testing has been made from

2019 to 2020. Measures have been put in place to improve this and rates of appropriate follow up testing further, including template reporting of MMR IHC and in-house BRAF testing. We will be repeating this audit on an annual basis.

ABSTRACT 20 (21S102)

The Current Role of Specialist Palliative Care in Patients with End Stage Liver Disease – a Single Centre Review

Author(s)
A. Ni Nuallain C. Deane C. Walker N. Breslin
Department(s)/Institutions
Gastroenterology Department, Tallaght University Hospital, Dublin, Ireland

Introduction
The British Association for the Study of Liver Disease (BASL) position statement highlights the role of specialist palliative care (SPC) in the management of patients with end stage liver disease (ESLD).

Aims/Background
The aim of this study was to explore the current collaborative practice between physicians and SPC in our centre in order to identify if there is scope for a more integrated approach.

Method
We conducted a retrospective study of patients with ESLD who passed away between 2018-2020. Key patient characteristics were identified, patient's data was stored in compliance with GDPR.

Results
57 patients who died of ESLD were admitted between 2018 -2020. 53% of these were referred to SPC or had active SPC involvement prior to death. Of those who were referred to SPC, the median age was 68. Alcohol was the leading cause of cirrhosis (57%) followed by NASH (13%) & other (30%). None of these patients had been listed for transplant. 43% of patients referred had co-existing HCC. 57% had a MELD score of >18. 40% had >3 admissions within their last year of life , only 13% had been referred to palliative care prior to their final admission. Patients were predominantly referred for end of life care (53%), a third (33%) for symptom management/ community input and the remaining (14%) were referred for a separate co-morbidity. 93% of these patients died in hospital, 7% in a home or hospice setting.

Conclusions
Patients with a high MELD score have a poor prognosis and advanced care planning could avoid unnecessary intervention.

ABSTRACT 21 (21S103)

Performance of the PRO-C3 collagen neo-epitope biomarker in non-alcoholic fatty liver disease

Author(s)
Marie P. Boyle. Quentin M. Anstee
Department(s)/Institutions
Freeman Hospital Newcastle. Newcastle University.

Introduction
There is an unmet need for non-invasive biomarkers in non-alcoholic fatty liver disease (NAFLD) that can diagnose advanced disease and identify patients suitable for clinical trials.

Aims/Background
To assess the performance of PRO-C3 collagen, a neo-epitope, which is a putative direct marker of fibrogenesis for the detection of advanced fibrosis in NAFLD

Method
Plasma PRO-C3 levels were determined in a prospectively recruited international cohort of 449 patients with biopsy diagnosed NAFLD across the full disease spectrum. The cohort was divided into a discovery group (n = 151) and a validation group (n = 298). Logistic regression was performed to establish complex (FIBC3) and simplified (ABC3D) diagnostic scores that accurately identify advanced fibrosis. Performance for each was compared to established non-invasive fibrosis scoring systems.

Results
Plasma PRO-C3 levels correlated with grade of histological steatohepatitis (rs = 0.367, p <0.0001) and stage of fibrosis (rs = 0.462, p <0.0001), exhibiting similar performance to current fibrosis scores for the detection of F≥3 fibrosis. FIBC3 exhibited substantially improved accuracy (AUROC 0.89) and outperformed FIB4 and other similar diagnostic panels. The simplified version, ABC3D, was concurrently developed and had comparable diagnostic accuracy (AUROC 0.88).

Conclusions
Plasma PRO-C3 levels correlate with severity of steatohepatitis and fibrosis stage. The FIBC3 panel is an accurate tool with a single threshold value that maintains both sensitivity and specificity for the identification of F≥3 fibrosis in NAFLD, eliminating indeterminate results and outperforming commonly used non-invasive tools. A greatly simplified version (ABC3D) that is readily amenable to use in the clinic has been validated and shown to perform with similar accuracy and may eliminate the need for online calculators

ABSTRACT 22 (21S104)

Health-care burden of NAFLD in UK hospital-based outpatient hepatology clinics: real-world prospective data from the CONSTANS study

Author(s)
Marie Boyle. Quentin Anstee
Department(s)/Institutions
Freeman Hospital. Newcastle University.

Introduction
In Europe data on the burden of NAFLD a real-life setting in outpatient hepatology clinics is lacking

Aims/Background
This study aimed to assess the prevalence of NAFLD and ALD among outpatients in a specialized liver clinic at a tertiary care center

Method
Prospective observational study of pts attending the outpatient hepatology clinic period at the Freeman hospital, Newcastle during a 1- month period was recorded. Suspected or already confirmed NAFLD and an ALD cohort were included in a 12 months follow-up study which included diagnostic/monitoring work-up and cost of use of medical procedures

Results

Winter Meeting 2020

Dr Garret Cullen, Hon Secretary ISG
& Dr Tony Tham, President, ISG

Dr Tony Tham , President ISG,
Mr John Burke, Colorectal Surgeon Beaumont Hospital Dublin
and Dr Ciara Egan, St. Vincent's University Hospital Dublin.

664 patients were initially assessed in a 4-week period. The patient spectrum included; Suspected NAFLD (9%); known NAFLD (15%); ALD (14%); viral hepatitis (9%). In the follow-up study 49 patients with suspected NAFLD, 89 patients with known NAFLD and 79 patients with ALD were included. Follow up investigations in the NAFLD cohort included; ultrasound (45.7%); blood tests (99%); fibroscan (36%); liver biopsy (7%) with 24% being hospitalised compared to the ALD cohort with service utilisation including ultrasound (78.5%); blood tests (100%); fibroscan (14%); liver biopsy (0) with 29% being hospitalised. Costs were stratified NAFLD versus ALD (£93, 5993.28 versus £1,309,214.16), NAFLD cirrhotics versus ALD cirrhotics (£612,409.44 versus £1,261,084.80)) and known versus suspected NAFLD (£69, 1084.92 versus £24, 4908.36). Multivariate regression analysis in the NAFLD cohort established main cost drivers to be the number of clinic appointments and the presence of advanced disease ($p<0.05$)

Conclusions

In a large, prospective study of tertiary care outpatient hepatology clinics, NAFLD and ALD have a high prevalence at referral and represent a major burden on hepatology outpatient clinics

ABSTRACT 23 (21S107)

Plasma DNA methylation as a biomarker for stratification of mild and severe liver fibrosis in chronic liver disease

Author(s)

Marie Boyle. Quentin Anstee

Department(s)/Institutions

Freeman Hospital. Newcastle University

Introduction

Differential DNA methylation in the human PPARγ promoter is detectable in circulating cell-free DNA (ccfDNA) and can be quantified to stratify fibrosis grade (mild versus severe) in NAFLD patients.

Aims/Background

To determine if CpG methylation at the PPARγ gene promoter is a potential methylation signature for advanced fibrosis in chronic liver disease independent of liver disease aetiology which is specific for liver fibrosis.

Method

Patients with fibrotic disease (liver and systemic sclerosis (SSc)) were recruited from clinics at the Freeman hospital (UK), Florence Nightingale Hospital (Turkey) and University Hospital Erlangen (Germany). Pyrosequencing was employed in a NAFLD (n=13) and HBV (n=13) cohort to quantitatively assess plasma cell-free circulating DNA methylation in the promoter region of PPARγ. To determine if hypermethylation was characteristic of fibrosis of liver origin, methylation in a cohort of patients with limited and diffuse systemic sclerosis (SSc) ccfDNA in patients who have various combinations of skin, lung and kidney fibrosis, but no hepatic fibrosis was quantified (n=30) for comparison.

Results

Uniform hypermethylation was detected at all three CpGs in ccfDNA in the cohorts of patients suffering from cirrhosis caused by chronic HBV infection and NAFLD (CpG1: 86%; CpG2: 65%). In the scleroderma cohort, all three CpG sites in SSc were relatively hypomethylated with similar methylation densities between individual patients with SSc. (CpG1: 16%; CpG2: 9%; CpG3:16%)

Conclusions

Uniform hypermethylation at the PPARγ gene promoter confirms this as a potential methylation signature for advanced fibrosis in chronic liver disease independent of liver disease aetiology which is potentially specific for liver fibrosis. This epigenetic signature has the potential to be developed as a blood-based liquid biomarker specific for hepatic fibrosis progression.

ABSTRACT 24 (21S108)

An Audit Of Proactive Therapeutic Drug Monitoring Of Patients With Inflammatory Bowel Disease On Biologics

Author(s)

Ng K.B., J. McCarthy, K. Sugrue

Department(s)/Institutions

Department of Gastroenterology, Mercy University Hospital IBD Center, Cork City, Cork

Introduction

Following the European Crohn's and Colitis Organisation (ECCO) guidelines, biologics can be utilised to manage inflammatory bowel disease (IBD). Therapeutic drug monitoring (TDM) is the clinical practice of measuring serum drug concentrations to guide clinical decision-making, offering a personalised treatment approach and is associated with sustained clinical remission.

Aims/Background

To audit the clinical practice of TDM in patients on biologics and to determine that the appropriate drug dose is administered to ensure therapeutic level is achieved.

Method

A retrospective clinical audit was performed in Mercy University Hospital. Study population included 100 adults receiving Infliximab or Vedolizumab intravenous infusions. Data was collected through medical charts. Patients were categorised into Crohn's disease, ulcerative colitis and unclassified IBD, further sub-categorised into "on Infliximab" and "on Vedolizumab" and grouped based on outcomes post-induction and post-dose escalation.

Results

Post-induction levels were often subtherapeutic, with 72% of patients needing dose escalation. With dose escalation protocol based on proactive TDM, 89% achieved therapeutic levels with improved clinical outcome. For remaining 11% of patients whose drug levels remained subtherapeutic, they either switched to a different biologic (9%) or are managed with a combination of biologics (2%). There was a trend where patients with Crohn's disease on Infliximab requiring higher doses to reach therapeutic levels.

Conclusions

This audit highlighted the effectiveness of practising proactive TDM in helping patients reach therapeutic levels. It might be useful to compare results to patients without undergoing TDM, to show difference in outcomes. A re-audit could then be performed to re-assess the practice of proactive TDM.

ABSTRACT 25 (21S109)

A rare case of isolated duodenal Crohn's disease

Author(s)
Mohammed Ali, Hind Awad, Maurice Murphy, Ashraf Morcos
Department(s)/Institutions
Department of Gastroenterology, University Hospital Waterford

Introduction
Although CD can affect any part of the gastrointestinal tract, it rarely affects duodenum in isolation with a prevalence reported to range between 0.5% and 4.0%.

Aims/Background
A previously healthy 55-year-old woman referred to GI team with a working diagnosis of possible malignant gastric outlet obstruction and thickened duodenal wall on abdominal imaging following admission to AMU with upper abdominal pain, early satiety and severe weight loss. She has a family history of IBD

Method
The CT showed significant duodenal wall thickening up to 7.4mm for approximate length of 36mm at the level of D1/D2 junction with narrowing of the lumen up to 3.5mm (Image). Gastroscopy showed mucosal oedema with serpentine-like ulcerations at the duodenal bulb and significant stenosis at D1/D2 junction requiring dilatation with TTS/CRE balloon (Image). Small bowel Crohns' disease was therefore suspected. Initial histopathology of duodenal biopsies was inconclusive and reported H.Pylori gastritis. We repeated the duodenal biopsies with multiple biopsies from duodenal bulb and D2 and histopathology confirmed the finding of non-caseating epithelioid granulomas (image). No such finding was reported in gastric biopsies. No evidence of distal small bowel involvement on abdominal imaging and she had no lower GI symptoms. Previous colonoscopy and biopsies were reported as normal. Biological therapy with infliximab infusion was commenced after proper surveillance . She had marked clinical response with resolution of all symptoms. Repeated gastroscopy at 6 months on Infliximab infusions showed complete endoscopic remission with residual minimal fibrotic stenosis at D1/D2 junction

Results
Symptomatic duodenal Crohn's disease (CD) is an uncommon disease presentation, especially in isolation. The most common duodenal disease phenotype is stricturing disease rather than inflammatory or perforating. The majority of patients with duodenal CD have concurrent involvement of the terminal ileum or large intestine at presentation, rather than presenting with symptomatic CD of the duodenum alone

Conclusions
High index of suspicion and repeated sampling might be needed to diagnose isolated duodenal Crohns disease

ABSTRACT 26 (21S110)

Acute bacterial gastroenteritis: a retrospective review of patients presenting to a large tertiary hospital

Author(s)
D. McGee, N. Reidy, C. Lahiff
Department(s)/Institutions
Gastroenterology Department, Mater Misericordiae University Hospital, Eccles St., Dublin 7

Introduction
A faeces molecular screen for Salmonella spp, Shigella spp, Campylobacter spp and VTEC can be ordered within three days of presentation to the Mater hospital with diarrhea.

Aims/Background
The aim was to differentiate organisms based on presentation and laboratory data, and to review investigation and treatment.

Method
All inpatients with a positive molecular screen from January to December 2019 were reviewed via the electronic patient record system. Acuity of presentation was measured using a validated clinical assessment tool: Early Warning Score (EWS). Data was analysed using SPSS.

Results
57 patients were included in the analysis, mean age 45±21 years. Case split by organism: Campylobacter 63.2%, Salmonella 19.3%, Shigella 10.5%, and VTEC 8.8%. There was no statistical significant difference in symptoms (diarrhea, vomiting, abdominal pain, PR bleeding, fever) between groups. The Shigella group had the highest mean EWS (2.6±1.6, p=0.616) and the highest mean CRP (131.4mg/L±162.5mg/L, p=0.802). 22.8% had an acute kidney injury, highest in the VTEC group (60%, p=0.025). 50.90% were prescribed antimicrobials, of which 60.7% were indicated and 53.6% in line with local guidelines. 15.8% of patients had lower GI endoscopy and 28.1% had a CT abdomen.

Conclusions
Antimicrobial prescribing was frequently inappropriate and highlights the need for quality improvement measures. Judicious use of endoscopy is appropriate in this cohort. The Shigella group presented with the highest acuity and inflammatory markers, although more data is needed.

ABSTRACT 27 (21S111)

Comparison of Efficacy of Plenvu Vs. Klean-Prep as Bowel Cleansing Agent in Colonoscopy

Author(s)
Muhammad Atif(1), Nithya Nair(1), Fiachra Cooke(2), You Yi Hong(1)
Department(s)/Institutions
1) Department of Gastroenterology, University Hospital Waterford
2) Department of Colorectal Surgery, University Hospital Waterford

Introduction
Efficacy and tolerability of bowel cleansing agent are important factors in performing good quality colonoscopy. The adverse consequences of ineffective bowel preparation include lower

diagnostic accuracy, lower adenoma detection rate, inferior caecal intubation rate, unsatisfactory patient experience, and shorter colonoscopy surveillance intervals. Plenvu is 1 litre, low volume PEG-based product indicated for bowel cleansing agent for colonoscopy. Bisschops et al demonstrated that Plenvu is a superior colon cleansing agent, versus standard 2L PEG with ascorbate.

Aims/Background

To compare the quality of bowel preparation score for colonoscopy with of Plenvu Vs. Klean-Prep

Method

This is a single centre, retrospective observational study, comparing the quality of bowel preparation of Plenvu Vs. Klean-Prep, by extracting the first 100 colonoscopies in 2019 (with Klean-Prep), comparing with the first 100 colonoscopies in 2020 (with Plenvu), from En-doRAAd. The standard bowel preparation used for colonoscopy in University Hospital Water-ford was changed from Klean-Prep to Plenvu in January 2020.

Results

55% of colonoscopies with Plenvu achieved excellent/good bowel preparation, comparing to only 38% of colonoscopies with Klean Prep. (P-value <0.05) There was only 6% of colonoscopies with poor bowel preparation with Plenvu, comparing to 14% of with poor bowel prepa-ration with Klean-Prep. (P-value =0.059) However, procedure completion rate (97% in both group), polyp detection rate (29% in Plenvu Vs. 28% in Klean-Prep), comfort score (moderate to severe discomfort - 7% in Plenvu Vs. 7% in Klean-Prep) was similar in both group.

Conclusions

This study shows that Plenvu is superior than Klean-Prep as a bowel cleansing agent.

ABSTRACT 28 (21S112)

The Impact of the COVID-19 Pandemic on Hepatocellular Carcinoma Surveillance in Cirrhotic Patients

Author(s)

E Morrissey, C McShane, C Kiat, O Crosbie

Department(s)/Institutions

Department of Gastroenterology, Cork University Hospital

Introduction

In populations with a high incidence of HCC, surveillance reduces mortality and is cost effective. The EASL 2018 guidelines recommend that biannual ultrasound surveillance should be performed in these populations. In response to the COVID-19 pandemic, updated guidance states that surveillance may be delayed. Accordingly, the ISG recommended surveillance ultrasound can be deferred by 3 months.

Aims/Background

This audit aims to assess the impact of COVID-19 on HCC surveillance.

Method

We retrospectively reviewed and compared HCC surveillance with ultrasound and AFP amongst cirrhotic patients attending hepatology clinics in a tertiary referral centre in July 2019 and July 2020. Optimal surveillance was defined as two ultrasounds at no greater than a six-month interval pre/post the clinic visit. A second cut-off of 9 months for was used for the 2020 patients.

Results

143 cirrhotic patients were identified (65 in 2019; 78 in 2020). In 2019, 40% had optimal ultrasound surveillance; the median time to ultrasound in the remainder was 10 months. In 2020, 21% had optimal ultrasound surveillance; the median time to ultrasound in the remainder was 19 months. When a cut off of 9 months was used, 33% of the 2020 patients were appropriately screened. In 2019, 71% of cirrhotic patients had appropriate AFP surveillance versus 37% in 2020.

Conclusions

Even with the updated recommendation, there was a clear decrease in the number of patients having optimal HCC surveillance from 2019 to 2020, which could potentially cause excess morbidity and mortality. This represents an important secondary effect of COVID-19.

ABSTRACT 29 (21S114)

Treatment Compliance in a Local IBD Cohort on Biologic Therapy During a Novel Coronavirus Pandemic

Author(s)

MA McCrossan, AR Aftab, F Zeb, G Courtney.

Department(s)/Institutions

Department of Gastroenterology, St Luke's Hospital, Kilkenny.

Introduction

In response to the COVID 19 pandemic, guidelines were produced for "at risk" groups, including those on immunosuppression for Inflammatory Bowel Disease (IBD). One major area of government advice involved "cocooning", with initial guidance published in March 2020. Advice specific to IBD patients was also published.

Aims/Background

1. To assess whether the pandemic has reduced compliance with 'biologic' medications, and whether this resulted in disease flares. 2. To assess patient awareness of current guidelines, and "cocooning" rates.

Method

We identified participants from authorisation documentation for adalimumab (Humira) between 2015 and 2020 (n=84). An 11-question postal survey was distributed, with a specified time frame of 1st March 2020 – 31st August 2020. A letter explaining the study, consent form, and return envelope were included. 50% of participants responded (n=42), with 2 responses excluded. Responses were analysed using Microsoft Excel.

Results

The 40 responses comprised of patients treated with adalimumab (n=31), infliximab (n=1), ustekinumab (n=6) and mesalazine monotherapy (n=2). 3 patients discontinued their biologic - 2 as advised by Gastroenterology, and 1 due to COVID 19 concern. This individual did not report worsening disease. 40% of respondents reported a "flare or worsening of IBD symptoms" (n=16). One respondent required admission. 48% (n=19) of respondents cocooned, with 33% (n=13) continuing to do so, [including all over 70s (n=3)]. 65% (n=26) believed themselves at increased risk from COVID 19. 43% (n=17) were aware of current guidelines.

Conclusions

This data suggests COVID 19 has not significantly reduced biologic compliance. Awareness of current guidance is suboptimal.

Speakers Winter Meeting 2020

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

Prof Michael B Wallace
Mayo Clinic, Florida, USA

Prof David Jones
Professer of Liver Immunology
Newcastle, UK

Dr Ian Rowe
Consultant Hepatologist
St James Hospital Leeds

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

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

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

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

Prof Catherine Nelson-Piercy
Imperial College, London

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

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

Prof Kieran Sheahan
Consultant Histopathologist. SVUH

Prof Robin Kennedy
Consultant Surgeon
St Marks Hospital, London

ABSTRACT 30 (21S115)

Did The COVID Pandemic Impact Admissions to The Mater Misericordiae University Hospital Gastroenterology Service?

Author(s)
T Dunne, A Alhakeem, J Campion, Z Galvin, S Stewart
Department(s)/Institutions
Gastroenterology Department, The Mater Misericordiae University Hospital, Dublin 7.

Introduction
Patients presenting to MMUH with gastroenterology-specific complaints are admitted under the gastrointestinal (GI) or hepatology services as appropriate. The literature suggests the COVID-19 pandemic has altered the volume and nature of unplanned admissions to hospital. Regular audit aids in optimising patient care and workforce planning.

Aims/Background
1. To characterise gastroenterology admissions to MMUH in the pre- and post-COVID eras.

Method
1. Gastroenterology admissions were identified using an encrypted messaging application (14/09/2019-14/11/2019 and 14/09/2020-14/11/2020). 2. Patient information was extracted from electronic patient records.

Results
In total, 216 GI patients were admitted. Of 111 pre-COVID admissions, 59 (51%) and 52 (49%) were managed by the luminal and hepatology teams respectively. Of 105 post-COVID admissions, 64 (61%) and 41 (36%) were managed by the luminal and hepatology teams respectively. There was no significant difference in the reason for admission pre- and post-COVID. GI bleeds (18% pre-COVID and 23% post-COVID) and decompensated cirrhosis (excluding GI bleeds; 15% pre-COVID and 13% post-COVID) were the most common. 68 (31% of total) admissions were for alcohol-related issues. Comparing pre- and post-COVID eras, there was no significant difference in length of stay (9.47±8.93 days v 7.26±10.49 days; p=0.0961), rate of admission to critical care (5% v 2%; p=0.2814) or mortality (5% v 3%; p=0.5000).

Conclusions
The COVID pandemic did not significantly impact the number, nature or severity of gastroenterology admissions. The pandemic has resulted in staff shortages and redeployment so an unchanged workload is significant. Alcohol-related illness remains a common reason for admission and demands dedicated care.

ABSTRACT 31 (21S116)

The Impact of The COVID Pandemic on Alcohol-Related Admissions to The Mater Misericordiae University Hospital Gastroenterology Service

Author(s)
T Dunne, A Alhakeem, J Campion, Z Galvin, S Stewart
Department(s)/Institutions
Gastroenterology Department, The Mater Misericordiae University Hospital, Dublin 7

Introduction
Alcohol-related issues are a common cause of hospital admission. Alcohol sales have risen during the pandemic leading to concerns regarding a concurrent increase in alcohol-related harms.

Aims/Background
1. To characterise alcohol-related admissions under the MMUH gastroenterology service. 2. To characterise the subgroup of patients with alcohol-related liver disease (ALD). 3. To describe any differences in the pre- and post-COVID eras.

Method
1. Gastroenterology admissions were identified using an encrypted messaging application (14/09/2019-14/11/2019 and 14/09/2020-14/11/2020). 2. Patient information was extracted from electronic patient records.

Results
Alcohol-related issues contributed to 68 (31%) gastroenterology admissions. Compared to other gastroenterology in-patients, this group had a longer hospital stay (10.37±11.40 v 7.49±8.80 days; p=0.0436), more previous admissions (13.96±18.39 v 9.58±10.41; p=0.0272) and more ED attendances (34.21±47.98 v 11.73±17.09; p<0.0001). Over half (53%) of these patients had evidence of ALD. Compared to other gastroenterology in-patients, this subgroup had a longer length of stay (11.69±11.09 v 7.73±9.73 days; p=0.0259) and higher mortality (14% v 3%; p=0.0443). The rate of alcohol-related admissions, including ALD, did not increase post-pandemic (34% v 29%; p=0.3834). Comparing pre and post-COVID eras, length of stay (11.05±11.37 v 9.50±11.57 days; p=0.5809), rate of admission to critical care (11% v 0%; p=0.1243) and mortality rate (8%v 3%; p=0.6245) were unchanged for alcohol-related admissions, including ALD.

Conclusions
Alcohol-related issues contribute significantly to gastroenterology admissions. Within this cohort, patients with ALD have longer hospital stays and higher mortality. Whilst the pandemic has seen reduced numbers of certain conditions presenting to hospital, the proportion and severity of alcohol-related gastroenterology admissions are unchanged.

ABSTRACT 32 (21S117)

Implementation and Survey of the first Liver Support Clinic in Ireland

Author(s)
Foley C1., Dillon P1., Noone D1., Stobie L1., Ruxton A1., Bolger E1., Howard L1., Cunningham S1., Carolan E2., Ryan J1 .
Department(s)/Institutions
1. Department of Hepatology, Beaumont Hospital, Dublin 9. 2. Pharmacy Department, Beaumont Hospital, Dublin 9.

Introduction
Advanced liver disease poses a significant strain on acute hospitals, with high lengths of stay, re-admission rates, and mortality. Evidence indicates that early and frequent outpatient review can reduce re-admission and improve survival.

Aims/Background
We aimed to establish a new liver support clinic, a one-stop facility for patients with advanced liver disease.

Method
Medical, specialist nurse, pharmacist and counselling are provided during a single outpatient assessment. Patients were provided with a 'Liver Passport' on their first review, which provides patients, their carers, and healthcare professionals with a tool to monitor symptoms, medications and weight, whilst providing educational information and contact details for the Hepatology team. A patient satisfaction survey was used to obtain feedback relating the liver passport and clinic.

Results
Since implementation of the clinic in July 2020, 324 patients with cirrhosis have been identified, and 118 liver passports have been distributed. The clinic DNA rate is 5%, and admission rate is 15%. Feedback from the survey showed 77% compliance with passport use, 84% found it easy to use; 84% felt that they knew only a bit or very little about liver disease prior to the passport; 62% now felt they knew a lot more now, and 85% felt that they had excellent support now from the clinic.

Conclusions
The implementation of a multi-disciplinary liver support clinic, the first of its kind nationally, has been an extremely positive experience for patients with advanced liver disease. The impact of this clinic on hospital metrics, costs, and morbidity/morality will be assessed.

ABSTRACT 33 (21S118)

An appropriately triaged functional GI clinic as an alternative to endoscopy in the post COVID-19 era?

Author(s)
Clodagh L Murphy, John Campion, Sean O' Gorman, Alison McHugo, Jan Leyden
Department(s)/Institutions
Mater University Hospital

Introduction
COVID 19 has substantially affected endoscopy waiting lists. At present alternative methods of patient assessment rather than direct endoscopy are being considered for suitable patients. A direct access IBS clinic with dietetic input would represent a viable pathway for young patients meeting criteria for IBS symptoms.

Aims/Background
To evaluate compliance with colonoscopy triage guidelines for patients aged under 45 with a view to gauging a patient cohort suitable for diversion to a functional GI clinic with dietetic support.

Method
A retrospective review was completed of all patients aged under 45 who attended for colonoscopy over a 2 month period in the pre-COVID-19 era, Jan-Feb 2020, looking for compliance with local colonoscopy triage guidelines.

Results
A total of 598 colonoscopies and 239 sigmoidoscopies were completed during this time frame, 101 and 94 respectively for patients aged under 45. 6.05% of colonoscopies and 8.45% of sigmoidoscopies were for IBS symptoms and fell outside of current triage guidelines Extrapolating the data to one year, this would save 3.33% of sigmoidoscopies and 1% of colonoscopies overall.

Conclusions
A certain cohort of adequately triaged patients aged under 45 with IBS symptoms could be diverted to a dedicated functional GI clinic saving endoscopy slots.

ABSTRACT 34 (21S119)

Cystic Fibrosis-Related GI Disease: A Growing Burden For Both Services

Author(s)
C Mc Closkey, T Nicholson, E McKone, C Gallagher, SM O'Reilly
Department(s)/Institutions
Centre for Colorectal Disease, St. Vincent's University Hospital, Elm Park, Dublin 4

Introduction
Much of the morbidity in patients with Cystic Fibrosis (CF) has traditionally related to their respiratory disease. Over time, this patient cohort has seen an increase in GI symptoms due to a number of factors, including the advent of CFTR modulators, chronic PPI and laxative use, and increasing life expectancy. Data in recent years has also demonstrated significantly increased risk of GI tract malignancies in this cohort.

Aims/Background
To explore the burden of GI disease in the CF population at a National Specialist Centre

Method
We used the Hospital In-Patient Enquiry (HIPE) dataset to ascertain the total number of admissions, and GI related admissions, in the CF patient cohort between 2015 and 2020. We then determined the prevalence of GI disorders in this cohort from discharge and outpatient clinic letters.

Results
From 2015-2020, there were 485 patients admitted a total of 11483 times, to the day or inpatient ward. 132 patients (27.2%) had at least one admission with a gastrointestinal issue as either a primary or secondary diagnosis over 6 years. The number of GI related admissions has increased almost threefold over the past 5 years, from 2.9% (55) to 8.4% (165). The prevalence of diagnoses among this

cohort were as follows; GORD (42.4%), CFRLD (40.2%) of which 4.5% had OLT, DIOS (19.7%), PEG/RIG insertion(11.4%), Chronic constipation (7.6%), Pancreatitis (3%) and Barrett's oesphagus (2.3%).

Conclusions

There is a rising prevalence of GI disease among the CF patient cohort, which is likely attributable at least in part to the introduction of CFTR modulators. This is leading to an increased need for gastroenterology input and access to endoscopy services over the coming years. More work is needed to analyse this cohort in terms of how best to optimize their quality of life from a GI standpoint.

ABSTRACT 35 (21S121)

Compare and consult: the burden of inpatient consultation in differing hospital systems

Author(s)

Neary BP, Schwartz H, Marrinan A, Sengupta S, Keohane J, Sheridan J, Cullen G, Doherty GA, Mulcahy HE

Department(s)/Institutions

St. Vincent's University Hospital Our Lady of Lourdes Hospital, Drogheda

Introduction

While providing general medical service, outpatients and diagnostic and interventional endoscopy, there is also a significant burden of consultation. This can vary depending on institution.

Aims/Background

To quantify the nature, source and amount of GI consultation requests in a 600 bed Model 4, tertiary referral Centre and and compare with a 340 bed Model 3, University Centre.

Method

The online consultation request system was used to measure the number and nature of consultation requests over 9 months. This was compared to data from the Model 3 institution over a year to evaluate differences in number, source and nature of request, also appropriateness of the consult based on the Hounslow Clinical Commissioning Group Referral Guidance 2013. SPSS was used for analysis.

Results

154 referrals were made in the Model 4 from 22 specialties, while 174 were made in the Model 3 from 8 specialties. There was a higher rate of referral in the Model 3 hospital when adjusted for hospital size. There was no significant difference in the proportion of consults from general surgical specialties (31.8% vs 39.7% p=0.23) however, referrals from medical specialties were more common in the Model 3 centre (42.4% vs 56.3% p=0.04). There were significantly more requests for colitis seen on CT (16.9% vs 29.4% p=0.04) and liver disease (0% vs 26.4% $p<0.05$) in the Model 3, while there were significantly more referrals for diarrhoea (14.9% vs 2.8%, $p<0.05$) in the Model 4. All consults in both centres were considered to be appropriate.

Conclusions

While, as expected, the source of consults is more varied in a Model 4, there was a higher per patient rate of referral in the Model 3 centre. There was a similar proportion of referrals from surgical specialties.

ABSTRACT 36 (21S122)

Role of EUS for MRCPs Doubtful of CBD Stone In Tertiary Referral Hospital

Author(s)

SI. Bhutta1, C. Constigan1, T. Sheehan1,H.Akhtar1, A. Adams1, MHM.Kammal1, M. Moloney1, MM. Skelly1, PK. Mahehswari1.

Department(s)/Institutions

Department of Gastroenterology, University Hospital Limerick (UHL).

Introduction

MRCP is useful if there is a high clinical suspicion of CBD stones. However, MRCP is not the most sensitive test for CBD stones. In UHL,MRCP that suggests CBD stones likely results in an ERCP and attempt at stone extraction.

Aims/Background

Our aim is to assess concordance of CBD stones diagnosed on MRCP with subsequent ERCP findings to support the case for development of an EUS service in UHL.

Method

The Endoscopy Software Unisoft and the Radiology Archive System RIS in UHL were examined for all MRCP and ERCP performed in (January to December 2020) for suspected CBD stones.

Results

A total of 116 ERCPs were performed where radiology was reported as showing likely biliary tract stones.Median age was 70 years and 72 (62%) were male patients.Median waiting time of booking to performance of scan was 1 day and of scan to ERCP was 5 days. Median stone size of 116 scans was 9mm and median CBD size was 10mm.Most frequent reported sites of CBD stone on scans were distal (N=66),proximal(N=5) and mid CBD(N=4) respectively. Of 116 ERCPs performed,76 (65%) was positive for stone and remainder of 40 ERCPs(35%) were negative for stone.

Conclusions

In this study, 35% of ERCPs done on suspicion of stones reported at MRCP did not reveal any stones. This is a concern as cannulation of the biliary system is associated with post-ERCP complications and can cause significant morbidity and even mortality.This risk to patients could be avoided by having EUS available to confirm the presence of stones.

ABSTRACT 37 (21S123)

Investigating the increased prevalence of VTEC colitis at University Hospital Galway

Author(s)

A. Alvain, D. Keady, V. Byrnes

Department(s)/Institutions

University Hospital Galway

Introduction

VTEC are a subgroup of Escherichia coli, present in the gut of ruminants, which, by oro-fecal transmission, can lead to hemorrhagic colitis and Haemolytic Uraemic Syndrome (HUS). Ireland has a rising incidence of VTEC infections and the highest in Europe.

VTEC is more prevalent during the summer.

Aims/Background

It was anecdotally noted that cases of VTEC colitis were unusually common at University Hospital Galway (UHG) in the summer of 2020. It was hypothesised that the Covid-19 pandemic lockdowns impacted behaviours explaining this observation. The aim of this study was to establish the demographic of VTEC cases at UHG in 2020, measure hospital burden and attempt to identify factors.

Method

A list of VTEC detected stool samples at UHG for 2020 was retrieved. Data collected included patient ID, date of sample, sample type, age, living area, presenting complaint, lengths of stay (LOS), and complications, was collected.

Results

25 patients had a VTEC colitis at UHG in 2020. 15 were children, 10 were adults. 74% were from rural areas. 21 cases occurred between May and October. August was the peak month with 7 cases. 10 patients had hemorrhagic colitis. 8% developed HUS. 19 patients were admitted making a total LOS of 113 days.

Conclusions

The total LOS shows a significant hospital burden. Reducing the prevalence of infection would decrease hospital burden. A correlation with the Covid-19 pandemic lockdowns was not found. Given most patients were from rural areas, cattle farming may be a more valid hypothesis in explaining the increased presentation.

ABSTRACT 38 (21S124)

Impact of Covid-19 on the out of hours (OOH) endoscopy service in theatre in a tertiary hospital

Author(s)

Yousuf, H; Boland, K; Cheriyan, D

Department(s)/Institutions

Department of Gastroenterology, Beaumont Hospital

Introduction

The out of hours (OOH) endoscopy service is a potential life saving service, for patients who require immediate endoscopic intervention

Aims/Background

To review outcomes for patients undergoing endoscopic intervention, in OOH service To assess if there was an impact on this service from the Covid-19 pandemic

Method

All endoscopic procedures carried out OOH in a theatre setting over a twelve month period.

Results

52 patients had endoscopic procedures done in OOH setting over a 12 month period from September 2019-2020. Of them, 21% were female. Median age was 62 years. The most common indication was dysphagia followed by upper gastrointestinal bleed(UGIB). 16 cases of UGIB were recorded , 4 were variceal bleeds who had intervention with endoscopic band ligation. 8 were bleeds from ulcers, which were treated appropriately, and two went on to have surgery. There were 27 procedures done during April to September 2020 when the impact of Covid-19 was severe on our routine services , and 25 procedures done during the months of September 2019 to April 2020, when the impact was not as severe.

Conclusions

31% of procedures were done for upper GI bleeds, nearly all (88%) of these patients were unstable who required ICU/HDU care with a 30 day mortality in this cohort of 14% (n=2). The rate of complications was low, with only 3 patients re admitted within 6 months (6%), and overall 30 day mortality of 4% (n=2). Impact of Covid-19 on this life saving service was generally minimal, with similar numbers of patients presenting during both the periods

ABSTRACT 39 (21S125)

Methadone related asymptomatic bile duct dilatation in an Irish HCV cohort

Author(s)

Sopena-Falco J*, Skeehan S**, Feeney E***, McCormick A*, Houlihan D*

Department(s)/Institutions

* Liver Unit, SVUH ** Radiology Department, SVUH *** Infectious Disease, SVUH

Introduction

Morphine related biliary dyskinesia is a well-documented effect. Methadone is a synthetic opiate that has a half-life of 14 hours and is not addictive. Previous reports have reported a common bile duct (CBD) dilatation prevalence between 8.3% to 22.5% in patients on methadone. Most of the clinicians are unaware of this relationship, which causes a burden on secondary investigations in order to rule out pancreatico-biliary malignancy.

Aims/Background

Determine the prevalence of asymptomatic CBD dilatation in patients with chronic HCV infection who are on methadone. CBD dilatation is defined as a CBD diameter ≥ 7mm.

Method

Retrospective review of patients who attended HCV clinic and had abdominal imaging performed. Patients with previous cholecystectomy were excluded from the study.

Results

205 patients with HCV infection attending the HCV clinic were on methadone treatment, of whom 74.6% (n:153) had had abdominal imaging during their follow-up. 77,8% were male with a mean age of 41,3 (std± 8,03) and 43.1% were cirrhotics. 40 patients (26.1%) had an incidental finding of biliary dilatation, with a mean diameter of 9.98mm (7-22mm), 11 also had intrahepatic biliary dilatation and 10 also had pancreatic dilatation (mean 4,3mm; std±1,3). 5% (n:2) had cholestatic liver tests. 18% of the patients completed workup with MRCP and/or EUS and just 1 patient (n:2.5%) had CBD stones. Age and cirrhosis where associated with the presence of CBD dilatation.

Conclusions

CBD dilatation is common in patients on methadone. Further investigations should not be performed if patients are asymptomatic and cholestatic parameters are non-existent.

ABSTRACT 40 (21S126)

Introduction Of Abdominal Paracentesis Proforma to Improve The Documentation Of Ascitic Tap in Tertiary Referral Hospital

Author(s)
SI.Bhutta1,H.Akhtar1,T.Sheehan1,C.Constigan1,C.Patterson1,M.Moloney1,MM.Skelly1,PK.Maheshwari1
Department(s)/Institutions
Department of Gastroenterology, University Hospital Limerick(UHL).

Introduction
Abdominal paracentesis is a common procedure performed in patients with cirrhosis with ascites. It is pivotal for trainees to have knowledge of practicalities and documentation of the procedure, therefore, we are introducing an Abdominal Paracentesis proforma according to BSG and European guidelines.

Aims/Background
Introduction of abdominal paracentesis proforma for improving quality of procedural documentation at UHL.

Method
We determined sixteen points of scoring for documentation informed by guidelines, a survey regarding the experience of 24 trainees, and baseline documentation of 10 procedures. The abdominal paracentesis proforma (primary driver) was then introduced and uploaded to the NCHD application of the hospital. A PDSA cycle was conducted after every 5-procedure based on the scoring of 16 key elements.

Results
A score of the initial 10 pre-Proforma procedures ranged from 4 to 8, meaning compliance with 16 key elements ranged from 25%-50% and the median score was 6. Following the introduction of proforma, in PDSA-1 cycle score ranged from 8 to 16, with compliance, therefore, improving to 50%-100% and the median score was 12. Repeat PDSA cycle-2, a score of compliance with 16 key elements ranged from 10 to 16 (62%-100%) and a median score of 16. In the 3rd PDSA cycle score of compliance ranged from ranged between 14 to 16(87% to100%) and the median score was 16.

Conclusions
This intervention proved to be successful in increasing the quality of documentation >80% in the 3rd PDSA cycle. However, We will repeat a 4th PDSA cycle to check the sustainability

ABSTRACT 41 (21S127)

Rates of admission of acute IBD flares during the COVID-19 Pandemic in a Tertiary Healthcare Setting

Author(s)
K Hazel, E Glynn, K Boland & A O'Toole
Department(s)/Institutions
Department of Gastroenterology, Beaumont Hospital, Dublin 9, Ireland

Introduction
Environmental tiggers are thought to contribute to Inflammatory Bowel Disease flares. The COVID-19 pandemic and resulting lockdown led to an emphasis on outpatient care, fewer presentations to hospital for non-COVID-19-related illnesses, changes in work practices and a reduction in air pollution.

Aims/Background
To determine the impact of these changes on hospital admissions with acute IBD flares.

Method
The Hospital In-Patient Enquiry (HIPE) Department provided records of all patients admitted with acute IBD flares during the first Irish lockdown from March to May 2020 and for the corresponding period in 2017, 2018 and 2019. Electronic patient records were used to assess patient demographics, biochemical markers, imaging, medication use and outcome.

Results
101 patients were admitted with an acute IBD flare. This was a marked reduction when compared to the corresponding period in the previous three years ($p<0.0001$). Despite the rates of admission decreasing in this period, rates of colectomy were significantly increased ($p<0.0001$)

Conclusions
We demonstrated a significant decrease in hospital admissions for acute IBD flares during the first wave of the pandemic. We postulate that changes in environmental triggers of IBD such as working from home and reduced stress levels in addition to reduced air pollution may account for this reduction. The increased rate of colectomy likely reflects a more severe presentation of IBD and patients' reluctance to attend the hospital at an early stage in their disease flare as well as non-adherence to prescribed IBD therapies due to a perceived COVID-19-related risk.

ABSTRACT 42 (21S130)

Supporting MMUH Endoscopy services during Covid-19

Author(s)
H Kerr, MC Byrne, J Cudmore, S. Byrne, A. Bohan, C. Lahiff, Z. Galvin, B. Kelleher, J. Leyden, S. Stewart, P. MacMathuna, G. Bennett
Department(s)/Institutions
1. Department of Gastroenterology, Mater Misericordiae University Hospital (MMUH) 2. Mater Private Hospital (MPH), Dublin, Ireland

Introduction
During COVID-19, from April-June 2020, the Health Authorities in Ireland procured private hospitals to help meet the need for urgent endoscopy procedures.

Aims/Background
The aims of this study were: 1. to determine if additional private hospital capacity was utilised effectively for endoscopy 2. to compare pathology and follow up rates between the two institutions.

Method
We analysed all documentation relating to 242 endoscopy procedures outsourced to the private institution (MPH). For the period of June 2020 we compared indications, follow up rates and pathology for outpatient endoscopy procedures performed in our public institution, MMUH (n=111) and MPH (n=104).

Results
197/242 (81.4%) procedures in 167 patients were completed. Non-completion was due to refusal or failure to attend (32) and illness (6). 102 patients (61%) were subsequently discharged to the GP and 39% of patients required hospital follow up. There was no significant difference between indications in both institutions (p=0.843). As shown in Table 1, rates of significant pathology in MPH vs MMUH were not statistically significant, 4% vs 7% ; p=0.315. There was no difference in follow up rates in MPH vs MMUH, 62% vs 51%, p=0.849.
Conclusions
Similar numbers of urgent outpatient endoscopy procedures were performed in our public and private institution. Although the endoscopy procedures performed in both institutions were deemed 'urgent', significant pathology was rare, between 4-7%, suggesting more stringent criteria for patient selection for endoscopy should be applied in the future. Despite the reduction in the burden of procedures on the public sector during the first wave, the arrangement of necessary follow up for the 39% of patients from the private hospital generated a substantial clinical and administrative workload on the already overstretched public system.

ABSTRACT 43 (21S133)

A Retrospective audit of biologic-centered care given to the Inflammatory Bowel Disease cohort of a Model 3 Hospital

Author(s)
Rajan M., Ismadi F., Neary B., O'Regan P.,
Department(s)/Institutions
Department of Gastroenterology, South Tipperary General Hospital
Introduction
The advent of biologics has revolutionised treatment of inflammatory bowel disease (IBD) in recent years. Although effective, their immunosuppressive effects predispose individuals to opportunistic infections. The British Society of Gastroenterology recommends screening for HepB, HepC, VZV, HIV and TB prior to biologic commencement, with subsequent annual review.
Aims/Background
To review adherence of biologic-centred care given to IBD patients commenced on biologics between 2006–2020 to the BSG Guidelines (2019) with regard to pre-biologic screening and follow-up.
Method
Candidates commenced on biologics between 2006–2020 were selected from Medical Investigations Clinic records. Exclusion criteria includes: biologic commencement in other centres, lost to follow up or discontinued treatment. Age, gender, annual follow-up status, year of biologic commencement and screening were sourced from electronic clinical and outpatient records and analysed. Ethical approval was not required. GDPR guidelines were followed.
Results
88 patients were eligible; 43 female, aged 17-76 years. 40 with Crohn's, 45 Ulcerative colitis, 3 indeterminate. 98% had either partial or completed pre-biologic screen. Of these, 81.8% were screened for >3 components (3=27%, 4=30.7%, 5=26.3%), with highest proportions for TB (93.2%), Hep B (85.2%) and VZV (80.7%). Of the completed screening, 85.7% were among patients commenced on biologics between 2016-2020. Pearson correlation between biologic commencement year and screening rate is 0.717 (p<0.001). 77% had annual review scheduled.
Conclusions
Virtually all IBD patients commenced on biologics had some form of pre-biologic workup, with our data reflecting significant improvement in standard of screening in recent years. Further assessment of compliance rates with cervical cancer screening programmes is considered for database completion.

ABSTRACT 44 (21S134)

An Evaluation of Early Inpatient Management of Inflammatory Bowel Disease Flares in a Tertiary Irish Hospital

Author(s)
C Walker, H Coyle, R Grainger, C Deane, N Breslin, D McNamara, A O'Connor, B Ryan, S O'Donnell
Department(s)/Institutions
Department of Gastroenterology, Tallaght University Hospital, Tallaght, Dublin 24
Introduction
Early and appropriate management of inpatient inflammatory bowel disease (IBD) flares improves patient outcomes. Best practice can be achieved by adherence to international guidelines.
Aims/Background
Audit our practice of early inpatient management of IBD flares against international standards of care, by measuring key performance indicators: venous thromboembolism (VTE) prophylaxis, c.difficile screening, nutritional assessment, analgesic prescribing, and early endoscopy.
Method
A retrospective audit of the first 7 days of admission for 50 patients who presented with diarrhoea without overt features of obstruction, and were admitted with suspected and later confirmed IBD flares, over a two-year period. C.difficile colitis in patients with known IBD was included. Charts were reviewed to obtain the relevant information.
Results
At admission, 78% of patients were prescribed appropriate VTE prophylaxis, and an additional 12% was prescribed later during admission. 74% of patients had stool sent for c.difficile, with an 8% positivity rate, at a median of two days. Dietetics reviewed 68% of patients with subsequent higher rates of haematinics and vitamin D levels checked. Analgesia: paracetamol (81%), buscopan (26%), and strong opioids (15%). 21% of patients with Crohn's disease were prescribed strong opiates, but none were continued post discharge. 82% of ulcerative colitis patients had endoscopy, at a median of 2 days.
Conclusions
This audit revealed good levels of early endoscopic investigation in ulcerative colitis patients. However, it highlighted the need for earlier and increased prescribing of VTE prophylaxis, increased testing for c.difficile and involvement of dietetics, and stricter reviews of analgesia. Continued NCHD education is vital to improving our practices.

ABSTRACT 45 (21S136)

Detecting Lynch Syndrome in a BowelScreen Population

Author(s)
J.Cudmore, L. Kumar, G. Cullen, G. Horgan, J.Aird, K. Sheehan, J. Leyden
Department(s)/Institutions
1. Department of Gastroenterology, Mater Misericordiae University Hospital 2. Department of Gastroenterology, St Vincents University Hospital
Introduction
Lynch Syndrome(LS), the most common cause of hereditary colorectal cancer(CRC), accounts for 2-4% of CRCs. LS is characterised by pathogenic mutations in MLH1, PMS2, MSH2, MSH6 and EPCAM genes, which are involved in the mismatch repair(MMR) pathway. Universal testing for LS, in all diagnosis of CRC, is recommended with microsatellite instability(MSI) testing or immunohistochemistry(IHC) for MMR proteins.
Aims/Background
To identify the number of CRCs, diagnosed through BowelScreen, tested for Lynch Syndrome and to examine the outcomes of testing.
Method
CRCs diagnosed through BowelScreen at two screening sites between 2015 and 2020 were identified. Histopathology reports were utilised to determine if tumors were tested for LS, the outcomes of the testing and if any further investigation was carried out on those with MMR deficiency.
Results
207 CRCs were identified. All CRCs in site A underwent LS testing with IHC compared to 68% of cases in site B. However, in 2019 and 2020 94% of cases at site B were tested. 6.7% of CRCs had a deficiency in MMR proteins. Loss of MLH1/PMS2 accounted for 93% of abnormalities with 84% of these cases determined to be sporadic cancers based on the finding of either a BRAF V600 mutation(46%) or hypermethylation of the MLH1 promoter region(38%). The only other abnormality identified was loss of MSH6(n=1). Of 3 patients offered germline testing, 2 proceeded with neither having a germline mutation.
Conclusions
Our study has shown that from 2019 almost all CRCs diagnosed through BowelScreen were tested for LS, in keeping with current guidelines. Although only a small proportion had a deficiency in MMR proteins it is important that resources and infrastructure are in place to follow up and manage these patients.

ABSTRACT 46 (21S137)

The Impact Of The COVID-19 Pandemic On Lower Gastrointestinal Adenocarcinoma Detection And Mortality In A Model 3 Hospital

Author(s)
O. Fagan, K. Van Der Mewre, T. Muller, D. Crosnoi, V. Parihar, C. Steele
Department(s)/Institutions
Gastroenterology Department, Letterkenny University Hospital
Introduction
The COVID-19 pandemic has disrupted cancer and endoscopy services worldwide. Numerous reports indicate reduced access to cancer diagnostic services during the pandemic.

Aims/Background
- To compare new lower gastrointestinal (GI) adenocarcinoma diagnosis during COVID restrictions (February 2020-February 2021) with those diagnosed in pre-COVID times (February 2019-February 2020). - To compare cancer staging and mortality between the COVID and Pre-COVID groups
Method
We examined and compared MDM records for February 2019-February 2020 and Feb 2020-Feb 2021. Data collected from electronic health records included gastrointestinal endoscopy, surgery, oncology and radiotherapy.
Results
Sixty-six of 224 cases discussed at the GI MDM were diagnosed with lower GI adenocarcinomas February 2020-2021 (COVID affected period) compared with 86 of 255 cases discussed at GI MDM during February 2019-2020 (pre-COVID). This represents nearly a 25% reduction in lower GI adenocarcinoma diagnosis. Similar stages of cancer were noted in the COVID affected period, with 28% diagnosed at stage 4 disease versus 27% stage 4 diagnoses in pre-COVID times. Higher mortality was seen in the pre-COVID group with a rate of 19% compared with 3%.
Conclusions
Full impact of the COVID pandemic on diagnosis, treatment and outcomes of GI cancers, particularly colorectal cancer, has yet to be fully established. These preliminary data give a worrying insight into reduced detection of colorectal cancer with unknown stage disease at diagnosis and thus unknown implications for outcomes. We would strongly recommend national correlation for all colorectal sites to establish the magnitude of this.

ABSTRACT 47 (21S138)

Endoscopy Guidelines for Triage and Surveillance – Can We Improve Adherence ?

Author(s)
J. Cudmore, S. Stewart, H.Kerr, P. MacMathuna, J. Leyden, B. Kelleher, C. Lahiff, J. Mulsow, G. Bennett.
Department(s)/Institutions
Department of Gastroenterology, Mater Misericordiae University Hospital
Introduction
Encouraging adherence to agreed triage guidelines is a critical facet of endoscopy waiting list management, particularly in the current climate of COVID-19. Unfortunately, few such guidelines exist and there is considerable variability in their application.
Aims/Background
The aim of this study was to determine if the use of locally

developed flowsheets, created using existing guidelines, could aid in standardisation of endoscopy triage and surveillance in a single endoscopy unit.

Method

Existing international (BSG) and national (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 colorectal cancer. A baseline quiz involving clinical scenarios was devised and endoscopy users were invited to participate. The quiz was then retaken after reviewing the relevant flowsheets.

Results

20 endoscopy users took part. The mean number of correct answers increased significantly after reviewing flowsheets (45±11% v 71±12%; p=<0.0001). Similar improvements were noted across both the triage and surveillance sections (25±15% v 25±18%; p=0.8368), and between nursing and medical staff (24±18% v 27±15%; p=0.7075). Consultants had more correct answers than nurses at initial assessment (56±5% v 42±12%; p=0.054) but there was no significant difference after reviewing the flowsheets (71±10% v 66±14%; p=0.5566).

Conclusions

We have shown a significant improvement in triage accuracy after reviewing appropriate guideline flowsheets among medical and nursing staff. While medical staff performed better at initial assessment, there was no significant difference between medical and nursing staff scores after reviewing the guidelines. We conclude that all staff should refer to guidelines when triaging clinical requests. In addition it reassures us that nurses, with appropriate guidelines as reference, can be utilised to support or replace doctor-led triage.

ABSTRACT 48 (21S139)

Retention of Small Bowel Video Capsule Endoscopy- Experience of an Irish Tertiary Referral Centre

Author(s)

Siofra Bennett, John O'Grady, Anne Fennessy, Aidan Kaar, Lorraine Nolan, Lucy Quinlivan, Martin Buckley

Department(s)/Institutions

Department of Gastroenterology, Mercy University Hospital, Grenville Place, Cork

Introduction

Small bowel capsule retention is rare, approximately 2%, defined as visible retention on plain film of abdomen (PFA) after 14-days. Currently PFA is performed if the capsule is not seen to reach the large bowel during recording. Alternatively, for upper-gastrointestinal (UGI) capsule studies, risk of retention is determined if the capsule fails to reach the small bowel during recording

Aims/Background

Given the similar physical specifications of the capsules (Medtronic) used, we hypothesize whether 14-day PFA is no longer required for small bowel capsules not observed in the large bowel

Method

The use of patency capsule in our lab allows careful selection of small bowel capsule studies to minimise risk of retention. All PFAs performed over a 5-year period were reviewed to determine if careful selection and use of patency negates the need for capsule retention PFA screening.

Results

688 small-bowel capsules were performed during the study period, 3% had prior patency capsule. 31 PFAs with a query of capsule retention were performed during the study period on 28 patients. This included 15 females, and the median age was 53.5 years. None of the films demonstrated evidence of capsule retention.

Conclusions

Our data suggest that 14-day PFA may no longer be required for capsules not seen to reach the large bowel. Advice regarding symptoms of capsule retention and precaution with magnetic resonance imaging, similar to current UGI capsule advice, may suffice. This may reduce the burden on radiology imaging slots and, in particular, eliminate unnecessary radiation exposure and repeat hospital attendance for patients.

ABSTRACT 49 (21S140)

Clinical Nutrition Education: Attitudes and Unmet Needs. An initiative from the Irish Society of Nutrition and Clinical Metabolism

Author(s)

1,2. Dr Karen Boland 3. Dr Cara Dunne

Department(s)/Institutions

1. Department of Gastroenterology, Beaumont Hospital , Dublin 2. School of Medicine, Royal College of Surgeons in Ireland, Dublin 3. Department of Gastroenterology, St James Hospital, Dublin

Introduction

The Nutrition Education in Medical Schools (NEMS) was launched in 2019 with cooperation from 12 European universities, aiming to introduce a minimum standard for clinical nutrition education in the undergraduate medical curriculum.

Aims/Background

IrSPEN commissioned this survey of attitudes and needs with regard to clinical nutrition from physicians in Ireland.

Method

A 34-question survey was generated and distributed among hospital and community-based physicians practicing in Ireland. Attitudes to nutrition and opinions with regard to undergraduate and postgraduate training in this field were elicited.

Results

To date, 95 physicians have responded, 79% under 40 years and 62% female. The majority (91%) work in the hospital setting. Most respondents (45%) were at registrar grade, and 38% were consultants. Specialities represented were mixed including 40% gastroenterology, 9% surgical. When questioned about their own practices, one in 5 respondents are rarely involved in nutritional assessment. With regard to nutrition advice, 20% deliver daily, 35% weekly, 18% monthly and 25% less than once per month. Although over half are regularly or sometimes involved in management of total parenteral nutrition (53%), 55% reported lack of confidence in managing these patients. Regarding their education, 80% of respondents reported

that undergraduate training did not prepare them for their practice and 88% indicated that clinical nutrition should be incorporated into postgraduate training.

Conclusions

This survey demonstrates the heterogenous approach to nutrition medical education. IrSPEN is working with universities to develop this aspect of the curriculum with changes underway at UL and RCSI

ABSTRACT 50 (21S141)

Polypectomy of Lesions ≥10mm Are We Doing It Right and Are We Clearing the Margins?

Author(s)

Neasa Mc Gettigan, Mohamed Adam, Aidan Harhen, Edric Leung, Jane Burnes, James Bergin, Ann Cooney, Nicky Kennedy, Syafiq Ismail, Margaret Walshe, John Keohane, Subhasish Sengupta

Department(s)/Institutions

Our Lady Of Lourdes Hospital, Drogheda

Introduction

Polypectomy is an essential skill for endoscopists performing lower endoscopy. Significant differences in polypectomy techniques and quality have been reported between endoscopists. Aims of polypectomy include complete safe removal with retrieval for histological analysis.

Aims/Background

To review the quality and safety of polypectomy of lesions ≥10mm.

Method

A 5 year review was performed of endoscopy/histology reports of polyps ≥10mm removed during endoscopy. Data focused on endoscopist's reporting and histological assessment.

Results

A total of 239 polyps were identified, n= 39 were excluded. The mean age of patients was 64.9yrs and 56% were male. The most common location was sigmoid 36% (n=68), followed by ascending 18% (n=35). 53% had other polyps, mean=2.4 (95% CI: 1.88, 2.89). 50% (n=95) of endoscopists reported polyp size in the text and 7% (n=14) used the Paris classification, 2.6% (n=5) the NICE classification. There was a significant difference between endoscopic/histologic size, p-value <0.005. Pedunculated polyps (n=69) were the most common 36%, flat lesions 32% (n=61), sessile 31% (n=60). TVAs were the most common histological finding 53% (n=116) with 13% (n=15) showing HGD. Adenocarcinoma was found in 6% (n=11). Polyp retrieval occurred in 98% (n=187), of the 'enbloc' resections 87% (n=63) had clear margins. Use of adrenaline was specified in 18% (n=34) of cases. 7% (n=14) patients were on anticoagulation, restart guidance was given for 36% (n=5). Bleeding occurred in 10% (n=19), no perforations reported.

Conclusions

A high rate of polyp retrieval and clear margins were evident with low complication rates. Standardised reporting and inspection of complex polyps including NBI/pit pattern should be implemented.

ABSTRACT 51 (21S143)

Intraprocedural Bleeding During Polypectomy- When Does It Happen and How Are We Managing It?

Author(s)

Neasa Mc Gettigan, Aidan Harhen, Edric Leung, Mohamed Adam, Jane Burns, Jame Bergin, Ann Cooney, Nicky Kennedy, Syafiq Ismail, Margaret Walshe, John Keohane, Subhasish Sengupta

Department(s)/Institutions

Our Lady of Lourdes Hospital Drogheda

Introduction

Bleeding is the most common complication of polypectomy and can be categorized as intraprocedural bleeding (IPB) or delayed bleeding. IPB occurs in up to 11% during EMR. Risk factors for IPB include larger lesions, Paris 0-IIa/b Is, villous or tubulovillous histology.

Aims/Background

To review the management of intraprocedural bleeding during polypectomy in a JAG accredited Bowel Cancer Screening unit and to identify common patient characteristics in IPB.

Method

A review of polypectomy reports in the past 5 years to identify patients who underwent polypectomy for lesions ≥10mm with the occurrence of IPB. Minitab17 was used to carry out statistical analysis.

Results

Polypectomy was carried out in 191 patients, 19 of which experienced IPB (10%). The mean age was 68.2yrs (95%CI:63.6, 72.7) and 53% were (n=10) female. The majority of polyps were 10-30mm (n=16, 85%), the mean histological size was 15.6mm (95%CI:12.2, 18.9). The most common site was right sided- ascending 37% (n=7), caecum (n=2), hepatic flexure (n=1). The most common histological lesion was TVA 53% (n=10), 9 with LGD; 1 HGD. There was one adenocarcinoma in a 25mm rectal lesion. 53% (n=10) were removed enbloc- 2 of which were removed by hot snare. Sessile (n=8) and flat lesions (n=10) were most common. Adrenaline use was reported in 26% (n=5). Haemostatic clips were used in 84% (n=16). Soft coag was used in 21% (n=4), APC in 5% (n=1) patient and Endoclot in 11% (n=2).

Conclusions

IPB in our patient cohort occurred proportionate to that reported in the literature. IPB were managed endoscopically with the most common technique used being haemostatic clipping.

ABSTRACT 52 (21S146)

Improved Efficiencies for Patients Attending a Dietitian First Gastroenterology Clinic (DFGC) in Naas General Hospital.

Author(s)

Holly Guiden(1), Patricia Jane Briscoe(2), Dr. Ion Cretu(2)

Department(s)/Institutions

(1)Department of Nutrition and Dietetics, Naas General Hospital, Naas, Co. Kildare. (2)Department of Gastroenterology and Endoscopy, Naas General Hospital, Naas, Co. Kildare.

Introduction

It is estimated that approximately 40% of all gastroenterology referrals are suitable for dietetic intervention. Numerous gastrointestinal disease states require nutritional counselling and disease-specific advice from a registered dietitian.

Aims/Background

To evaluate the efficacy of a DFGC clinic and associated referral pathways to improve efficiencies and assess its impact on endoscopy and outpatient services in a regional Irish hospital.

Method

Patients were recruited from outpatient and endoscopy waiting lists. Initial triage was completed by the consultant gastroenterologist or endoscopy triage nurse. The dietitian provided an initial assessment, tailored nutritional advice and management strategies for patients, under the clinical governance of the gastroenterology consultant. Patients who were not deemed suitable to be managed exclusively by the dietitian progressed to a consultation with the gastroenterologist. Avoidable scopes and discharge outcomes were recorded.

Results

A total of 178 patients were referred to DFGC. A total of 74 patients were discharged from the gastroenterology service. This included prevented endoscopy procedures as follows: OGD - 25 prevented; Colonoscopy: 14 prevented; OGD & Colonoscopy: 4 prevented. A total of 59 patients were re-referred to gastroenterology (OPD/Endoscopy): An additional 19 patients were referred by the dietitian to the IBS clinic thus diverting them from the routine gastroenterology clinic. Twenty-six patients are pending assessment.

Conclusions

The DFGC is an initiative that was established in response to increased gastroenterology clinical demands. Evidence suggests numerous cost-saving benefits of the DFGC with many positive outcomes for stakeholders, including decreased waiting times and costs, correct patient diagnosis, timely interventions, enhanced patient health outcomes, and excellent patient satisfaction.

ABSTRACT 53 (21S147)

Establishment of an Irritable Bowel Syndrome (IBS) Pathway to help reduce and streamline Gastroenterology outpatient and endoscopy services in Naas General Hospital.

Author(s)

Holly Guiden(1), Dr. Catherine Kinsella(2) and Dr. Ion Cretu(2)

Department(s)/Institutions

(1)Department of Nutrition and Dietetics, Naas General Hospital, Naas, Co. Kildare. (2)Department of Gastroenterology, Naas General Hospital, Naas, Co. Kildare.

Introduction

Irritable Bowel Syndrome (IBS) remains one of the most common gastrointestinal disorders seen by clinicians, with approximately 30% being referred on to specialist services. Advances have been made in understanding its complex pathophysiology, resulting in its re-classification as a disorder of gut-brain interaction.

Aims/Background

To evaluate the efficacy of an IBS management pathway, and its impact on endoscopy and out-patient services in a regional Irish hospital.

Method

Patients recruited from outpatient and endoscopy lists were medically assessed. Those who met the Rome IV criteria for IBS diagnosis received tailored dietetic advice on condition management. Avoidable colonoscopies and discharge outcomes were recorded.

Results

Total of 26 patients (16.6%) out of 157 patients have completed the pathway thusfar. A further 12 patients (7.6%) did not respond and were removed from the waiting lists. Of the 26 patients seen, 5 were recruited directly from endoscopy, and 21 patients from the outpatient waiting list. Of the 26 patients seen, 23 (14.7%) were deemed suitable for dietetic management, and 3 (1.9%) were unsuitable. Seven (4.5%) patients required referral back to gastroenterology (3 to OPD, 3 colonoscopy, 1 OGD). A further 119 (75.8%) patients are in the process of completing the pathway.

Conclusions

The positive outcomes from this pathway prove the efficacy of integrated care for IBS patients, by preventing unnecessary investigations and redirecting patients from the general gastroenterology clinics. This provides a practical framework for evidence-based management of these patients. The pathway has resulted thus far, in the removal of 34 patients from the scope and/or outpatient waiting lists.

ABSTRACT 54 (21S148)

Upper Gastrointestinal Bleeding (UGIB) Inpatient Referrals – An Audit On Identifying Gaps For Optimal Gastroscopy Delivery

Author(s)

R.Varley, C. Dunne, K Hartery, D Kevans, F MacCarthy, S. McKiernan, D.O'Toole, B Christopher

Department(s)/Institutions

Trinity Academic Department of Clinical Medicine & Gastroenterology, St James's Hospital, Dublin

Introduction

Acute upper GI bleeding (UGIB) is a potentially life-threatening abdominal emergency. BSG and ESGE advocate endoscopy to be performed within 24 hours as early intervention is associated with better prognosis with reduced morbidity and mortality. Patient risk stratification is crucial and includes pre-assessment scoring systems incorporating parameters predicting haemodynamic stability.

Aims/Background

The primary study aims were to define the volume of endoscopy referrals for upper GI bleeding and identify factors associated with time to endoscopy in patients with UGIB. A secondary aim was to assess the quality of referral information by evaluating the proportion of patients with a calculated Glasgow Blatchford score (GBS) and the proportion of referrals formally discussed by the referring team with the endoscopy service.

Method

Prospective study was conducted over an 8-week period from February to April 2021. All inpatient UGIB referrals were triaged by a Consultant Gastroenterologist in the endoscopy unit. A questionnaire was completed the Consultant Gastroenterologist and triaging endoscopy nurse at the time of receipt of referral.

The electronic patient record & endoscopy reporting system were interrogated to collect clinical and endoscopic data. Information on upper GI endoscopy performed in ICU and operating theatre settings, for UGIB, during the study time period were collected.

Results

63 upper GI endoscopies for inpatient UGIB were performed during the study period. 54 (86%) in the endoscopy unit, 4 (6%) in ICU and 5 (8%) in the operating theatre out-of-hours. 75% (n=47) upper GI endoscopies were performed within 24 hours of referral, 25% (n=16) upper GI endoscopies were performed after an interval of >24hrs. Median time from referral to endoscopy was 7 hrs (1.5 - 48). Reasons identified for an upper GI endoscopy being performed at an interval > 24 hours included: weekend / bank holiday (n=10), requirement for blood product resuscitation (n=1), infection status (n=2), patient refusal (n=1) and unclear reason (n=2). GBS was documented with 20% (n= 12) of referrals. Median GBS was 12 for cohort undergoing upper GI endoscopy in operating theatre setting compared to 8.5 (1-16) for cohort undergoing upper GI endoscopy in endoscopy unit. 52% of UGIB referrals to endoscopy were discussed with triaging endoscopist.

Conclusions

In a large academic teaching hospital, referral for upper GI endoscopy with an indication of UGIB is common. The vast majority of endoscopy, performed to assess UGIB, is performed in the endoscopy unit with a minority performed in ICU & operating theatre settings. Patients requiring endoscopy in the ICU or operating theatre setting have more severe upper GI bleeding as assessed by GBS. Education and implementation of an UGIB care pathway are likely to improve endoscopy triage, pre-procedure care and timely endoscopy access in patient with UGIB.

ABSTRACT 55 (21S149)

Improving Inflammatory Bowel Disease Care: Implementation of a Care Pathway in an Acute Hospital

Author(s)

Dr. C Moloney, Dr. A Fennessy, Dr. R Hughes, Dr. J O'Grady, Dr. H Zaid, Dr. M Buckley, Dr. C Moran, Dr. J McCarthy

Department(s)/Institutions

Mercy University Hospital, Cork

Introduction

Acute severe colitis is a potentially life threatening condition that requires specialist input from gastroenterology and colorectal surgeons. In an on-call setting, gastroenterology input may not be readily available, and as such it is important that medical non-consultant hospital doctors (NCHDs) implement important aspects of management at presentation (within 12 hours) which are in line with current guidelines.

Aims/Background

This study aimed to assess the knowledge of NCHDs in an acute hospital (Mercy University Hospital) regarding the management of Inflammatory Bowel Disease (IBD) patients presenting with acute colitis, and establish if knowledge improved after education and introduction of a care pathway.

Method

Medical NCHDs were asked to complete an anonymous questionnaire on the management of acute severe colitis. Participants (N=25) were selected by convenience random sampling. Subsequent to this, we conducted an educational session and introduced an IBD care pathway for use in the on-call setting, in line with ECCO (European Crohn's and Colitis Organisation) guideline. Our aim was to establish if these interventions improved NCHD knowledge. Responses before and after intervention (presentation at grand rounds, introduction of IBD admission pathway in ED) were compared.

Results

8 out of 10 points of information assessed demonstrated improvements in correct response rate, and average scores improved from 6.1 to 6.72 (out of 10).

Conclusions

NCHD knowledge and awareness of key aspects of the management of acute severe colitis was improved following educational interventions and the introduction of an IBD admission pathway.

ABSTRACT 56 (21S151)

A Prospective Audit of 5-ASA use in Crohn's Disease and The Costs Incurred

Author(s)

C Hurley; C McShane; A Marrinan; D Sawbridge; SA Zulquernain

Department(s)/Institutions

Department of Gastroenterology & Hepatology, Cork University Hospital, Wilton, Cork

Introduction

Oral 5-ASAs are now mostly known to be ineffective at maintaining remission in Crohn's Disease (CD) and can cause both adverse reactions and expense.

Aims/Background

We evaluated the number of CD patients maintained on 5-ASAs and associated cost implications.

Method

This prospective audit was carried out on CD patients attending our IBD clinic over 4 weeks. Baseline characteristics and current medications were obtained via chart review. A flare was defined as need for steroids, hospitalisation or treatment escalation.

Results

255 patients attended during this time (104 with CD). 30 (29%) of the CD patients were prescribed 5-ASA. Of these, 33% were female, median age 47 years (range 20-72years), median age at diagnosis 28 years. 37% had a previous resection. 3% had a flare in the past year. 100% were prescribed Mesalazine. 47% had 5-ASA monotherapy. 47% dual therapy; 37% 5-ASA and monoclonal antibody, 10% 5-ASA and thiopurine, 3% 5-ASA and oral steroid. 3% were on 5-ASA, monoclonal antibody and topical steroid. The average cost of Mesalazine maintenance therapy is €40/month (range €22.65-€55/month), representing an average cost of €480/patient/year.

Conclusions

A high number of CD patients remain on a 5-ASA despite a supposed lack of efficacy and significant financial cost incurred. This is

however in keeping with recent European cohort studies where up to 60% of CD patients had been prescribed a 5-ASA. Studies evaluating the efficacy of 5-ASA in CD have had mixed results, while others have suggested a 5-ASA dependence. This likely contributes to the ongoing prescription of 5-ASA in CD.

ABSTRACT 57 (21S152)

Age at Diagnosis Associated with Mortality in Patients with Hereditary Hemochromatosis

Author(s)
Foley C1., Diong S1., Colclough F1, Ryan JD1 .
Department(s)/Institutions
1. Hepatology Unit, Beaumont Hospital, Dublin 9.
Introduction
Hereditary Haemochromatosis (HH) a disorder of iron metabolism, is the most common autosomal recessive disorder in Caucasians, with Ireland having the highest prevalence in the world. Despite this, no formal screening exists for the condition. Treatment by therapeutic phlebotomy reduces morbidity and mortality.
Aims/Background
This study aimed to identify factors associated with mortality in HH patients attending a Hemochromatosis service.
Method
1043 patients with HH were identified and assessed for factors associated with mortality.
Results
1043 patients with HH were identified; 65% were male and 35% were female. Fatigue was the most common presenting complaint (37%), with family history (22%), incidental finding of raised iron studies (16%) and screening programs (13%) being other common causes of referral to the service. Homozygosity for C282Y was the most common HFE genetic mutation in this cohort (68%) with compound HFE heterozygosity accounting for 26%. Median Ferritin at diagnosis was 332 ug/L (range 22-4655ug/L). Mean Transferrin saturation at diagnosis: 68% (SD+/-17). At the time of assessment, 0.03% (30/1043) of patients had died, with a median follow up time of 10 years (range 0.06-26). Of those that died, 70% were male, 43% were homozygous for C282Y, and 36% were compound heterozygotes. Median ferritin at diagnosis was 265ug/L (dead) vs 264ug/L (alive). Median age at diagnosis was significantly higher in those that died, 63.9yrs vs 49.1yrs for those alive at follow up ($p<0.0001$). No significant difference was observed between groups based on gender, HFE genotype, or serum ferritin at diagnosis.
Conclusions
In a large sample of patients with patients with Haemochromatosis, age at diagnosis appears to be associated with death. Further investigation is warranted to detail the causes of death, and to determine whether HH screening in an at-risk population would reduce morbidity and mortality.

ABSTRACT 58 (21S153)

ANP Led Clinic Maintains Standards Of Care For IBD Patients During Covid-19 Pandemic

Author(s)
Siofra Bennett, John O'Grady, Anne Fennessy, Catriona O'Sullivan, Sarah Gleeson, Carthage Moran, Martin Buckley, Jane McCarthy, Kathleen Sugrue
Department(s)/Institutions
Department of Gastroenterology, Mercy University Hospital, Cork
Introduction
During the third wave of the covid-19 pandemic, hospital management cancelled all outpatient clinics. After discussion with the gastroenterology consultants, the advanced nurse practitioner (ANP) conducted review of the inflammatory bowel disease (IBD) outpatients for a defined period.
Aims/Background
To quantify the number of outpatient clinic appointments prevented from cancellation.
Method
3 gastroenterology clinics are held weekly. The ANP identified the IBD patients due to attend using the letters on the online dictation service (TPRO) and records of patients maintained by the service. From there the patients were telephoned for a virtual consultation. We then audited the outcomes from these interactions.
Results
In total 336 patients were phoned over a two month period (Jan, Feb 2021). Of these, 215 were managed with ANP clinical management. The other 121 (36%) were discussed with the consultant. Reasons for consultant discussion included decision to start or switch biologic agent, a decision regarding dual-biologic therapy or complex cases /comorbidities that were outside the scope of practice of the ANP.
Conclusions
336 clinic appointments were prevented from being cancelled. This ensured ongoing safe care and prevented a future backlog and potentially additional hospital attendances. It also demonstrates the benefit of virtual clinics, allowing us to increase access to face-face clinic appointments clinics for the complex IBD patients. This maintained the usual standard of IBD care during a challenging time. ANP-led clinics are a safe and acceptable way to manage IBD and this could potentially be expanded in future.

ABSTRACT 59 (21S154)

Eating Disorders and the Dentist: Diagnosis, Considerations and Referral

Author(s)
Smorthit, Kelly 1., Sawbridge, David 2. and Fitzgerald, Rhian 3.
Department(s)/Institutions
1. Department of Orthodontics, Lancashire Teaching Hospitals NHS Trust, Preston, Lancs., UK 2. Department of Gastroenterology and Hepatology, Cork University Hospital, Cork 3. Department of Orthodontics, University College Cork
Introduction
Eating disorders have a significant impact on patient morbidity and

mortality and on both dental and orthodontic outcomes. Management is complex and requires careful consideration and team working. Dentists will benefit from an appreciation of the aetiology and oral manifestations of these mental health conditions to ensure appropriate patient treatment.

Aims/Background

The aims were to describe the oral, psychological and systemic complications of eating disorders and to enable clinicians to recognise their features, with a focus upon dental care.

Method

A literature review was performed. Articles published on PUBMED and MEDLINE relevant to orthodontics and eating disorders were reviewed. Key information was extracted, and the relevant evidence for the dentist summarised.

Results

Eating disorders may present to the dentist in specialist or hospital practice, either undiagnosed or as a co-morbidity. Orthodontists and other dentists may benefit from an appreciation of these potential diagnoses, the orthodontic implications and have the confidence to refer their patients to the necessary services.

Conclusions

Eating disorders have a significant impact on patient morbidity and mortality. This cohort of patients is not suitable for orthodontic treatment while their disease is active. The impact of a developing eating disorder can adversely affect orthodontic treatment.

ABSTRACT 60 (21S155)

A Retrospective Audit Of A Nurse-Led Inflammatory Bowel Disease (IBD) Service

Author(s)

Siofra Bennett, John O'Grady, Anne Fennessy, Catriona O'Sullivan, Sarah Gleeson, Carthage Moran, Martin Buckley, Jane McCarthy, Kathleen Sugrue

Department(s)/Institutions

Gastroenterology Department, Mercy University Hospital, Cork

Introduction

Nurse-specialists in IBD are demonstrated to improve patient outcomes and be cost-effective. The Mercy Hospital was the first hospital in Ireland to have an IBD Advanced Nurse Practitioner and has two Clinical Nurse Specialists.

Aims/Background

In this article we aim to delineate the role undertaken by 3 nurse-specialists in the gastroenterology service in a university teaching hospital.

Method

This was a retrospective audit of a 4 week period, chosen to reflect the usual levels of activity, whilst minimising the impact of covid-19. Type of patient encounter with CNS (phone, email, infusion clinic review) was recorded, along with the result. Outcomes included expedited clinic appointment, nurse-led decision, discussion with the gastroenterology consultant or advice to attend the emergency department (ED).

Results

There were 1528 patient-nurse contacts. These consisted of 694 telephone calls, 610 via email and 224 reviews at the infusion clinic. Most were managed with nurse-led decision making. Approximately a quarter of patients were discussed with the consultant, and 56 (3.7% of total number) patients required a change in treatment. 16 (1%) had an expedited clinic appointment. Only 4 (<0.5%) patients were advised to attend ED. No patients attending infusion clinic attended outpatient clinic.

Conclusions

Our audit shows that the IBD nurse-specialist led service conducts a large volume of work, both virtual and in person. Remote management of patients is facilitated in the majority, leading to lower healthcare costs. Access to prompt response from an IBD trained professional allows a rapid treatment of flares.

ABSTRACT 61 (21S156)

A Systematic Review of Clinical Risk Prediction Models for Pancreatic Cancer Development

Author(s)

Ralph Santos1; Helen G. Coleman1,2; Victoria Cairnduff1; Andrew T. Kunzmann1

Department(s)/Institutions

1. Centre for Public Health, Queen's University Belfast, UK. 2. Patrick G. Johnston Centre for Cancer Research, Queen's University Belfast, UK.

Introduction

Pancreatic cancer is commonly diagnosed at an advanced stage, contributing to poor survival. Due to the low incident of pancreatic cancer, population-based screening is not recommended. However, identifying high-risk individuals using a risk prediction model has the potential to identify subgroups of the population in whom screening could be introduced to aid early detection of pancreatic cancer.

Aims/Background

To critically evaluate published literature that develops or validates a risk prediction model for developing pancreatic cancer based on clinical risk factors.

Method

MEDLINE, EMBASE and Web of Science were searched for relevant articles up to March 2020. Study selection and data extraction were conducted by two independent reviewers. Meta-analysis was not possible. The PROBAST tool was applied to assess risk of bias.

Results

In total, 30 articles were included describing 34 risk prediction models. Twelve models were developed to predict the risk of pancreatic cancer in the general population (n=12), patients with diabetes (n=7), chronic pancreatitis (n=1), pancreatic cysts (n=2), or symptomatic patients (symptoms include abdominal pain, unexplained weight loss, jaundice, change in bowl habits, indigestion) (n=10). Most models were rated as high risk of bias, due to poor reporting, methodological conduct for data sources used, predictor and outcome assessment, and statistical techniques employed. Only four models were rated as low risk of bias. In the few studies that assessed model performance C-statistics ranged from 0.61 to 0.98.

Conclusions

Most studies were rated as having high risk of bias. Further validation of the model may allow the implementation of the model in clinical practice.

ABSTRACT 62 (21S158)

An audit on the performance of colonic biopsies in persistent diarrhoea

Author(s)
Tormey R, Harhen A, Conlon C, Keohane J
Department(s)/Institutions
Endoscopy Unit, Louth County Hospital

Introduction
International and national guidelines advise colonic biopsies to be performed in colonoscopies with the indication of persistent diarrhoea. National guidelines recommends that mucosal biopsies should be performed in greater than or equal to 95% of these colonoscopies performed.

Aims/Background
To assess the compliance in Louth County Hospital (LCH) Endoscopy Unit with the performance of colonic mucosa biopsies in colonoscopies performed for persistent diarrhoea.

Method
Colonoscopies performed in 2019 and 2020 in LCH with the indications of chronic diarrhoea were included. Procedures performed by Gastroenterology, General Surgery and Advanced Nurse Practitioners were included. Data was collected using electronic patient records. The percentage of colonoscopies with mucosal biopsies performed was calculated. The standard used was the 'National GI Endoscopy Quality Improvement Guidelines, version 6'

Results
283 colonoscopies were performed for the indications of chronic diarrhoea over the two year period (2019: n=180; 2020: n=103). 112 patients (39.58%) were male. The median age was 54 years (Range: 17-87 years). Colonic mucosa biopsies were performed in 86.57% of procedures (n=245). The difference in procedures performed in 2019 and 2020 is likely secondary to service changes due to the SARS-CoV-2 pandemic.

Conclusions
Our compliance with national and international recommendations needs to be improved. Discussion at local Endoscopy Users' Group and the GI multidisciplinary meeting is suggested. Education of all endoscopists on the importance of biopsies in colonoscopies performed for diarrhoea will be required to improve the standard of endoscopy and patient care in line with standards. A re-audit should be performed following quality improvement interventions.

ABSTRACT 63 (21S160)

Infliximab Intravenous to Subcutaneous switch: A Patient's Perspective

Author(s)
C McShane, A Marrinan, C Byron, D Sawbridge, SA Zulquernain
Department(s)/Institutions
Gastroenterology Department, Cork University Hospital

Introduction
Biologics have greatly improved outcomes in IBD. Biosimilars have reduced cost and improved access to treatment. The Infliximab biosimilar CT-P13 (Remsima) shows comparable subcutaneous efficacy and safety to IV formulations.

Aims/Background
We looked to ascertain if patients wished to switch from IV to SC Infliximab and why; treatment costs were also reviewed.

Method
A 9-point questionnaire was administered to patients receiving Infliximab for IBD at our centre. Baseline characteristics and disease behaviour were extracted from electronic records. Eligible patients were clinically stable, on maintenance Infliximab therapy for ≥14 weeks and demonstrated no active inflammation.

Results
104 patients received Infliximab, with an 85% response rate. 38% were female; median age was 38.5years (range 17-76years); 69% CD, 28% UC and 3% IC. 57% were eligible for switch. 78% wanted to switch (m=82%, f=75.6%). Common reasons for switching; convenience (80%), time (59%), COVID-19 risk (23%). Common reasons for not switching; reassured by attending hospital (60%), fear of flare (42%). Mean non-drug cost for administration in CUH €224.54/treatment, mean time 143.78 mins (2018). CT-P13 SC has been quoted as costing <€300/120mg pre-filled disposable injection (EOW;120mg if <80kg, 240mg if ≥80kg).

Conclusions
This study shows a clear preference for switching from IV to SC Infliximab. Potential barriers to switching were identified. Pre-emptive patient education and clear lines of patient-IBD team communication will improve transition to home administration. The study highlights the unseen cost of infusion therapies regarding non-drug costs and expenditure of patient time. Currently the National Centre for Pharmacoeconomics does not recommend reimbursement for CT-P13 SC.

ABSTRACT 64 (21S161)

A Clinical Deficiency: Investigation and Diagnostic Yield of Iron Deficiency in the Frail, Older Population

Author(s)
Neary BP, McCready M, Foley A, Cooney F, Pillay I
Department(s)/Institutions
Tipperary University Hospital, Clonmel

Introduction
The appropriate extent and yield of investigation of iron deficiency anaemia (IDA) in the frail, older population remains undetermined.

Aims/Background
To measure and compare the prevalence of IDA in a cohort of Frail (FP) and Non-Frail (NFP) Level 3 Hospital inpatients. Then compare the extent to which the anaemia is investigated, aetiology diagnosed and degree of haemoglobin correction.

Method
Using a Comprehensive Geriatric Assessment excel database, all Frail (Clinical Frailty Score >4) and Non-Frail (CFS <5) inpatients assessed from June 2019-August 2020 were identified. Digital databases were used to retrospectively identify those with iron deficiency and anaemia. The extent to which anaemia and iron deficiency were corrected, investigated and diagnosed with an

aetiology was assessed and compared.

Results

526 patients were included. 409 (77.8%) had a CFS >4. There was a significantly higher prevalence of anaemia in FP compared to NFP (59.2% vs 47%, p=0.02). There was a higher non-significant prevalence of iron deficiency in FP (39.9% vs 31.6%, p=0.1). A significantly higher proportion of NFP with iron deficiency had an OGD (37.8% vs 12.9%, p<0.05) and appropriate CT imaging (40.5% vs 26.7%, p=0.005) performed. A non-significant higher proportion of NFP had a Colonoscopy performed (27% vs 14.7%, p=0.07). The diagnostic yield of investigation was non-significantly higher in NFP (18.9% vs 14.1%, p=0.45). A higher but non-significant proportion of NFP had their anaemia corrected within the study period (29.1% vs 21.3%, p=0.21).

Conclusions

FP were more likely to be anaemic and iron deficient. They were less likely to undergo recommended investigation and have anaemia corrected, despite a similar diagnostic yield. The reason is likely multifactorial. Risk associated with endoscopy was a likely consideration but it has been shown that endoscopy is safe and efficacious in older patients. Guidelines are required for investigation of anaemia in this cohort.

ABSTRACT 65 (21S162)

Quality of scans in a Advanced Nurse Practitioner (ANP) led FibroScan® clinic.

Author(s)

Dr T Sheehan, Dr M Skelly

Department(s)/Institutions

Gastroenterology, University Hospital Limerick

Introduction

Transient Elastography is a pulse echo ultrasound used to assess liver fibrosis in patients with chronic liver disease. Our GI department has a shortage of medical staff and has redesigned service delivery to optimise resources as we emerge from the curtailment of services during the Covid 19 pandemic.

Aims/Background

To assess quality of scans performed by an ANP in a new role delivering our Fibroscan service and to compare with the pre-pandmic delivery of scans by one Consultant and a number of NCHDs.

Method

Data was downloaded from the departmental FibroScan® machine for 94 scans and analyzsed by indication,scan performer and quality of scan. (IQR/m of >25% or n=<10 indicated poor quality).

Results

Data are reported on 94 patients (58M/36F, median age 54.14 range 17-86), 31(32%) were above the accepted target of IQR/m <25%. Our ANP (n=61) had a quality rate of 75% compared to NCHDs (n=11) with a quality rate of 45% in reliable measurments.. Steathosis grade S3 (65%), XL probe (43%) and marked fibrosis (56%) provided lesser quality scans. One consultant performed 24 scans, 59% quality scans, 41% of these deemed technically more difficult.

Conclusions

Strongest link to performance quality was user experience. Other factors effecting quality included severity of fibrosis, probe size, disease modality and increased Liver Fat (CAP) score. Our ANP provided a quality service, the scan performance was stable as the complexity of patients increased, suggesting increasing performance delivery. Moving traditional medical roles to ANPs may help service delivery recover in post pandemic times.

ABSTRACT 66 (21S164)

Experiences and Attitudes of Medical Trainees with Diagnostic Paracentesis

Author(s)

Dr Gerard Forde, Dr Gillian Madders, Dr Ciarán McHale, Dr Eoin Slattery, Professor John Lee

Department(s)/Institutions

Department of Gastroenterology, Galway University Hospital

Introduction

Ascitic fluid can be sampled and analysed to help determine the cause of ascites and the presence of infection or malignancy, particularly in patients with liver cirrhosis. It is recommended that an ascitic tap is performed within twenty-four hours of patient presentation and ascitic fluid sent for cell count, culture and sensitivity and albumin.

Aims/Background

To investigate medical trainees' understanding and experiences in performing diagnostic paracentesis. To determine trainees' awareness of guidelines available for initial management of patients with ascites. To establish what barriers may lead to failure of performance of prompt diagnostic paracentesis in patients with decompensated liver cirrhosis. To ascertain potential methods of teaching to improve medical trainees' skills and competencies with regard to diagnostic paracentesis.

Method

NCHDs currently enrolled on Basic Specialist Training and Higher Specialist Training in General Internal Medicine and Medical Subspecialties were asked to complete an anonymous online survey.

Results

Fifty-four (74%) out of seventy-seven people responded. 71% of trainees were not aware of any guidelines or care bundles describing initial management of patients with decompensated liver cirrhosis. 68% had previously performed a diagnostic paracentesis. The main barriers reported were poor undergraduate teaching, lack of supervision, time constraints and concerns regarding complications.

Conclusions

Medical trainees are aware of the benefits and risks of diagnostic paracentesis. However, many expressed concern around their experience to date and teaching of this vital clinical skill. The use of simulation based teaching and usage of a care pathway could improve the frequency of performance of diagnostic paracentesis for patients with ascites.

ABSTRACT 67 (21S167)

Dramatic reduction of Hepatitis C related Hepatomas in Ireland 2015-2020

Author(s)
N. Mehigan, M.Bourke, C. Clifford, W. Shanahan, J. Falco, R.MacNicholas, A. McCormick
Department(s)/Institutions
St.Vincents University Hospital

Introduction
Hepatitis C is a major cause of morbidity and mortality word wide. Since 2015 very effective curative treatment has become widely available. The aim of this study was to see if the incidence of HCV related HCC has decreased over this period. SVUH has become the de facto national center for the diagnosis and treatment of HCC in Ireland. Most HCCs are referred to the unit for assesment.

Aims/Background
Analysis of the HCV cohort attending the HCC clinic and its change overtime associated with advances in HCV treatment.

Method
A retrospective review of data from patients attending HCC clinic from 2015-2020.

Results
From 2015-2020 633 patients presented with HCC, 19%(n=117) had HCV related disease. Median age was 59 year, 80%(n=94) were male, 30%(n=34) had additional risk factors for liver disease, 66%(n=79) had been treated for HCV at the time of diagnosis and 68%(n=73) presented with curative disease(BCLC 0/A). In 2015 23%(n=18) of patients presented with HCC related to HepC, this decreased to 9%(n=10) in 2019 and 11%(n=12) in 2020. This amounts to a 33% reduction (P=0.016) in hepC related HCC. In 2020 only 33% of patients presented with curative disease, which was likely COVID related.

Conclusions
There has been a reduction in the absolute numbers of patients with HCV related HCC and in the proportion of patients with HCC related to HCV. This suggests antiviral treatment is having a significant beneficial effect on prognosis.

ABSTRACT 68 (21S168)

Upper Gastrointestinal Bleeding (UGIB) Inpatient Referrals (Part 2) – An Audit On Focused Cohorts: - delayed >24hrs OGD, ICU and Theatre (out-of-hours) cases

Author(s)
R.Varley, C. Dunne, K Hartery, D Kevans, F MacCarthy, S. McKiernan, D.O'Toole, B Christopher
Department(s)/Institutions
Trinity Academic Department of Clinical Medicine & Gastroenterology, St James's Hospital, Dublin

Introduction
Acute upper GI bleeding (UGIB) is a potentially life-threatening abdominal emergency. BSG and ESGE advocate endoscopy to be performed within 24 hours as early intervention is associated with better prognosis with reduced morbidity and mortality. We reviewed the outcomes of patients admitted with UGIB over an 8-week period including those performed in ICU and out-of-hours operating theatre (OT) cases, in particular those which were performed >24hours after presentation.

Aims
The primary study aim was to assess whether delayed endoscopy provision (>24hrs) due to weekend factor resulted in any detrimental patient outcomes. Secondary aims were to evaluate provision of endoscopy for UGIB outside of routine endoscopy suite via ICU and out-of-hours theatre and analyse the aetiologies and severity of our UGIB presentations to our academic teaching hospital.

Methods
Prospective study on all UGIB inpatient referrals was conducted over an 8-week period from February to April 2021. The electronic patient record, endoscopy reporting system and theatre records were interrogated to collect clinical and endoscopic data

Results
63 upper GI endoscopies for inpatient UGIB were performed during the study period. 54 (86%) in the endoscopy unit, 4 (6%) in ICU and 5 (8%) in OT.
25%(n=16) of cases were performed after 24hrs, of which 62.5% (n=10) were due to weekend/bank holiday delays. For this cohort, the median GBS was 6(1-12), average Hb was 11.9g/dL (8.8-15.6), mean systolic blood pressure at presentation was 128mmHg (101-167mmHg), 10% (n=1) of whom required RCC transfusion. There was no demonstrable increase in negative outcomes including 30-day mortality amongst this cohort despite delayed access to endoscopy.
For ICU cases (n=4), median GBS was 9 (6-12), all were index cases with 3 (75%) patients received RCC. Median time from referral to scope was 3.5 hrs (2.5-7). 3 cases had combination treatment with adrenaline injection and endoclip therapy. One case required a re-look OGD and CT angiogram performed within 24hrs post index gastroscopy showed no active extravasation. ICU cases correlated with a higher GBS vs endoscopy (p value=0.058)
OT cohort (n=5) the median GBS was 12 (12-14), all were index cases, average Hb was 8.3g/dL. Only 2 patients (40%) required endoscopic intervention. OT cases had higher mean GBS vs endoscopy cohort (p value <0.00001)
Of our study, 12.5% (n=8) had background portal hypertension, of which 5 (62.5%) required therapeutic intervention with variceal band ligation. There was no 30-day mortality in this portal hypertension cohort. There was no variceal UGIB aetiology in ICU / OT cases.

Conclusion
In a large academic teaching hospital, referral for upper GI endoscopy with an indication of UGIB is common. Risk stratification is imperative to optimize endoscopy provision to ensure vulnerable cohort gets OGD performed within 24hrs.
Patients requiring endoscopy in the ICU or operating theatre setting have more severe upper GI bleeding as assessed by GBS. Education and implementation of an UGIB care pathway are likely to improve endoscopy triage, pre-procedure care and timely endoscopy access in patient with UGIB.

FUTURE MEETINGS
Dates to Remember

usg Ulster Society of Gastroenterology

Autumn Meeting
Thursday 14th October 2021

Irish Society of Gastroenterology

Winter Meeting
25th and 26th November 2021

ISG Meeting Summer, 2021 Exhibitors

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