Irish Society of Gastroenterology

Hybrid Summer Meeting

June 22nd & 23rd
Grand Hotel
Malahide, Co. Dublin

Welcome Message

A Chairde,

It is my great pleasure to welcome you all to the 2023 hybrid summer meeting, unexpectedly back in Malahide. The war in Ukraine still rages and our small inconvenience of having to reschedule and relocate our meeting is easy to accept in the face of their ongoing suffering and trauma. The ISG is proud to continue our support for Ukrainian Irish Refugees. My special thanks though to everyone who has graciously rescheduled their calendars to participate in the meeting.

I am delighted to welcome our distinguished international faculty who will address topics across three core meeting themes; precision medicine, premalignant disease management and emergency GI care. Again, the themed e-poster and the NCHD led, clinical case sessions are retained. A packed program across the two days, which I hope, has something for everyone and which we can all learn from and enjoy.

As we are all aware the "Green Endoscopy" theme continues to grow and gather support, similarly my push towards a "Green ISG" continues, with e-program's and brochures and a hybrid format to support virtual participation retained. Also now a new policy of offsetting a portion of our carbon contribution, by planting native Irish trees.

As my last welcome address, I would like to take this opportunity to thank Michael and Cora especially and all the ISG team for their support and assistance during my term as president. Similarly my thanks to, Manus for minding the finances, Garret, and Eoin for their work as Secretary and to the wider ISG board for their help and assistance as needed. Perhaps most importantly my thanks to you our members, who continue to support the society and our meetings, without your input, there would be no ISG, indeed many a session would have had no chairperson, and many an abstract would never have been scored. My thanks again to you all it has been a pleasure and an honour to serve the ISG. I'm delighted now to pass on the mantel to President Elect Orla Crosbie, I wish her every success and look forward to what I am sure will be a very successful contribution.

Slan go foill

Professor Deirdre Mc Namara
President, Irish Society of Gastroenterology
Consultant Gastroenterologist
Tallaght Hospital, Dublin

Irish Society of Gastroenterology
Hybrid Summer Meeting
June 22nd & 23rd
Grand Hotel, Malahide, Co. Dublin

Day 1 Thursday 22nd June Morning

09.00 - 09.30 **Registration / Coffee / Visit Stands**

09.30 - 11.00 **Symposium 1:**
Precision Medicine in Gastroenterology
Chairs: **Prof. Anthony O'Connor,** Tallaght University Hospital, Dublin
Dr Zita Galvin, St Vincent's Hospital, Dublin

09.30 - 10.00 ***Precision Medicine in IBD. Current role and future directions.***
Prof. Joana Torres,
Consultantant Gastroenterologist
Hospital Beatriz Angelo, Loures, Portugal

10.00 - 10.30 ***Precision Medicine in Hepatology from guideline-specific therapy to personalised patient care (in cirrhosis).***
Prof. Guruprasad Aithal,
Deputy Director and Theme Lead
NIHR Nottingham Biomedical Research Centre

10.30 - 11.00 ***Precision Colonoscopy- towards personalised colorectal cancer screening and post polypectomy surveillance.***
Dr Craig Mowat,
Clinical Senior Lecturer / Honorary Consultant in Gastroenterology,
School of Medicine, University of Dundee, Scotland.

11.00 - 11.30 **Coffee / Visit Stands**

11.30 - 12.45 **Parallel E-Poster Sessions**
Endoscopy / IBD / Hepatology / Other GI

Endoscopy Chairs: **Dr Barry Hall,** Connolly Hospital, Dublin
Dr Syafiq Ismail, Cavan & Monaghan Hospitals
IBD Chairs: **Dr Orlaith Kelly,** Connolly Hospital, Dublin
Dr Mary Hussey, Galway University Hospital
Hepatology Chairs: **Prof. Orla Crosbie,** Cork University Hospital
Prof. John Ryan, Beaumont Hospital, Dublin
Other GI: **Dr Nadeem Iqbal,** Beaumont Hospital, Dublin
Dr Anna Kelly, Wexford General Hospital

12.45 - 14.00 **Lunch / Visit Stands**

Day 1 Thursday 22nd June Afternoon

14.00 - 15.30 **Symposium 2:**
Early neoplasia of the upper GI Tract.
Chairs: **Dr Raquel Ballaster,** Tallaght University Hospital, Dublin
Dr Danny Cheriyan, Beaumont Hospital, Dublin

14.00 - 14.30 ***Barrett's dysplasia & early neoplasia management.***
Prof. Bas Weusten,
Professor of GI Endoscopy,
University Medical Centre Utrecht and
St. Antonius Hospital Nieuwegein, The Netherlands.

14.30 - 15.00 ***Early detection and management of epithelial precancerous conditions and lesions in the stomach (MAPS II).***
Prof. Mario Dinis-Ribeiro,
Consultant Gastreoenterologist,
Portuguese Institute of Oncology, Porto, Portugal.

15.00 - 15.30 ***The genomic landscape of pancreatic cancer- challenges and opportunities for early detection.***
Dr Grainne O'Kane,
Consultant Oncologist
St. James's Hospital, Dublin.

15.30 - 16.00 **Coffee / Visit Stands**

16.00 - 17.00 **Y- ISG Case Presentation Session**
Chairs: **Prof. Orla Crosbie,** Cork University Hospital
Dr Orlaith Kelly, Connolly Hospital, Dublin
Dr Gareth Horgan, St. Vincent's University Hospital, Dublin
Dr Anne Fennessy, St. Vincent's University Hospital, Dublin

17.00 **E-Poster and Audit Awards Ceremony and Close Day 1**

17.30 - 18.00 **ISG Annual General Meeting**

18.00 - 19.00 **Satellite Meeting**
Sponsored by **AbbVie**
SELECTING THE RIGHT TREATMENT – an evidence-based approach to IBD Management
Peter Bossuyt MD PHD
Gastroenterologist, IBD specialist, Researcher at Imeldaziekenhuis, Bonheiden, Belgium.

19.30 **Reception and Conference Dinner**

Day 2 Friday 23rd June 2023

09.00 - 10.15 ***Parallel Best Clinical and Scientific Abstract Sessions***
Clinical Chairs: **Dr Geraldine McCormack**, Midlands Regional Hospital Tullamore
Prof. Eoin Slattery, Galway University Hospital
Scientific Chairs: **Dr Grainne Holleran,** St James's Hospital, Dublin
Dr Gareth Horgan, St. Vincent's University Hospital, Dublin

10.15 - 10.45 **Coffee / Visit Stands**

10.45 - 12.30 **Symposium 3:**
Emergency Gastroenterology
Chairs: **Dr Jan Leyden,** Mater Misericordiae University Hospital, Dublin
Dr Manus Moloney, University Limerick Hospital Group

10.45 - 11.15 ***Acute Liver Failure: What every gastroenterologist needs to know.***
Dr Audrey Dillon,
Consultant Hepatologist,
National Liver Transplant Unit,
St. Vincent's University Hospital, Dublin.

11.15 - 11.45 ***What's new in upper G.I. bleeding.***
Prof. Adrian Stanley,
Consultant Gastreoenterologist,
Glasgow Royal Infirmary, Scotland

11.45 - 12.15 ***Pancreaticobiliary Emergencies:***
The Gastroenterologists Role In Pancreaticobiliary Emergencies.
Prof. Marianna Arvanitaki,
Head of the Clinic of Pancreatology & Clinical Nutrition,
Erasme University Hospital, Brussels.

12.15 - 12.30 **Panel Discussion**

12.30 - 12.45 **Awards Ceremony + Meeting Close**

Photo Gallery

Audience View

Dr Jan Leyden & Dr Manus Moloney

Photo Gallery

Dr William Shanhan & Dr Thomas Sheehan

Suzanne Dennison, Athena
Breda McKee, Abbvie & Dr David Walley

Biographical Sketches

Prof. Joana Torres
Consultantant Gastroenterologist
Hospital Beatriz Angelo, Loures, Portugal

Joana Torres received her medical degree from the University of Coimbra, Portugal, and completed her fellowship in Gastroenterology at the Hospital Center of Coimbra, Portugal. After post-doctoral training in Icahn School of Medicine at Mount Sinai, New York (Professor Jean-Frederic Colombel), she completed her PhD at Medicine Faculty, University of Lisbon, and was appointed Assistant Professor. She is currently working in Hospital Beatriz Ângelo, Loures, and Hospital da Luz, Lisbon, Portugal as a Gastroenterology Consultant and as responsible for the IBD clinic. She is an active member of ECCO and has served as a committee member for the Ecco´s Guideline committee (GuiCom), where she has participated in the implementation of GRADE guidelines in ECCO and in the development of the Crohn´s disease Guidelines and Pregnancy Guidelines. She is currently a member of the UEG Public Affair Committee, trying to raise awareness for IBD across Europe. Prof. Dr. Joana Torres has given several invited lectures at international meetings and has authored many scientific papers in peer-reviewed journals. Her research focus in populations at risk for developing inflammatory bowel disease with the goal of better understanding the events taking place before disease is diagnosed, with the aim of finding better treatments and developing preventive strategies.

Prof. Guruprasad Aithal
Deputy Director and Theme Lead
NIHR Notthingham Biomedical
Research Centre

Guruprasad P. Aithal is Professor of Hepatology and the Deputy Director of Translational Medical Sciences, School of Medicine, University of Nottingham. He is also the Deputy Director and Gastrointestinal & Liver Theme lead of the NIHR Nottingham Biomedical Research Centre (BRC). He was the President of the British Association for the Study of the Liver between 2020 and 2021.
After being awarded PhD from the University of Newcastle in 2000, he completed Advanced Fellowship at the University of South Carolina, Charleston, USA. He has been the Consultant Hepatobiliary Physician in the Nottingham University Hospitals NHS Trust since 2001. He has won NHS Innovation Award (2013), SAGE National Award (2015) and 'Scarred Liver' project that he co-developed was selected by the European Association for the Study of the Liver for submission to the European Commission- Best Practice platform in 2022.
He co-chaired International Drug-induced Liver Injury Consortium (iDILIC) (2010-13) that delivered crucial breakthrough in the field. Currently he is the Deputy Co-ordinator and work-package lead of Innovation Medicines Initiative programme of the European Union, *'Translational Safety Biomarker Pipeline'* (2019-24).
He has over 300 publications (H index: 73 with over 26,900 citations) including original articles in Nature Genetics, Nature Medicine, Nature Communications, Lancet, BMJ, Journal of Hepatology, Gastroenterology, Gut, Hepatology, Gastrointestinal Endoscopy and Endoscopy.

Dr Craig Mowat
Clinical Senior Lecturer / Honorary
Consultant in Gastroenterology,
School of Medicine,
University of Dundee, Scotland.

Dr Mowat graduated MBChB with Commendation from University of Glasgow in 1992, and was awarded the Stockman Medal. He trained in medicine and gastroenterology on the West of Scotland training programme and completed his MD thesis under the guidance of Prof Kenneth McColl.
He was appointed Consultant Gastroenterologist at Ninewells Hospital & Medical School, Dundee, in 2002. He has served time as Lead for Endoscopy, then Gastroenterology and in 2017 he became Clinical Lead for Bowel Cancer Screening in NHS Tayside. He was appointed as a Clinical Senior Lecturer at the University of Dundee in 2019.
His research interests centre on the utility of measuring faecal haemoglobin (using FIT) in primary care in the context of the assessment of new bowel symptoms. He has acted as an advisor for the national roll-out of FIT testing to primary care in Scotland and NICE in advance of pending guidance.

Prof. Bas Weusten
Professor of GI Endoscopy,
University Medical Centre Utrecht and
St. Antonius Hospital Nieuwegein,
The Netherlands.

Bas Weusten (1967) has graduated from medical school at Utrecht State University, the Netherlands. He has written his PhD thesis on gastroesophageal reflux disease and esophageal perception from 1992 to 1995. After his traineeship in gastroenterology he became a staff member at St Antonius Hospital in Nieuwegein, the Netherlands in 2002.
In 2011 he became professor of Innovative GI Endoscopy at the University Medical Center in Amsterdam. In 2017 he moved from Amsterdam to Utrecht, where he became appointed as professor of GI Endoscopy. He chaired the Dutch society for gastrointestinal endoscopy for many years.
His main focus in both clinical work and research is on endoscopic management of early neoplasia of the upper GI tract. He has been involved in several guidelines, and chaired the 2017 ESGE Position Statement on the Endoscopic Management of Barrett's Esophagus, which is currently being revised under his leadership

Prof. Mario Dinis-Ribeiro
Consultant Gastreoenterologist,
Portuguese Institute of Oncology,
Porto, Portugal.

Mário Dinis-Ribeiro is a Senior Consultant of Gastroenterology at the IPO-Porto / Porto Comprehensive Cancer Center (Porto.CCC) and Invited Full Professor at Faculty of Medicine of the University of Porto (FMUP). He is currently the Head of Medicine Department, Vice-Diretor and Group Leader at the Research Centre of IPO Porto, and member of the Scientific Committee Faculty of Medicine of the University of Porto (FMUP). Also, he is Treasurer of World Endoscopy Organization and Co-Editor-in-Chief of the journal Endoscopy. He was formerly the Head of Gastroenterology (2014-2023), Fellowship Programme (2006-2013), Porto School of Oncology / Education Department (2009-2011) at IPO Porto and Coordinated the Master in Evidence and Decision in Health (2012-2018) at FMUP, being also the President of the Portuguese Society of Digestive Endoscopy (2019-2021) and the European Society of Gastrointestinal Endoscopy (2021-2023). He published over 350 manuscript (HI = 53 ISI), supervised 13 PhDs and over 30 Master students and is PI or Co-PI of national and european projects with current over 2.5M€ of funding. He won the BIAL Award in Clinical Medicine in 2018 and co-authored the Pfizer Award in 2016.

Dr Grainne O'Kane
Consultant Oncologist
St. James's Hospital, Dublin.

Prof. Grainne O'Kane is a GI medical oncologist and associate Professor at the Trinity St James's Cancer Institute with an adjunct role at the Princess Margaret Cancer Centre and Ontario Institute for Cancer Research. Her main research has been in biomarkers and cancer genomics. She has a strong interest in clinical trials particularly for hard to treat cancers.

Dr Audrey Dillon
Consultant Hepatologist,
National Liver Transplant Unit,
St. Vincent's University Hospital, Dublin.

Dr Audrey Dillon completed specialist training in gastroenterology and general medicine in Dublin, and completed a fellowship in liver transplantation in the Queen Elizabeth Hospital, Birmingham. She was appointed as a consultant transplant Hepatologist in the Leeds Liver Unit at St James University Hospital Leeds in 2016, where she led on management of patients with complex portal hypertension, in particular TIPSS and liver transplant assessments. She also served as clinical governance lead for hepatology and liver transplantation. She has an interest in ethics, and was vice president and chair of the Ethics committee of the Irish Medical Council (2013- 2018). She was appointed as a consultant Hepatologist to the National Liver Unit in St Vincent's University Hospital in 2021.
She is passionate about patient centred care and her special areas of interest are liver transplantation, frailty in liver disease and cirrhosis, complex portal hypertension and alcohol related liver disease.

Prof. Adrian Stanley
Consultant Gastreoenterologist,
Glasgow Royal Infirmary, Scotland

After graduating from Edinburgh in 1988, Prof Stanley trained in Edinburgh, New Zealand, Australia and London, and completed his MD thesis in 1998. He was appointed Consultant Gastroenterologist at Glasgow Royal Infirmary in 1999 and Honorary Professor at the University of Glasgow in 2018.
He has published over 150 peer-reviewed papers and several book chapters to date, and has co-authored several national and international guidelines in the fields of GI bleeding and Hepatology. He is Director of the annual Glasgow-Gastro Conference and is on the organising committee of several other major educational meetings. He has performed live endoscopy at several UK and international educational events
Prof Stanley was elected Vice-President (Medical) of the RCPSG (2019-22). He was a founder member of the BSG International committee and the RCPSG Global health group, and is heavily involved in a Gastroenterology training project in Malawi (2012-present). He was appointed Secretary of the BSG (2019-21) and Senior Secretary (2021-23) and was elected President of the Scottish Society of Gastroenterology (2022-24).

Prof. Marianna Arvanitaki
Head of the Clinic of Pancreatology
& Clinical Nutrition,
Erasme University Hospital, Brussels.

Marianna Arvanitakis finished her medical degree in 1997 in Brussels, Université Libre de Bruxelles, and pursued her fellowship in Internal Medicine/ Gastroenterology. She has been working in the Erasme University Hospital since 2002, where she has a position of full professor since 2018. She is head of the Clinic of Pancreatology and Clinical Nutrition.
She presented a PhD thesis focused on diagnosis and treatment of pancreatic diseases in 2007. Her main clinical and research interest are pancreatic diseases, clinical nutrition, training and therapeutic endoscopy, with 160 cited publications.
She has an active role in the European Society of Gastrointestinal Endoscopy (ESGE) Governing Board as the individual member representative since 2014, the chair of the Education Committee since 2018 and is currently the scientific committee chair involved in the organization of the ESGE days. She has been part of numerous ESGE guidelines and is in the Editorial Board of the journal Endoscopy. She was also member of in the UEG scientific committee since 2014 and chair of the postgraduate teaching

(PGT) course, member of the UEG Education committee and Research committee. She is also an active member of the European Society of Enteral and Parenteral Nutrition (ESPEN), of the American Gastroenterology Association (AGA) and the American Society of Gastrointestinal Endoscopy (ASGE).

ISG Board Members

Professor Deirdre McNamara
President ISG
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.

Professor Eoin Slattery
Hon Secretary ISG
Consultant Gastroenterologist
University Hospital Galway

Professor Eoin Slattery graduated with honours from University College Dublin in 2002. He completed his internship and general professional training at St Vincent's University Hospital. He became a member of the Royal College of Physicians of Ireland in 2005. Thereafter, he commenced higher specialist training in gastroenterology, rotating through St Vincent's Hospital, Beaumont Hospital and St Luke's Hospital Kilkenny.
During his training he obtained a post-graduate Doctorate of Medicine as the Abbott Newman fellow in Inflammatory Bowel Disease at University College Dublin. His translational research project focused on the beneficial effects of cigarette smoke on Ulcerative Colitis.
Following completion of higher specialist training, Professor Slattery embarked on sub-specialist fellowship training. He was appointed as the Irish Society of Gastroenterology Boston Scientific Advanced endoscopy fellow rotating through the Mater Hospital, Dublin and then on to Beth Israel Deaconess Medical Centre/ Harvard Medical School, Boston, MA. He then proceeded to spend 2 years as the Advanced GI nutrition support fellow in New York Presbyterian Hospital/ Columbia University Medical Centre..
He returned home to Ireland in 2015 where he was appointed as a consultant gastroenterologist at University Hospital Galway. Professor Slattery is also the Saolta group clinical lead for Endoscopy. In 2019 he was appointed as the National Specialty Director for training in Gastroenterology by the RCPI.

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 Garret Cullen
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 Patrick Allen
Consultant Gastroenterologist
South East Trust, Belfast

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.

Professor Laurence Egan,
Dean of College of Medicine,
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 and as Head of the discipline of Pharmacology and Therapeutics. He was associate editor at Gut, and has been editor-in-chief of the Journal of Crohn's and Colitis since 2014.

Dr Zita Galvin,
Consultant Hepatologist
St. Vincent's University Hospital, Dublin.

Dr. Zita Galvin is a consultant Hepatologist at St. Vincent's University Hospital, Dublin. Zita graduated from the Medical School in University College Dublin in 2008 and also has a degree in Pharmacy from Trinity College Dublin (1999). She completed a post graduate Doctorate of Medicine, in the complications of portal hypertension, at University College Dublin/Mater Misericordiae University Hospital, Dublin (2013). She completed her General Internal Medicine, Gastroenterology and Hepatology training in Ireland before moving to Canada to do a fellowship in Transplant Hepatology at the Multi Organ Transplant Programme at Toronto General Hospital. She was appointed as Assistant Professor at the University of Toronto and Staff Medical Gastroenterologist and Hepatologist at Toronto General Hospital from 2017 to 2021. She is the author of a number of peer-reviewed articles. She has served as a reviewer for a number of medical journals including Journal of Hepatology, Transplantation and Liver Transplantation. Zita is passionate about education, teaching and mentorship. She completed the Master Teacher Program at the Department of Medicine, University Health Network (UHN), Toronto. During her time in Toronto, she was the Director of Education for the Multi-Organ Transplant Program and the Director of the Transplant Hepatology Fellowship Program.

Mr James O'Riordan
Consultant Colorectal Surgeon
Tallaght University Hospital

James O' Riordan MD FRCSI graduated from Trinity College Dublin in 1998 with an honours degree. He completed basic surgical training scheme in Ireland and was awarded Membership of the Royal College of Surgeons in Ireland in 2001. He then undertook a research degree and was awarded the Degree of Doctor in Medicine from Trinity College Dublin in 2004. He then commenced higher surgical training in Ireland, was awarded the Intercollegiate Specialty Exam in General Surgery in 2008 and completed an international colorectal fellowship at the University of Toronto in 2011. He has been working as a consultant colorectal and general surgeon in Tallaght University Hospital and St James' Hospital since 2011. His subspecialist interests include laparoscopic surgery, proctology, colorectal cancer and inflammatory bowel disease. He currently has 47 peer reviewed publications in general and colorectal surgery.

Professor Orla M Crosbie,
Consultant Hepatolologist
Cork University Hospital

Prof. Orla Crosbie is the Consultant Hepatolologist at Cork University Hospital and Lead for Gastroenterology and Hepatology at CUH. Prof. Crosbie trained in the National Liver Unit at St Vincent's Hospital and carried out her MD thesis while there on Lymphohaematopoietic stem cells in the adult human liver; completing her SpR training in Addenbrookes Hospital, Cambridge. Prof Crosbie has research interests in Hepatitis C epidemiology and molecular virology. Prof Crosbie previously served as the National Specialty Director for Gastroenterology at RCPI and was on the RCPI Council for two terms. Prof Crosbie was previous Chair of the Post Graduate Educational Committee with Irpen, treasurer for ICORN ((Irish Hepatitis C Outcomes and Research Network) and NDTP Training Lead for the S/SW Hospital group. Current activities include a busy Hepatology service at CUH and teaching commitments with UCC.

Professor Martin Buckley
Consultant Gastroenterologist
Mercy University Hospital, Cork

Prof Martin Buckley qualified from University College Cork and did intern training at the Mercy University Hospital, Cork. He completed his BST training at the Federated Dublin Hospitals. He did specialist training in Dublin Hospitals and was Lecturer in Medicine at Trinity College Dublin. He completed a therapeutic endoscopy fellowship (ERCP/EUS) at Nice University Hospital, France. He worked as a consultant gastroenterologist at Tallaght University Hospital from 1998 to 2004 and is now at the Mercy University Hospital, Cork with a special interest in GI Physiology and therapeutic endoscopy.

Dr John McGoran
Consultant Gastroenterologist
Altnagelvin Area Hospital

John has been a consultant gastroenterologist at Altnagelvin Hospital since October 2020, having completed specialty training in Northern Ireland and an endoscopy and research fellowship in University Hospitals of Leicester. During this time he worked with colleagues in the UK, USA and Australia to conduct research into Barrett's oesophagus, patient experiences in endoscopy and the learning process for advanced endotherapy. He was a BSG trainee representative for 3 years and in this time sat on the UK specialty advisory committee which implemented the 2022 gastroenterology curriculum. At Altnagelvin he maintains an interest in therapeutic luminal endoscopy, translational research and postgraduate training, incorporating his role as director of the ever in-demand endoscopy skills courses. When he can escape the hospital he tries to make it to County Donegal, by bike or car. On rainy days he stays in and plays piano (badly).

Dr Cathy McShane
Gastroenterologist SpR
St James's Hospital, Dublin

Dr Cathy McShane graduated from Trinity College Dublin in 2014 with an honours degree. She became a member of the Royal College of Physicians Ireland in 2016. She was awarded the European Specialty Examination in Gastroenterology & Hepatology in 2022. She is in her final year of the Gastroenterology Higher Specialist Training scheme. She is currently working in St James's Hospital whilst undertaking a post-graduate Doctorate of Medicine at Trinity College Dublin. Her area of research focuses on immunometabolism in inflammatory bowel disease. She plans to undertake an advanced inflammatory bowel disease fellowship on completion of her Doctorate of Medicine in 2024.

Photo Gallery

Ms Orla Smith, Ms Annie Coe & Dr Anne Fennessy

Dr Sadhbh Doherty & Dr Tiarnan Fallon Verbruggen

Honorary Officers and Board Members

Professor Deirdre McNamara,
President ISG
Consultant Gastroenterologist

Professor Eoin Slattery, Hon Secretary ISG
Consultant Gastroenterologist

Dr Manus Moloney, Hon Treasurer ISG
Consultant Gastroenterologist

Dr Garret Cullen
Consultant Gastroenterologist

Professor Laurence Egan
Professor of Pharmacology

Dr Geraldine McCormack
Consultant Gastroenterologist

Dr Patrick Allen,
Consultant Gastroenterologist

Dr Zita Galvin,
Consultant Hepatologist

Mr James O'Riordan
Consultant Colorectal Surgeon

Professor Orla M Crosbie
Consultant Hepatololologist

Professor Martin Buckley
Consultant Gastroenterologist

Dr John McGoran
Consultant Gastroenterologist

Dr Cathy McShane
Gastroenterologist SpR
SpR Training Rep

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1971-1972	Professor Patrick Collins
1969-1970	Professor Peter Gatenby
1967-1968	Dr Byran G Alton
1964-1966	Professor Patrick Fitzgerald
1962-1964	Professor Oliver Fitzgerald

Abstract Submissions selected for Endoscopy E-Poster Presentation

Thursday 22nd June 2023, Tara Suite - Main Meeting Room

Abstract No.	Ref:	Title	Author	Time
1	23S128	Optical Diagnosis in Colonoscopy: More to it than meets the AI.	Robert Varley	11.30
2	23S151	Endoscopic Full Thickness Resection for Colorectal Lesions: A single-centre experience	Anne Fennessy	11.36
3	23S143	ENDOSCOPIC ULTRASOUND GUIDED LIVER BIOPSY: A Single Centre Irish Experience	Olufemi Aoko	11.42
4	23S167	The Impact of Nurse Led Clinical Validation of Endoscopy Waiting Lists in a Tertiary Irish Hospital	Joy Gordon	11.48
5	23S146	Two Year Experience Delivering A New Device-Assisted Enteroscopy Service In An Irish Teaching Hospital	Eimear Gibbons	11.54
6	23S114	The Diclofenac Dilemma: delivering enhanced ERCP documentation	Dr. Sammar Ali	12.00
7	23S141	Digitalization as a strategy in green endoscopy: a patient based survey on digital device access and openness to a paper free approach.	Charlene Deane	12.06
8	23S132	A Retrospective Single-Centre Review of Complications Post ERCP with Sphincterotomy Performed to Evaluate the Safety of Same Day Discharge	Aimee Drudy	12.12
9	23S175	Patency testing prior to Video Capsule Endoscopy: An Irish Experience.	Conor Costigan	12.18
10	23S121	Deferred vs Index Endoscopic Mucosal Resection for screen detected complex polyps	Eoin Keating	12.24

ENDOSCOPY POSTER PRESENTATIONS

ABSTRACT 1 (23S128)

Optical Diagnosis in Colonoscopy: More to it than meets the AI.

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Introduction
Computer-Aided Diagnosis (CADx) allows for real-time characterisation of polyps. CADx accuracy in polyp characterisation is comparable to expert endoscopists and better than novel endoscopists in limited studies to date. CADx may allow a resect and discard strategy providing significant economic impacts. CADx may also be a useful tool in improving polyp management in a training setting.

Aims/Background
To compare the performance of expert endoscopists, trainee endoscopists and CADx in characterising colonic polyps.

Method
This multi-centre prospective comparison study utilised two endoscopists to photo-document polyps between August and November 2022. CADx diagnosis (GI Genius, Medtronic) and histologic diagnosis were recorded. Blinded to CADx and histologic diagnosis, expert and trainee endoscopists predicted polyp type based on photo-documentation. Sensitivity and specificity was calculated for each group using histologic diagnosis as gold standard.

Results
139 polyps across two centres were photo-documented. Expert endoscopists (Sensitivity 91.67% [95% CI 77.53-98.25%]) were better at polyp characterisation than CADx (Sensitivity 84.31% [95% CI 71.41-92.98%]) and trainee endoscopists (Sensitivity 87.23% [95% CI 74.26-95.17%]). Expert endoscopists (Sensitivity 77.27% [95% CI 54.63-92.18%] and trainee endoscopists (Sensitivity 63.16% [95% CI 38.36-83.71%]) performed better than CADx (Sensitivity 42.11% [95% CI 20.25-66.50%]) in the characterisation of non- adenomatous polyps.

Conclusions
Our data corresponds with previously published studies although trainee characterisation was similar to CADx predictions in our study. Both trainees are experienced endoscopists nearing the end of their respective training schemes. CADx may be useful in early training but further studies are necessary. Resect and discard strategy utilising CADx doesn't currently appear feasible.

ABSTRACT 2 (23S151)

Endoscopic Full Thickness Resection for Colorectal Lesions: A single-centre experience

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Introduction
Endoscopic full-thickness resection (FTR) is a minimally-invasive day-case procedure which can be performed under conscious sedation for complex colorectal polyps.

Aims/Background
To assess endoscopic FTR outcomes in a tertiary-referral centre over a seven-year period.

Method
Referrals for FTR to our hospital were identified using the endoscopy reporting system. Patient, procedural and histological data was collected and analysed.

Results
Thirty-six referrals were received for endoscopic FTR between June 2016 and March 2023. The population was 61% male. Median age was 68 years. For 28 patients (77.8%), endoscopic removal of the polyp or lesion was attempted prior to FTR. Endoscopic removal with the FTR device was possible in 27 of the 36 patients (75%); 71% of these were left sided colonic lesions. One patient underwent FTR for two polyps. Endoscopic FTR was successful in 25 patients (92.6%). Delayed post-polypectomy bleeding occurred in three patients (10.7%); all of whom required anticoagulation or dual-antiplatelet therapy at baseline. One patient was admitted for 24 hours for this reason (3.6%). No further post-endoscopy admissions occurred. Thirty-day mortality was 0%. Endoscopic surveillance has been performed in 79% of patients post-FTR (with a further 14% scheduled for surveillance). Endoscopic recurrence post-FTR occurred in one case at two years which was managed endoscopically (3.6%). Two patients underwent surgical resection post-FTR as histology revealed invasive adenocarcinoma.

Conclusions
Endoscopic FTR represents a safe and minimally invasive alternative to surgery for complex polyps; FTR outcomes at our centre reflect this with high rates of successful resection, and adverse events comparable to international data.

ABSTRACT 3 (23S143)

ENDOSCOPIC ULTRASOUND GUIDED LIVER BIOPSY: A Single Centre Irish Experience

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Introduction
Endoscopic Ultrasound-Guided Liver Biopsy (EUS-GLB) has emerged as an alternative modality for sampling liver parenchyma. Access and protocols related to percutaneous or transjugular liver biopsy can be a practical challenge. Current literature suggests EUS-GLB has an excellent safety profile and high diagnostic yield. The optimal endosonographic tools and technique for consistent acquisition of adequate liver tissue samples, however, remains unclear.

Aims/Background
To evaluate the efficacy and safety of endoscopic ultrasound guided liver biopsy using a 22-gauge fine needle biopsy (FNB) device.

Method
This was a prospective study conducted as part of a larger study (IBENO study) to assess the impact of Intragastric Balloon Therapy in Obese patients with Non-Alcoholic Fatty Liver Disease (NAFLD). EUS-GLB was performed with the Boston Scientific Acquire 22-gauge FNB device prior to Intragastric balloon (IGB) placement. Only the left liver lobe was biopsied, and a "slow stylet pull" technique was employed.

Results
Fourteen obese patients with NAFLD had EUS-GLB performed. All the procedures were done as day cases. 8 (57%) patients were males. The mean age was 47 years, and mean BMI was 40.9 kg/m2. Overall, there was 100% technical success. 13 (93%) patients had adequate samples for histological analysis with a mean total specimen length (TSL) of 40.1mm and complete portal tracts (CPT) of 8.9. No adverse events were recorded.

Conclusions
Our data aligns with published data on the efficacy and safety of endoscopic ultrasound guided biver biopsy as a safe and effective alternative for parenchymal liver biopsy.

ABSTRACT 4 (23S167)

The Impact of Nurse Led Clinical Validation of Endoscopy Waiting Lists in a Tertiary Irish Hospital

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Introduction
In response to the increasing demand for endoscopy nationally, the HSE Acute Operations Endoscopy Programme & The Dublin Midlands Hospital Group began a pilot program of endoscopy validation clinical nurse managers. By increasing adherence to current guidelines, offering alternative pathways where appropriate, and identifying unnecessary endoscopy procedures, endoscopy validation clinical nurse managers can reduce endoscopy surveillance waiting lists.

Aims/Background
To assess the impact of nurse-led clinical review and application of current endoscopy guidelines to endoscopy surveillance waiting lists.

Method
A retrospective audit of 4 years of nurse-led clinical validation of patients overdue surveillance procedures on the 2015-2019 surveillance waiting lists. Previous endoscopy and histopathology reports were reviewed to evaluate the appropriateness of the procedure. Selected patients were contacted for up-to-date information and preference. From the guidelines, a framework of criteria was developed and applied to defer, remove, and schedule patients.

Results
In total, 1797 endoscopy procedures (1419 colonoscopies and 378 OGDs) were reviewed. 614 (43%) colonoscopies and 111 (30%) OGDs were removed, and 207 (15%) colonoscopies and 9 (2%) OGDs were deferred. The remaining 598 (42%) colonoscopies and 258 (68%) OGDs, (48%) were scheduled. The immediate cost saving of €487,676 was gained from the removal of 725 procedures. A further saving of €74,560 was gained with the deferral of 216 procedures, resulting in a total cost saving of €562,236. Additionally, 725 endoscopy beds were released.

Conclusions
This nurse-led role is a positive process which provides significant cost savings and increases endoscopy capacity, allowing for a more efficient and streamlined endoscopy service.

ABSTRACT 5 (23S146)

Two Year Experience Delivering A New Device-Assisted Enteroscopy Service In An Irish Teaching Hospital

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Introduction
Device-assisted enteroscopy (DAE) has established its diagnostic and therapeutic role with the most recent 2022 guidance from ESGE. There are currently only two centres in Ireland who deliver this service.

Aims/Background
The aim was to create a comprehensive DAE database for the purpose of audit/research and undertake an early appraisal of the service.

Method
All procedures performed over an 18 month period were included. A database was created for the purpose of audit and research. Information regarding demographics and histology was retrieved from patient medical records and the lab system in Connolly Hospital. We spoke with patients directly with regards to post procedural complications.

Results
55 procedures were performed over 18 months (median age 62, range 21-92, M:F 32:23). 74.5% had capsule endoscopy performed prior to referral. 73% of procedures were anterograde. The average length of an anterograde DAE was 36minutes and retrograde 42.8minutes. On average 4mg Midazolam with 100mg Fentanyl was used. Reasons for referral included angiectasia 30.9%, erosions/ enteritis 27.2% and abnormal radiology 16.3%. Others included assessment of known Crohn's, jejunal strictures, jejunal blunting and failed colonoscopy. There were no cases of post procedural pancreatitis. 2/17 (12%) who had APC performed rebled within 2 weeks. 69% of biopsies taken were normal. The remainder had acute inflammatory cells, focal active inflammation or were non-diagnostic.

Conclusions
With the expansion of capsule services nationally, the demand for DAE will likely increase significantly. A 2020 position statement from ESGE provided recommendations for standardising high quality training across Europe. Training opportunities remain limited.

ABSTRACT 6 (23S114)

The Diclofenac Dilemma: delivering enhanced ERCP documentation

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Introduction
Endoscopic retrograde cholangiopancreatography (ERCP) is a therapeutic procedure for hepatopancreaticobiliary (HPB) diseases. ERCP carries significant risk of complications, such as post-ERCP pancreatitis (PEP). Diclofenac, a nonsteroidal anti-inflammatory drug (NSAID), is shown to reduce the incidence of PEP. Endoscopic record systems (ERS) do not prompt the inclusion of diclofenac, requiring manual entry by the endoscopist.

Aims/Background
To assess the ERS for pre-ERCP diclofenac administration or justification for omission.

Method
A retrospective analysis of ERCPs was completed between June 2022 and February 2023. Specialist ERCP nurses tracked each patient for episodes of PEP. An interventional session was completed midway through the study period with ERCP endoscopists to emphasise the importance of diclofenac recording.

Results
346 ERCPs were conducted in the study period, 244 pre-intervention and 102 post-intervention. The mean age was 68 years with 51.7% females (n=179/346). Diclofenac recording in the ERS improved from 54% to 85% post-intervention. The overall rate of PEP was 3%; 2.4% (n=6/244) pre-intervention and 5.7% (n=6/102) post-intervention. A higher risk subgroup for PEP (females, <40 years), accounted for 4.6% of all patients. Diclofenac administration was recorded in 88% of these patients. Within this subgroup, there were no incidences of PEP. The most common ERCP indication which developed PEP was CBD stones (58.3%), followed by pancreatic masses (16.6%) and cholangiocarcinoma (16.6%). Diclofenac was recorded for 58.3% of patients who developed PEP overall (42.8% for CBD stones).

Conclusions
Diclofenac prophylaxis against PEP is standard practice but ERS records of diclofenac administration are variable. Dedicated diclofenac prompts within an ERS may improve recording.

ABSTRACT 7 (23S141)

Digitalization as a strategy in green endoscopy: a patient based survey on digital device access and openness to a paper free approach.

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Introduction
The ESGE identified digitalisation as a tool to reduce the environmental impact of endoscopy.

Aims/Background
We aimed to evaluate patients' digital device access and openness to receiving information through digital means.

Method
We conducted an anonymous survey of patients attending for endoscopy in April 2023.

Results
In total, 77 patients responded to the survey median age was 72(range 19-90).97%(n=75) of patients reported having their own personal digital device(i.e. smartphone, laptop, smartwatch or tablet),86%(n=65) of whom had an email address, with 98%(n=64) ableto open an email attachment, and81%(n=51) having no objection to receiving information through email. Notably, 37% would still have printed the file in full or in part. Overall 66%(n=48) would have preferred an email over the current paper-based methods.Objections expressed concerned e-mail going to spam and cybersecurity. When questioned about receiving a text message with a link to a healthcare service website 77%(n=57) reported they would be able to open the link.79%(n=58) had no objections to a link as a source of information.76%(n=57) of respondents did not know that the endoscopy department already had a website., withonly 44%(n=8) of those who did consulting it prior to their procedure. 46%(n=33) expressed a preference for receiving information through e-mail, 21%(n=15) through a text(+ website link) with 33%(n=24) preferring paper based information.

Conclusions
In our cohort of digitally non-native patients, this study highlights a strong preference and acceptance for a digital distribution of information.. A minority requests paper-based information.

ABSTRACT 8 (23S132)

A Retrospective Single-Centre Review of Complications Post ERCP with Sphincterotomy Performed to Evaluate the Safety of Same Day Discharge

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Introduction
In most Irish hospitals, sphincterotomy during ERCP mandates admission for post-procedural monitoring. This use of hospital resources contrasts with international practice.

Aims/Background
To estimate complication rates in patients undergoing ERCP-with-sphincterotomy (ERCP-S) in a single tertiary referral centre in order to evaluate safety of same-day discharge in this patient cohort.

Method
Under a QI protocol, the Electronic Patient Record of patients who were admitted to St James's Hospital post ERCP-S between January 2020 and December 2021 were retrospectively identified and reviewed.

Results
In the study period, 222 patients were admitted post-ERCP-S. Significant intra-procedural complications occurred in 10 (5%). Minor (i.e., self-limited) haemorrhage occurred in 41 (19%). Among 212 patients without significant intra-procedural complication, post-procedural complications occurred in 27 (13%); pancreatitis (9, 4%),

biliary sepsis including abscess (9, 4%), subcapsular haematoma (1, 1%), perforation (3, 1%) and bleeding (10, 5%). Four patients (2%) had >1 post-procedural complication. No post-procedural haemorrhage occurred in patients with minor intra-procedural haemorrhage and vice versa. Among patients with post-procedural haemorrhage, 3 (30%) were haemodynamically unstable, 5 (50%) were treated conservatively and 5 (50%) were treated endoscopically. Severity of pancreatitis was mild in 5 (2%), moderate in 3 (1%) and severe in 1 (1%). No procedure-related mortality occurred.

Conclusions
In this retrospective single-centre study, observed complication rates are consistent with reported international experience. In patients without any major intra-procedural complications, morbidity appears low and same day discharge appears safe. If this practice was adopted nationally, a substantial number of bed-days would be diverted for alternate use.

ABSTRACT 9 (23S175)

Patency testing prior to Video Capsule Endoscopy: An Irish Experience.

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Introduction
Capsule retention, a rare but significant complication of Video Capsule Endoscopy(VCE), occurs in 1-2% of patients, depending on indication. Patency Capsules (PC) are dissolvable radio-opaque capsules which assess GI tract patency & effectively identify patients with retention risk. ESGE recommends PC prior to VCE in certain conditions.

Aims/Background
To assess PC protocols in use & the factors affecting outcomes.

Method
Procedural data:VCE & PC Indication, Local protocols & Success rates were collected from 5 tertiary centres. Demographics & Radiological results were collected from the EPR.

Results
364 procedures were reviewed. 212(58%) were female, mean age= 48years. VCE indications: Suspected IBD 115(34%), IBD assessment 82(24%), IDA/GI Bleeding 62(20%), Low Risk Symptoms 33(10%), Abnormal Imaging 15(4%). PC indications: GI Surgery 68(20%), Known Crohn's 72(21%), Obstructive Symptoms 52(15%), Stenosis on Imaging 33(10%), NSAIDs 30(9%). 81 Patients(23%) had an invalid PC indication per ESGE guidelines. Overall, 77 patients(21%) were fasted. 184(51%) Passed(Mean age=49, 53% female). Another 32(10%) proceeded to CE despite 'failure'. Age, Gender & Fasting were not predictors of PC passage (p=0.4126, p=0.2032, p=0.4441). Pass rates were similar in all centres(χ2=7.3.647,p=0.66733) . Analysis of pass rate by VCE indication (χ2=13.354,p=0.639) and PC indication (χ2=7.86,p=0.2482) also failed to show significance.

Conclusions
There are similar completion rates for PC across Ireland, and for Age, Gender and PC/VCE indication. This is surprising as we know transit time slows with age. Fasting does not appear necessary for PC. Similar completion rates for patients with a valid ESGE PC indications and without, likely represents a high false negative rate. We recommend the introduction of 3D imaging to more accurately assess location & increase PC pass rate.

ABSTRACT 10 (23S121)

Deferred vs Index Endoscopic Mucosal Resection for screen detected complex polyps

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Introduction
BowelScreen colonoscopies may identify large polyps >20mm which require Endoscopic Mucosal Resection (EMR) to successfully remove. EMR is a time-consuming procedure which has additional patient risks to consider. Optimising EMR timing has safety and financial implications for BowelScreen.

Aims/Background
To assess outcomes of deferred vs index EMRs completed within the BowelScreen programme.

Method
A retrospective analysis of prospectively-maintained EMR Registry over a 5-year period.

Results
Fifty-two EMRs in 50 BowelScreen patients were identified. 71.2% (n=37/52) were completed at index vs 28.8% (n=15/52) deferred. Median size was larger for deferred polyps (30mm vs 25mm, p=0.01). Challenging access was recorded in more deferred polyps (47%, 7/15 vs 5%, 2/36, p=0.004). Median total SMSA score was also numerically higher (13 vs 10, p=0.062). STSC rates was higher in index vs deferred groups (78.4% vs 60%, p=0.19) Complications were recorded in 2.7% of index vs 13.3% of deferred EMRs (p=0.079). There were no cases of perforation or post-polypectomy syndrome. Higher IPB rates were recorded in the deferred polyp EMRs (16.2% vs 40%, p=0.081). SC1 data was available for 66.7% of deferred and 70.3% of index EMRs. Recurrence rates were comparable in both groups (10% v 7.1%, p=1.00).

Conclusions
Completing EMRs on the date of BowelScreen colonoscopy appears safe and effective. Larger polyps >30mm and higher SMSA scores at index BowelScreen procedure require consideration for deferring EMR procedures.

Message from Michael Dineen

As another term of Presidential duty comes to an end it might be a good time to sit back and reflect on where we are and how we have reached this summit.

Prof Deirdre McNamara is the tenth President that I have worked with and is the first woman to hold the position. I am now in my twentieth year with ISG which means that every two years I get sweaty palms wondering how I might develop a good working relationship with the new incumbent. Generally, my fears are groundless, all new Presidents will try to stamp their own imprimatur on their presidential period and the majority try to incorporate the board in decisions and activities. Deirdre certainly did this and tried to spread the load by establishing sub committees to share the load.

From next year going forward we have established several bursaries for trainees which will be reviewed on an annual basis. All venues for conferences have been agreed either physically or provisionally up to the end 2025. I would like to thank the President for her support and advice during the past two years and wish her well going forward with similar sentiments to the officers and board.

Every year there are usually three vacancies on the board of ISG. I would ask people who let their names go forward to consider the commitment involved. Directors are asked to attend four Board meetings annually which are virtual and two conference meetings. In addition to this they may be required to review abstract submissions or cases and possibly to sit on a subcommittee. Since ISG is a CLG it is incumbent on all board members to sign a B10 form which means that personal information e.g. Private address, DOB and membership of other companies may be displayed at the Companies Office. All Directors will be named on the audit report.

It is also worth mentioning that the board is the body responsible for the management of the affairs of ISG and not any individual member or group. It has its own Bye Laws, Code of Governance and Memo and Articles of Association. Just setting out the structures which may not be obvious to all concerned.

When a President retires, he/she carries a lot of knowledge and information which may be lost to the Society. I have felt for many years that this might be harnessed and put to practical use for ISG. Two areas we might look at are how a new President is selected and how Lifetime Award recipients are selected. In the last twenty years only six Lifetime Awards have been given out and there is no actual process for selecting new Presidents.

I feel that consideration should be given to embracing the last five or six past Presidents into a subgroup to look at the two processes that I have outlined.

It is very important that we have a strong voice promoting ISG. To this end I would ask you to ensure that you are a fully registered member of the society, a strong membership can be an influential factor. You will find all the information that you need on www.isge.ie.

Have a great conference.

Michael Dineen
Chief Executive ISG

Photo Gallery

Dr Navneet Ramlaul & Dr Ambily Tony

Dr David O'Sullivan & Dr Emma McDonnell

Abstract Submissions selected for IBD E-Poster Presentation

Thursday 22nd June 2023, Graham Bell Suite

Abstract No.	Ref:	Title	Author	Time
11	23S110	Subcutaneous Vedolizumab – A Real World Experience	Edmond Morrissey	11.30
12	23S131	Know Nocebo: Predicting Patient Outcomes in a 32-Month Adalimumab Biosimilar Switch Study	Ciaran Mc Closkey	11.36
13	23S137	Implementation of Accurate Electronic Documentation of a Nurse-Led IBD Advice line	Tincymol Lukose	11.42
14	23S138	Cost and Convenience: Major Drivers of Patient Preference on Route of Biologic Administration	John Campion	11.48
15	23S149	Impact of Micronutrient Deficiency in an IBD Cohort on Response to Covid-19 Booster Vaccination	Jayne Doherty	11.54
16	23S163	Intestinal Ultrasound in IBD: Patient satisfaction and impact on disease-related knowledge in an Irish Cohort	Lakshman Kumar	12.00
17	23S177	A Novel App-based Self management approach to UC flare management may reduce OPD visits and steroid use	Éabha Ring	12.06
18	23S107	Anxiety and Depression is Associated with Poor Sleep Quality in patients with Inflammatory Bowel Disease (IBD)	Róisín Connaughton	12.12
19	23S169	The Impact of An IBD Nursing Service to Naas General Hospital	Joanna Rea	12.18
20	23S101	The Number of Inflammatory Bowel Disease Unclassified/Indeterminate Colitis (IBDU/IC) Patients Followed Up In The Gastroenterology Clinic In A Tertiary Referral Centre.	Ahmed Tawfik	12.24

IBD POSTER PRESENTATIONS

ABSTRACT 11 (23S110)

Subcutaneous Vedolizumab – A Real World Experience

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Introduction
Vedolizumab is an important treatment option in the management of inflammatory bowel disease (IBD). It has traditionally been administered as an intravenous(IV) infusion but is now available as a subcutaneous (SC) injection. There is a lack of real world data around SC vedolizumab use and drug levels. In Ireland, IV medications are paid for by the hospital budget and SC medications are paid for from the community health budget.

Aims/Background
1. To assess the trough levels of vedolizumab when given in SC formulation compared to IV formulation 2. To assess faecal calprotectin pre and post switching drug route 3. To assess patient's attitudes to SC therapy 4. To examine the cost savings associated with switching to SC vedolizumab

Method
Proactive therapeutic drug levels are routinely performed in our clinic and we routinely offer SC switch to patients on IV vedolizumab. Patients currently receiving vedolizumab were identified using the departmental IBD database. Inclusion and exclusion criteria were applied. Vedolizumab trough levels from when patient was receiving IV vedolizumab were compared to the most recent trough level while using SC vedolizumab. Response to SC vedolizumab was assessed using faecal calprotectin. Health related quality of life was also measured using the IBD Disk Questionnaire. A subset of patients completed a questionnaire about attitudes to SC therapy. The financial cost of providing IV vedolizumab to each patient was assessed. Data was analysed using Excel.

Results
In total 100 patients receiving SC VDZ for >3 months were identified. 5 were excluded due to missing data (4 had no drug levels while on IV, 1 had no drug level since switching to SC). 48 (50.5%) were male and 47 (49.5%) were female. The average age was 36 (18-78). 51 (54%) had ulcerative colitis (UC), 44 (46%) had Crohn's disease (CD). VDZ trough levels improved by an average of 11.51ug/mL (54%) after switching to SC ($P<0.05$). Faecal calprotectin fell by an average of 83.49ug/g (-18.5%) after switching from IV to SC formulation ($P<0.05$). There was a correlation between the VDZ level after switching to SC and the post SC switch faecal calprotectin, $r = -0.20$ ($p=0.05$). Average IBD disk score while on SC VDZ was 44.74/100. In a subset of patients surveyed (n=10) 90% preferred SC to IV VDZ. Our hospital saves 2.13 million euro per year due to the SC switch of the 95 patients included in the study. Our unit also saves 614 infusion suite appointments per year due to the SC VDZ switch.

Conclusions
Switching from IV to SC VDZ is not associated with a deterioration in drug levels or faecal calprotectin levels. Switching from IV to SC VDZ saved significant amounts of money for our hospital budget and has improved our infusion suite capacity.

ABSTRACT 12 (23S131)

Know Nocebo: Predicting Patient Outcomes in a 32-Month Adalimumab Biosimilar Switch Study

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Introduction
While randomized studies have shown that Amgevita (an adalimumab biosimilar) and Humira (adalimumab originator) are equivalent, concerns persist among patients and prescribers as to its efficacy. Patients switching to a medicine they perceive as lower cost may experience a 'nocebo' effect, whereby expectations of poorer efficacy may lead to worse clinical outcomes, resulting in an unmeasured health economic burden.

Aims/Background
We conducted a biosimilar switch study in August 2020, where patients changed treatment from Humira to Amgevita. We obtained baseline FCP, drug and drug-AB levels, Harvey-Bradshaw (HBI) and Partial-Mayo scores. Patient-Reported Outcomes (PROs) were recorded through the IBD control-8 (IBDC8) and IBCD visual analogue scale (IBDQ-VAS). Patients took psychometric tests pre-switch, including the 'Beliefs about Medicines' (BMQ), 'Health Anxiety Index' (HAI), and the EQ-5D questionnaires. The original study found no significant differences in clinical and PROs at 8-week follow-up. We planned to conduct a 32-month follow-up on these patients to examine for temporal changes in outcomes.

Method
Approval was obtained from the hospital ethics committee. Patient information from the original study was stored on an excel database. We retrospectively obtained clinical data from electronic records and lab data. Questionnaire results were obtained at OPD.

Results
70 patients were included in the study. 41 male, 29 female. 54 patients had Crohn's, 13 UC, and 4 indeterminate colitis. 25.7% of patients reported adverse events post-switch, with 33.3% of these patients switching back to Humira. The most common side effects related to skin (8.6%), injection site (5.7%), and headaches (2.8%). 8.6% of patients felt the medication to be less effective without specific symptoms. 32-months post switch, 72.7% remained on Amjevita, 9.1% had switched back to Humira, 7.6% had switched to another biologic, 10.6% had stopped biologic treatment. Median scores were calculated at 8 weeks pre and post-switch, and again at 32 months. HBI scores were 2, 1 and 1 respectively, with scores of 1, 0 and 0 in the switchback group. IBDC8 scores were 12, 13 and 14 overall, with scores of 12, 10 and 14 in the switchback group. IBDQ-VAS scores were 87, 80 and 90 overall, and scores of 100, 100 and 85 in the switchback group. Median HAI scores were 12 in the switchback group versus 17 overall indicating lower anxiety about their health. Median scores in all four domains of the BMQ questionnaire were lower in the switchback group. Scores were 12, 12, 8, 7, versus overall scores of 21, 14, 10, and 9 respectively, indicating more negative attitudes towards medicines in the switchback group.

Conclusions
Our study found no negative impact in clinical outcomes and PROs in patients switching from Humira to Amgevita at 32-months post-switch. Patients that had more negative attitudes to medicines in the BMQ questionnaire were more likely to switchback to Humira suggesting a nocebo effect. Enhanced patient education may help to mitigate the nocebo effect observed in our study and enhance the success rate of future biosimilar switch trials.

ABSTRACT 13 (23S137)

Implementation of Accurate Electronic Documentation of a Nurse-Led IBD Advice line

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Introduction
Beaumont Hospital is a tertiary referral centre providing care to over 2500 Inflammatory Bowel Disease (IBD) patients. The service offers an IBD nurse telephone advice line per international IBD standards. This was established to allow patients on-demand access to our service, improving the overall quality of care.

Aims/Background
1: Calls to the IBD line are accurately documented] 2: Response time is recorded for all calls 3:Calls are audited every month to ensure our response goals are met. 4:Auditing allows us to identify weaknesses in the service 5: These measures have allowed us to improve our services continually.

Method
We have compiled a spreadsheet to document the date of the call, date of the return call, patient name, hospital identification number, consultant name, reason for calling, and intervention time spent with each patient. This database is managed virtually directly by an IBD Nurse or discussed with the medical team.

Results
Two thousand six hundred thirty-three calls were received from January 2022 to September 2022. Auditing is performed monthly, identifying areas requiring improvement. Patients are frequently re-educated on how to best engage with our service. Pathways have been established to divert the calls to the appropriate alternative services such as administrators, endoscopy department, infusion service and GP services freeing our service for the appropriate calls only. 30% of calls related to IBD flares.82% of patients with flares were directly managed by IBD nurses. Overall, 75% of calls were managed by an IBD Nurse virtually. An online patient satisfaction survey conducted showed that 98% of patients expressed excellent satisfaction with the advice line service.

Conclusions
The documentation and precise measurement of each call through the IBD nurse advice line provided a better insight into the service. The continuous use of audits identified the gaps in our service, allowing improvement to be made. Continued patient education and diversion calls to other departments enhance the utilisation of IBD Nurse time.

ABSTRACT 14 (23S138)

Cost and Convenience: Major Drivers of Patient Preference on Route of Biologic Administration

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Introduction
Subcutaneous (SC) Infliximab (IFX) is non-inferior to intravenous (IV) IFX, for maintenance of remission in inflammatory bowel disease (IBD). There is limited data on factors affecting the decisions of patients who choose SC administration of biologics. Our centre offered suitable patients SC IFX from November 2022.

Aims/Background
(1) To determine whether there are disease-related or economic, social and personal factors that affect the decision of a patient with IBD to transition from IV to SC administration of IFX, (2) To assess the effects of SC administration on drug pharmacokinetics and disease control.

Method
Participants completed a questionnaire on their IBD history, personal and financial circumstance, reasons for electing or declining to transition. Clinical and biochemical data were retrieved from the electronic patient record.

Results
144 patients were offered the opportunity to transition during the study period. 80 (55.5%) agreed to transition. 101 patients (70.1%) agreed to participate in the study. 59.4% were male, 67.3% had Crohn's disease. Age ranged from 18-82 (median 41) years. Infusion frequency was every 4 (9.8%), 6 (22.8%), 7 (2.0%), or 8 weeks (65.4%). 76% were employed or self-employed, 41.6% had a medical card, 44.6% health insurance. The median (IQR) travel time was 90 mins (40, 130). 48 patients (47.5%) reported that they missed school/work for their infusions. At baseline, median (IQR) laboratory results were CRP 1.2mg/L (0.6, 2.7), IFX trough 7.4mg/mL (4.9, 11.8), faecal calprotectin 39 µg/g (10, 98), IBD-Control 14 (13, 16). 8 weeks after first SC dose. Median (IQR) results (n=36) were CRP 1.1mg/L (0.8, 2.0) IFX trough 17.8mg/mL (12.5, 21.4), IBD-Control 16 (14, 16). Among respondents who elected to transition, the strongest reasons (% agree/ strongly agree on five-point Likert scale) were, "I want to transition because I believe it will…" (1) reduce my travel time (94.5%), (2) fit my work/life balance better (87.3%) and (3) reduce my time away from work/school (74.5%). Among respondents who declined to transition, the strongest reasons (% agree/strongly agree) were, "I do not want to transition because…" (1)I would miss having my bloods checked regularly (84.8%), (2) I feel safer attending the infusion unit (80.4%), (3) I would not be able to voice concerns about my treatment as easily (80.4%) and (4) I would miss regular contact with a healthcare professional (69.6%). Binary logistic regression was used to examine what factors were associated with the likelihood of electing to transition. Drug payment scheme (DPS) status and missing work/school significantly contributed to the model (Table 1). Those who missed work/school to attend for their infusion had OR = 3.79 while those on the DPS had OR = 4.99.

Conclusions
SC IFX is safe, effective and well-tolerated by those who choose to transition. It is attractive to many patients, because attending for IV infusions can interrupt their employment, education and family life, however cost is a significant barrier for some patients. To support patients that choose to transition, IBD teams must be adequately resourced, in order to ensure that these patients continue to have easy access to high-quality medical care. Discrepancies in the healthcare market in Ireland may provide a perverse incentive to continue receiving IV biologic, for those who would prefer SC.

ABSTRACT 15 (23S149)

Impact of Micronutrient Deficiency in an IBD Cohort on Response to Covid-19 Booster Vaccination

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Introduction
Essential trace elements such as selenium (Se), copper (Cu) and zinc (Zn) are important in regulating the immune system. Deficiency in these elements can correlate with disease severity and mortality in COVID-19 infection; however, their observed impact on immune responses to COVID-19 vaccination is mixed.

Aims/Background
Our aim was to determine the association between suboptimal Se, Cu and Zn status in patients with inflammatory bowel disease (IBD) on Spike Protein (SP) immunoglobulin (Ig)G levels post-vaccination against COVID-19 and prevalence of SARS CoV2 infection.

Method
IBD patients and healthy controls (HC) were recruited prospectively from four hospitals. Quantitative antibody responses, Se, Cu, Zn, ferritin, selenoprotein P (SELENOP) and Glutathione peroxidase 3 (GPx3) concentrations were assessed following third COVID-19 vaccination. Infection with COVID-19 was defined by a positive IgG nucleocapsid antibody test (IgGNC).

Results
165 participants were included in analysis (117 IBD patients and 47 HC). We observed no statistically significant difference in median Cu ($p = 0.06$), Zn ($p = 0.44$), Se ($p = 0.78$), GPx3 ($p = 0.28$) or ferritin concentrations ($p = 0.51$) dependent on previous COVID-19 infection. Participants with a previous history of COVID-19 infection had statistically significant lower SELENOP concentrations (3.9 versus 4.34 mg/L, $p = 0.05$). Ferritin ($p = 0.14$), Se ($p = 0.34$), Zn ($p = 0.45$), GPx3 ($p = 0.59$) nor Cu concentrations ($p = 0.14$) showed no relationship with vaccine response. We observed participants with lower SELENOP concentrations (<3 mg/L) had significantly lower anti-SP IgG levels (5,250 versus 11,385 AU/ml, $p = 0.05$), which appears to be driven by the differences in IBD patients (5,003 versus 8,190 AU/ml, $p = 0.08$).

Conclusions
Lower SELENOP concentrations are associated with previous SARS CoV-2 infection and decreased anti-SP IgG levels in response to COVID-19 vaccination. The impact of SELENOP concentrations on COVID-19 infection and vaccine response requires further validation and investigation in prospective studies to better understand the mechanisms of attenuated response in patients with IBD.

ABSTRACT 16 (23S163)

Intestinal Ultrasound in IBD: Patient satisfaction and impact on disease-related knowledge in an Irish Cohort

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Introduction
Monitoring of disease activity is integral in guiding the management of inflammatory bowel disease (IBD). With many tools available at our disposal, patient preference should also play a role in determining the modality of assessment, along with accuracy, accessibility, and safety. Intestinal ultrasound (IUS), currently in its infancy in Ireland, is a non-invasive tool that is comparable to magnetic resonance imaging (MRI) and computed tomography (CT) in accurately assessing disease activity and extent.

Aims/Background
To evaluate patient perspectives on IUS and its impact on the knowledge of their disease.

Method
Patients with IBD who underwent IUS between February and March 2023 were offered a questionnaire which measured their satisfaction of the service, their acceptability of IUS compared to other monitoring tools and if IUS improved their IBD-specific knowledge using a 5-point Likert scale. Baseline demographics were recorded, and subgroup analysis, based on weighted average (w.a.) scores out of 5, was performed.

Results
A total of 31 patients participated in the study, of which 87.1% (n=27) had Crohn's Disease and 12.9% (n=4) had Ulcerative Colitis. The median age was 33 (SD 20.2) and 77.4% (n=24) were male. 71.0% (n=22) had previously underwent MRI and all patients had a previous colonoscopy. 93.5% (n=29) of patients were very satisfied (w.a. 4.94) with their IBD care on the day with 87.1% (n=27) fully agreeing that IUS positively influenced their satisfaction (w.a. 4.87). Patients did not feel that IUS took too long (w.a. 4.87) or caused discomfort (w.a. 4.68). Patients also had a strong preference for IUS over colonoscopy, MRI and CT but this was not the case for stool and blood sampling. Furthermore, patients felt that IUS improved their knowledge across all parameters including overall understanding (w.a. 4.52), disease activity (w.a. 4.58), disease extent (w.a. 4.55), need for therapy (w.a. 4.55) and adherence to therapy (4.48). No significant differences were seen in questionnaire results across age, gender, and primary diagnosis.

Conclusions
IUS has shown to be widely accepted in monitoring disease activity with excellent satisfaction scores. It is also preferred to other available imaging modalities, with an added benefit of improving patients' knowledge about their disease, making IUS a useful tool for our IBD patient cohort.

ABSTRACT 17 (23S177)

A Novel App-based Self management approach to UC flare management may reduce OPD visits and steroid use

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Introduction
The incidence of UC is increasing and with this comes the challenge to provide timely and high-quality care. Empowering patients to self-manage, with appropriate support, can help meet this challenge and improve the patient experience.

Aims/Background
To assess acceptability and efficacy of a novel remote monitoring and flare management intervention in a prospectively gathered cohort of patients with mild – moderate UC over a 1-year period and compare findings with a control group. We report initial results at 3 months. Endpoints include number of hospitalisations, endoscopy, OPD visits, steroid use and IBD nurse contacts. The study also secondarily aims to assess acceptability.

Method
Adult Patients with mild-moderate UC on 5-ASA monotherapy not actively flaring or on steroid were eligible for inclusion. Education on flare symptoms was provided. In the event of a potential flare, the patient was advised to use the faecal calprotectin (FCP) kit provided. If elevated, the patient then increases 5 –ASA dose, log FCP result onto an app resulting in notification to the IBD team triggering a phone call for further advice /treatment and a patient experience questionnaire is sent. A control group was also identified from the IBD database who continue with standard care in the study institution which is if the patient thinks they are flaring they contact the IBD nurses. Fishers exact test was used for the analysis.

Results
40 patients (20 cohort, 20 control) have been recruited in the first 3 months. The clinical and demographic features of both groups are similar. There is a trend towards less OPD visits (5%v 20% p=ns), fewer endoscopies (0% v 15%, p=ns) and significantly less topical steroid use (5% v 25% $p<0.01$) in the active group compared to controls.

Conclusions
Further follow-up is required but early analysis suggests reduced need for OPD visits, endoscopies and significantly less topical steroid use in the participant group.

ABSTRACT 18 (23S107)

Anxiety and Depression is Associated with Poor Sleep Quality in patients with Inflammatory Bowel Disease (IBD)

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Introduction
Sleep disturbances affect 40-50% of patients with IBD and are associated with disease flares. Symptoms, treatments side effects and pro-inflammatory status have shown to impact sleep quality and duration. Anxiety and Depression disorders are common with both conditions affecting 20% of patients.

Aims/Background
To assess for a correlation between sleep quality and mood disorders in people with IBD, and assess the impact of this on quality of life.

Method
87 patients with IBD completed a survey detailing general demographics, IBD information, Pittsburgh Sleep Quality Index (PSQI), Hospital Anxiety & Depression Scale (HADS), disease activity scores (HBI & partial MAYO score), and Short Inflammatory Bowel Disease Questionnaire (SIBDQ). Various tests were used to calculate statistical significance.

Results
Mean age 43years. 46% male (n=40) 54% female (n=47). Ulcerative Colitis 35.6% (n=31), Crohn's Disease 62.1% (n=54), indeterminate 2.3% (n=2). The mean global PSQI score was 7.66, with 62% (n=54) of participants having a global PSQI score >5, indicating poor sleep quality. Poor sleep quality was not associated with age or disease duration. It was associated with increased disease activity; Remission 5.89, mild activity 7.53,moderate activity 10.61 ($p<0.001$) Participants with poor sleep had significantly higher rates of anxiety (HADSA >8) with a mean HADS anxiety score of 10.78 with 79% (n=39/49) reporting anxiety, compared to those with reporting good sleep with mean scores of 4.97 and 21% (n=7/33) reporting anxiety $p<0.001$. They had higher rates of depression, 42%(n=21/49) versus 6%(n=2/33), $p<0.001$.

Conclusions
Poor sleep quality increases levels of anxiety and depression impacts quality of life in patients with IBD.

ABSTRACT 19 (23S169)

The Impact of an IBD Nursing Service to Naas General Hospital

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Introduction
In 2019 an Inflammatory Bowel Disease (IBD) nursing service was introduced to Naas General Hospital (NGH). The aim of the service was to provide support for patients and disease management education.

Aims/Background
The aim of the audit was to ensure that the service was being managed effectively and that patients were satisfied with the service.

Method
420 questionnaires were distributed to patients with IBD attending NGH. Questionnaires asked patients to rate the service according to benefits in relation to their disease. They were also asked to rate the service in relation to satisfaction of the service.

Results
Overall satisfaction was high amongst patients who had used the service with up to 26% of respondents not having used the service yet: Was the IBD service beneficial in managing symptoms, receiving disease and treatment information? • Strongly agreed or agreed 63 – 76% • Neutral 0 – 4% • Not answer or not applicable 21 – 25% General satisfaction and efficiency • Very satisfied or satisfied 66 – 75% • Neutral 0 – 3% • Not answered or not applicable 21 – 26% Patients testimony included • 'Full of knowledge and so quick to help' • 'Support making managing Crohns so much easier' • 'Keep doing what you're doing it's fabulous having a caring nurse at the end of the phone' • 'Very valuable and accessible service gives peace of mind to IBD patients.

Conclusions
The IBD nursing service has been an excellent addition to NGH. Patients feel more confident managing their disease knowing they have guidance available for when they are unwell with quick intervention to keep them out of hospital.

ABSTRACT 20 (23S101)

The Number of Inflammatory Bowel Disease Unclassified/Indeterminate Colitis (IBDU/IC) Patients Followed Up in The Gastroenterology Clinic in a Tertiary Referral Centre.

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Introduction
Inflammatory bowel diseases cover conditions generally grouped into Crohn's disease (CD) or ulcerative colitis (UC) based on clinical, laboratory, radiological, endoscopic, and histological criteria. However, inflammatory bowel disease unclassified/indeterminate colitis (IBDU/IC) is used when there are clinical and endoscopic signs of chronic colitis without specific features of UC or CD but features of both [1–3]. Previous studies have shown that a diagnosis of IBDU/IC is present in 5–15% of IBD cases [4]. Paediatric-onset IBDU/IC is twice as typical as adult-onset disease, with the highest prevalence among younger ages [5]. In some cohorts, pediatric IBDU/IC clinical follow-up shows that up to 80% of patients are reclassified as having CD or UC. This suggests that many cases may be early manifestations of CD or UC. However, other studies have reported that up to 69% of patients maintain their pediatric-onset diagnosis of IBDU/IC into adulthood [5]. Most patients diagnosed with IBDU/IC are treated similarly to UC, and treatment choices are based on disease severity. Others are managed again to CD if there are features suggestive of CD, including fissures, skin tags, or rectal sparing. In medically refractory IBDU/IC, surgical treatment options are limited and include total proctocolectomy (TPC) and ileal pouch–anal anastomosis (IPAA) [6].

Aims/Background
This study aimed to identify the number of cases not classified as a subtype of IBD, followed up at an IBD clinic at an Irish tertiary referral centre.

Method
Medical records of 1676 patients referred/followed up at the IBD clinic in Beaumont hospital were retrospectively studied, including clinical letters, endoscopy reports, and available previous biopsy results.

Results
We identified 97 IBDU patients out of 1676 patients followed up in the IBD clinic (5.79 %), and 1549 were IBD patients, of which 740 were CD patients (44.15%), and 809 were UC patients (48.27%), while the remaining 30 patients (1.79 %) diagnosed as Microscopic colitis (15 patients; 50%), IBS/NSAIDS-induced colitis (10 patients, 33.3%), infectious colitis (4 patients;4 %) and autoimmune enteropathy (1 patient; 3.3%). Interestingly, 5 out of 97 IBDU patients were on biological therapy (one patient on Adalimumab, two patients on Infliximab, one patient on Tofacitinib, one patient on Ustekinumab) and reclassified as UC (4 patients) and CD (1 patient).

Conclusions
Our retrospective study yielded 93 patients (5.5 %) followed up in the IBD clinic were IBDU/IC and this is consistent with published studies. Only five IBDU/IC patients were reclassified as IBD and required biological therapy to be commenced.

Photo Gallery

Dr Mairead McNally, Dr Fiona Jones & Dr Ciara Egan

Neil Power, Abbvie & Michael Doyle, Janssen

Abstract Submissions selected for Hepatology E-Poster Presentation

Thursday 22nd June 2023, Marconi Suite

Abstract No.	Ref:	Title	Author	Time
21	23S142	Disparities in access to timely diagnosis and treatment for hepatocellular carcinoma- need for standardisation across cancer types.	Niamh Mehigan Farrelly	11.30
22	23S120	A prospective evaluation of a nurse-led NAFLD clinic (NLNC); the impact on the Hepatology service and patient waiting times.	Orla Chambers	11.36
23	23S122	Use Of Non-invasive Tests For Liver Fibrosis Staging In Alpha-1 Deficiency Patients	Hassaan Yousuf	11.42
24	23S116	Delivery of a transient elastography service for vulnerable populations at risk of liver disease	Dr Donough Smyth	11.48
25	23S140	Non-invasive tests of liver fibrosis: pitfalls and opportunities	Leah Timon	11.54
26	23S127	What's the Delta? Hepatitis Delta virus prevalence and screening rates amongst patients with Hepatitis B virus	David O Sullivan	12.00
27	23S136	BMI Among First Liver Clinic Attendances To The Mater Misericordiae University Hospital (MMUH) – A Retrospective Observational Study	Siew Ting Ooi	12.06
28	23S134	Hepatology Inpatient End-of-Life-Care Guideline for Patients with End-Stage Liver Disease: A Quality Improvement Project.	Sara Naimimohasses	12.12
29	23S179	Cystic Fibrosis may be an exclusion criteria for Li-RADS	Dr. Khuram Shahzad	12.18
30	23S119	The Roll Our Of Hepatitis C Community Treatment Programme In Cork	Marih O'Leary	12.24

HEPATOLOGY POSTER PRESENTATIONS

ABSTRACT 21 (23S142)

Disparities in access to timely diagnosis and treatment for hepatocellular carcinoma- need for standardisation across cancer types.

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Introduction
Hepatocellular carcinoma(HCC) is the fifth most common cancer and second leading cause of cancer-related death globally. In Ireland, mortality from liver disease has increased 400% over the past 40 years; a contributing factor is a 300% increase in primary liver cancer.

Aims/Background
Target quality metrics for cancers at Cancer Centres in Ireland include time to diagnosis and time to treatment as less than 20 days. We wanted to outline the timelines for HCC diagnosis and treatment at our centre.

Method
Using local and tertiary referral center databases as well as discharge coding, all patients diagnosed with HCC from Jan 2021 to Dec 2022 were identified. Diagnosis was based on imaging criteria or histology.

Results
34 patients were diagnosed with HCC during this period. 85% were male with a median age of 70 years. Cirrhosis was present in 88% of cases. HCC was detected by surveillance in 47% and symptomatic in 53%. Of those diagnosed at surveillance 63% were BCLC stage A/0 compared to 12% being stage A/0 if symptomatic at diagnosis. Upon diagnosis only 21% were eligible for curative treatment and 44% were deemed for supportive care only. The median time from a suspicious scan(ultrasound or CT) to diagnostic radiology or histology was 49 days(range 1-267). The median time from diagnosis to treatment was 95 days(range 20-374).

Conclusions
The majority of HCC cases are diagnosed outside of surveillance, and are associated with advanced stage at diagnosis. Severe deficiencies in access to timely diagnostics and treatment for HCC are evident, and must be addressed urgently to improve survival and outcomes for patients.

ABSTRACT 22 (23S120)

A prospective evaluation of a nurse-led NAFLD clinic (NLNC); the impact on the Hepatology service and patient waiting times.

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Introduction
Non-alcoholic fatty liver disease (NAFLD) is the leading cause of chronic liver disease worldwide, affecting approximately 1 in 4 adults. Nurse-Led clinics have largely shown a positive impact on patient outcomes, ease access to care and reduce pressure on consultants.

Aims/Background
To assess and investigate patients with NAFLD at a 'one stop shop' visit, hence improving efficiency and reducing waiting times for the Hepatology Service.

Method
Hepatology referrals were screened by a Consultant Hepatologist and Hepatology CNM2. Inclusion criteria were; hepatic steatosis/ fatty liver disease on previous imaging, raised BMI, mildly raised liver function tests (LFT's). Nursing role at NAFLD clinic involved; record weight and BMI, patient consultation (medical/family history, current medications, and current lifestyle habits), perform Fibroscan, serological liver screen, calculate FIB-4 and NAFLD score, educate patient, and finally discuss with Consultant Hepatologist to create an individual patient plan.

Results
150 patients received appointments for the NLNC during a 10 month period; after removing cancellations and non-attenders 100 patients (67%) were reviewed by the Hepatology CNM2. Of the 100 patients reviewed, 26% had prediabetes/diabetes, 42% had hyperlipidaemia, 60% had raised LFT's, 69% had previous imaging completed of which 61% confirmed hepatic steatosis/fatty liver disease. 69% had a CAP of >260 confirming fatty liver disease, 76% had a kPa <7.9 confirming a lack of fibrosis. 66% of patients were discharged to their primary physician.

Conclusions
The introduction of a NLNC helped detect early fibrosis (kPa >7.9) in 24% of patients. 66% of patients were diagnosed with fatty liver disease without fibrosis and were suitable for discharge to their primary physician. As a result more appointments became available to patients requiring review in our general Hepatology clinic.

ABSTRACT 23 (23S122)

Use Of Non-invasive Tests For Liver Fibrosis Staging In Alpha-1 Deficiency Patients

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Introduction
Alpha-1 Antitrypsin Deficiency (AATD) is an inherited disorder characterised by lung and/or liver injury. The most severe form is seen in individuals with the homozygous PiZZ variant, while heterozygous (PiMZ; PiSZ) variants are associated with milder disease. Progressive liver fibrosis may lead to cirrhosis.

Aims/Background
To use blood-based fibrosis scores such as 1. NAFLD fibrosis score (NFS) 2. AST to platelet ratio index (APRI) 3. Fibrosis-4 (Fib-4) score and compare them to liver fibrosis stage as determined by Transient Elastography (TE)

Method
Clinical data, blood tests and TE measurements were taken on adult patients presenting to a dedicated AATD clinic over a 18-month period. LSM cutoffs used were were >7.1kPa for significant fibrosis, and >10kPa for advanced fibrosis/cirrhosis. Statistics were performed using Stata software.

Results
155 patients were assessed. Of them, 55% were female, mean age was 52.6 (+/- 16). Regarding AATD phenotype, 69 (44.5%) were PiZZ, and 62 PiMZ and 15 PiSZ. Of the overall cohort, 40 (25.8%) had significant fibrosis based on TE measurement, while 17 (11%) had advanced fibrosis. Of patients with the PiZZ phenotype, 20 (28.9% of PiZZ) had significant fibrosis, while 10 (14.4%) had advanced fibrosis. Of patients with the PiMZ phenotype, 12 (19% of PiMZ) had significant fibrosis, while 4 (6.4%) had advanced fibrosis. NAFLD fibrosis score (NFS), AST to platelet ratio index (APRI) and the Fibrosis-4 (Fib-4) score were compared with liver fibrosis stage as determined by TE. For both stages of fibrosis, these scores showed a modest ability to predict fibrosis stage without significant differences between scores; NFS (r = 0.72), APRI (r = 0.72) and Fib-4 (r = 0.74) for significant fibrosis, and NFS (r = 0.73), APRI (r = 0.76) and Fib-4 (r = 0.67) for advanced fibrosis.

Conclusions
In patients with AATD, existing blood-based, non-invasive markers of liver fibrosis have a modest ability to predict fibrosis. Reliable disease-specific tools are needed to accurately stage liver disease in AATD.

ABSTRACT 24 (23S116)

Delivery of a transient elastography service for vulnerable populations at risk of liver disease

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Introduction
The burden of liver disease in Ireland continues to grow and compete for resources. A logical method for managing this is to stratify disease at an early stage in order to manage modifiable risk factors. Transient Elastography (TE) is a safe and cost-effective assessment tool. Altnagelvin Hospital caters for some of the most socioeconomic deprived areas in Northern Ireland, who are prone to major health inequalities through inadequate engagement.

Aims/Background
A TE service has been newly established in our trust, focusing on delivering equitable care to vulnerable individuals. An iterative approach was applied to developing a sustainable, patient-centred service.

Method
Data from referral pathways, patient encounters (May 2022-February 2023), TE readings and clinical outcomes was collected. Analyses were made on indications, demographics, significant findings and implications for future care. A 'PDSA' approach was applied to service quality improvement.

Results
141 referrals were received from gastroenterology (83%) and colleagues. The bulk of referrals were of a metabolic or alcohol-related presumptive causation, with a significant proportion from hyperferritinaemia within haemochromatosis. Of the 56 patient outcomes recorded, 27% were deemed at low risk of significant fibrosis and discharged from secondary care. Cirrhosis diagnoses ensured a fast-track to specialty care.

Conclusions
TE's effectiveness has been proven in our service delivery. As we improve awareness, broaden the workforce and refine pathways, we expect colleagues within primary and secondary care to have more confidence in exploring the service. This will shorten time to definitive investigation, establish earlier diagnosis and reduce morbidity through management of modifiable risk factors in vulnerable populations.

ABSTRACT 25 (23S140)

Non-invasive tests of liver fibrosis: pitfalls and opportunities

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Department(s)/Institutions
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Introduction
Non-invasive tests (NIT) have become routine practice for diagnosis and prognosis in chronic liver disease, such as imaging elastography. Transient elastography (TE) is the oldest technique, but newer modalities such as shear wave elastography (2D-SWE) are becoming more prevalent. Nonetheless, results of these can be affected by many factors including BMI, non-fasting, alcohol and liver congestion, among others. It is essential to understand the influence of these factors on in order to optimize their use.

Aims/Background
To compare results obtained with TE and 2D-SWE in clinical practice.

Method
Retrospective review of patients who underwent TE and 2D-SWE within 6 months, between 2019-2021. TE <8kpa was considered to rule out fibrosis (NF) with TE> 10kPa considered advanced fibrosis (AF). 2D-SWE was defined as <8.3kPa for NF and >9.4kPa for AF. Values between those ranges were considered "grey area" (GA). Data was collected from TA plus and PRP database. SPSS analysis was performed.

Results
Of the 30 patients included 53.3% were female, mean age was 52.9 years (SD±14.4) and most common liver disease was NAFLD (30%). Median 2D-SWE was 7.13kPa (2.7-33.7) (63% NF, 17% GA, 20% AF) and TE 8.65kPa (3,3-68.5) (40% NF, 23% GA, 37% AF). Both tests had a low correlation (Pearson r 0.365, p 0.047). Higher age, higher BMI, NAFLD and using XL probe were factors significantly associated with lack of correlation. No data in relation to fasting was available for TE. 4 biopsies were performed and fibrosis assessed by 2D-SWE correlated with biopsy results.

Conclusions
Low correlation between TE and 2D-SWE.

ABSTRACT 26 (23S127)

What's the Delta? Hepatitis Delta virus prevalence and screening rates amongst patients with Hepatitis B virus

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Introduction
Hepatitis D virus (HDV) is a defective virus that requires the help of Hepatitis B virus (HBV) to enter hepatocytes. HDV/HBV coinfection is associated with greater progression to liver cirrhosis and mortality compared to HBV mono-infection. Screening all chronic HBV patients for HDV is standard practice. Novel anti-HDV therapeutics; such as the entry-inhibitor Bulevirtide have recently become available in Europe and show promise in treating HDV patients.

Aims/Background
To determine the prevalence and screening rate of HDV amongst HBsAg-positive patients in hepatology outpatients.

Method
All HBV hepatology outpatient attendees since 2004 were identified and corresponding serology, transient elastography, and treatment information were identified from electronic databases or medical charts.

Results
Total of 491 HBV patients, 318 of which were HBsAg-positive. Of the HBsAg-positive patients, 227 (71.4%) were screened for HDV and 8 were HDV-positive (2.5% prevalence). Of the HDV patients, 4 (50%) were females and the median age was 43.7 [40.4 – 48.0]. Countries included Romania (3), Ghana (2), Russia (1), Somalia (1), and Ukraine (1). Median HDV-positive liver elastography was 9.6 [5.9 – 20.8] and Controlled Attenuation Parameter (CAP) was 203 [169.5 – 244.3]. Treatment history of the HDV-positive patients included Tenofovir (1), Entecavir (1), Interferon (1) and no treatment (5).

Conclusions
There was an incomplete rate of HDV screening amongst HBsAg-positive patients (71.4%), and of those one-in-forty (2.5%) HBV patients were HDV-positive. Given the higher risk of adverse outcomes with HDV/HBV coinfection and the availability of novel anti-HDV therapy, there is room to further improve HDV screening to all HBsAg-positive patients.

ABSTRACT 27 (23S136)

BMI Among First Liver Clinic Attendances To The Mater Misericordiae University Hospital (MMUH) – A Retrospective Observational Study

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Introduction
The COVID-19 pandemic was associated with an increase in BMI. Obesity is a cofactor in many liver diseases. Systematic review has shown an increase in the prevalence and severity of liver disease during the pandemic. An increase in BMI could be contributing to this.

Aims/Background
The aim of this study was to investigate changes in the BMI among liver clinic referrals to MMUH before and after the onset of the COVID-19 pandemic.

Method
We reviewed electronic medical records of patients referred to the liver clinic during selected months from 2018 to 2022 and extracted data on demographics, clinical characteristics, and BMI.

Results
A total of 266 patients were included, of which 145 were referred before the pandemic (2018/2019) and 121 during the pandemic (2020/2021/2022). 54.7% were males and mean age of 52.78 (+/- 14.44 SD). The mean BMI pre- and during the pandemic were in the obese category. There was, however, no significant difference between mean BMI before (28.661) or during the pandemic (28.377) (p=0.49). There was no difference in the proportion of referrals for each liver disease subtype before and during the pandemic .

Conclusions
The mean BMI of first liver clinic attendances is in the overweight/obese range. There was no increase in mean BMI during the COVID pandemic, which was an unexpected finding. Given the role that obesity plays in the progression of liver disease, as well as in metabolic health and cancer risk, it would seem that new patient referrals to this liver clinic would be an ideal population for targeted obesity interventions.

ABSTRACT 28 (23S134)

Hepatology Inpatient End-of-Life-Care Guideline for Patients with End-Stage Liver Disease: A Quality Improvement Project.

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Introduction
Patients with end-stage malignant and non-malignant liver disease have unique needs including physical, psychosocial and spiritual, with complex medication pharmacokinetics and pharmacodynamics. The disease trajectory can be complicated by features of decompensated liver disease, co-existing or emergent renal disease and current or past drug and/or alcohol dependence. Up to date guidelines are necessary to guide management and optimise comfort and safety as these patients approach end-of-life particularly in a tertiary referral centre.

Aims/Background
To improve symptom control and prescribing for patients at end-of-life with end-stage liver disease in a tertiary referral centre.

Method
A multidisciplinary working group was established with Hepatology, Palliative Medicine and Senior Pharmacist with a special interest in Hepatology. Current practice was considered. A literature review was undertaken to inform best practice including national and international guidelines, pertinent studies and local practice. The guideline underwent multiple revisions with expert Hepatology, Pharmacy and Palliative Medicine input.

Results
A formal document was produced adopting a holistic approach to patient care with a consensus on medication guidance based on national and international guidelines, medication availability, medication familiarity and safety. Stakeholder feedback was obtained. The document will be available for prescribers through the institution intranet. Formal feedback will be obtained after a specified time period and revisions made in accordance with hospital policy and relevant guidelines.

Conclusions
Special consideration of patients with end-stage liver disease with specific attention to medication prescribing at end-of-life is essential. Specific guidance will aid symptom management and decrease the risk of unwanted side effects while improving patient comfort and safety.

ABSTRACT 29 (23S179)

Cystic Fibrosis may be an exclusion criteria for Li-RADS

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Introduction
Ireland has the highest prevalence of Cystic Fibrosis (CF) globally. Liver Imaging Reporting and Data System (LI-RADS) is the primary tool for diagnosing Hepatocellular carcinoma (HCC). Lesions are classified from LR-1 (definitely benign) to LR-5 (definitely HCC). The validity of LI-RADS in CF is unknown.

Aims/Background
Our aim is to identify all patients with CF who underwent liver imaging 2010-2022 with LR3-LR5 lesions and examine their outcomes

Method
Radiology Information System was searched for "CF" and "Cystic Fibrosis". Reports of all liver ultrasound, CT and MRI's were reviewed. Patients with a radiologically diagnosis of cirrhosis were identified including those with a liver lesion.

Results
93 patients had radiological evidence of cirrhosis, 10 had a lesion LR3 or higher. Patient 1 had a single 3.3cm LR5, biopsy was benign and the lesion remains unchanged on 22 month follow up. Patient 2 had >4 LR5's, biopsy showed regenerative nodules, confirmed on explant following transplant. Patient 3 had a 2cm LR4 lesion underwent liver transplant for hepatic decompensation, explant revealed a regenerative nodule. Patient 4 had a 4.3cm LR4 lesion which did not undergo biopsy, the lesion is unchanged on 4 year follow up. Patient 5 with a 6cm LRM underwent biopsy showing HCC. In the remaining 7 patient, LR3 lesions remain stable with median follow up of 36 months (6-168)

Conclusions
HCC is rare in CF with only 4 cases reported globally. Our data suggests that LI-RADS may not be applicable in CF. Histological confirmation should be considered.

ABSTRACT 30 (23S119)

The Roll Our Of Hepatitis C Community Treatment Programme In Cork

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Introduction
In 2022 community HCV treatment was launched in Cork. Hepatitis C is a liver infection caused by the Hepatitis C virus (HCV). It is estimated 10,000-24,000 people are infected in Ireland. In 2019 the National Hepatitis C Treatment Programme (NHCTP) published guidelines for the community treatment of patients receiving opioid substitution therapy (OST). It utilises 'Treatment as Prevention' (TasP) as a prospective HCV elimination strategy.

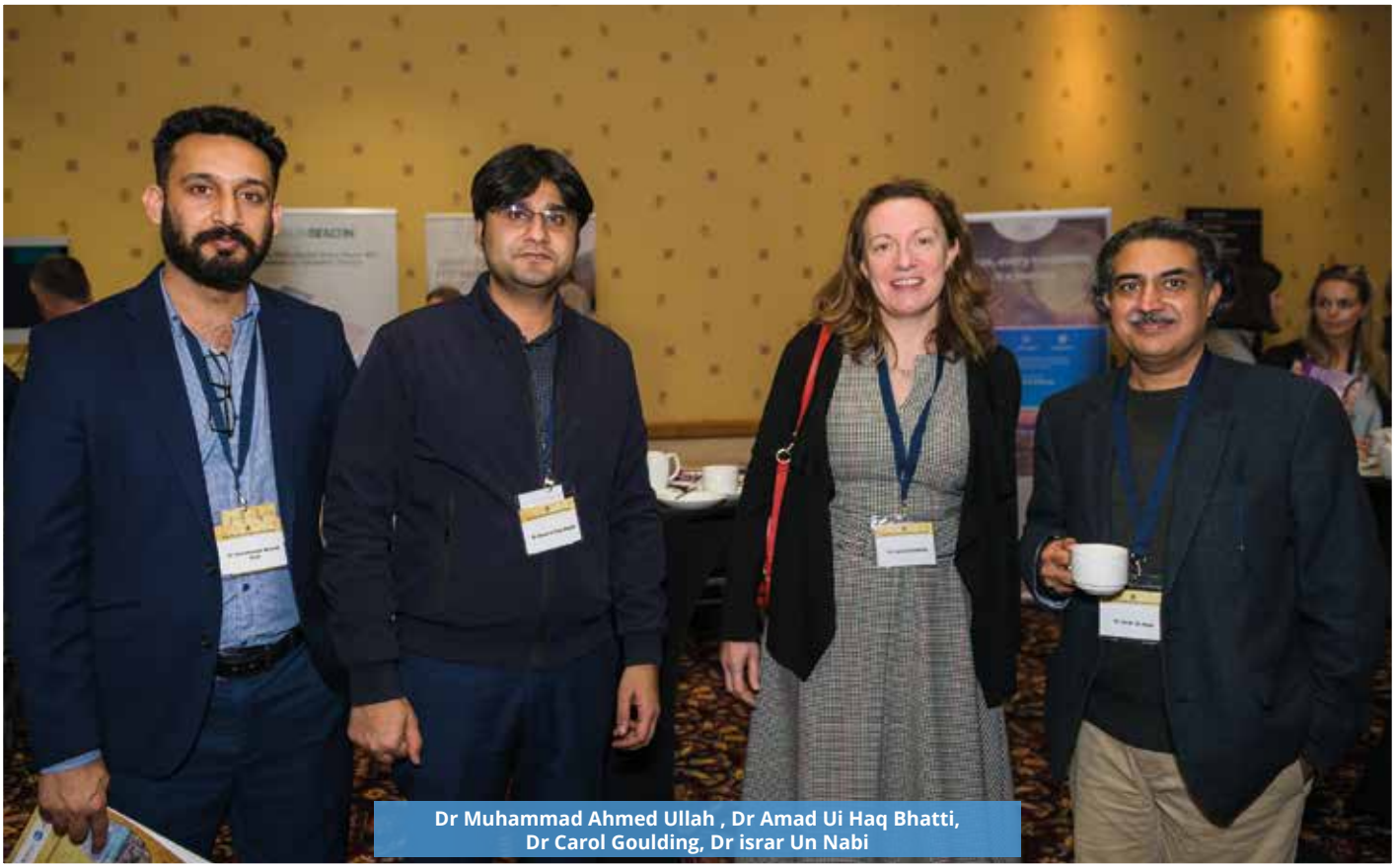
Aims/Background
To establish a working model between the hospital, addiction services and community pharmacists. To facilitate safe prescribing and dispensing of Direct Acting Antivirals (DAAs).

Method
Community pharmacies with a large number of OST patients were identified for early training. Screening days were arranged to identify positive patients and increase awareness of the new service to potential patients. Site visits were undertaken by the hospital HCV specialist nurse and hospital pharmacist to conduct education sessions on the service, the medications and answer any questions the key workers and the patients had.

Results
Over a 7 month period, 50 patients were screened for (HCV) infection with a positivity rate of 32% (n=16). All 16 patients commenced treatment via the community treatment pathway between May 2022 and December 2022. All patients completed their treatment.

Conclusions
Education prior to rolling out the service was key in ensuring those involved understood their roles and who to contact in all eventualities. As the national guidelines are reviewed with a view to extending the service to individuals not on OST, this service will be critical in reaching the "harder to reach" populations.

Photo Gallery



Dr Muhammad Ahmed Ullah , Dr Amad Ui Haq Bhatti, Dr Carol Goulding, Dr israr Un Nabi

Dr Emily Stenke & Ms Brid Devery

Photo Gallery

Ms Madeline Bennett, Ms Sharon Hough & Dr Ion Cretu

Dr Oliver Reed, Dr Nicholas Kelly & Dr Thomas Garvey

Photo Gallery

Prof Susan McKiernan, Prof Richard Farrell
& Dr Manus Moloney

Dr Sinead Smith, Dr M Syafiq Ismail
& Dr Margaret walshe

ISG Winter Meeting 2022 Award Winners

Dr Julia Sopena Falco

Dr Thomas Butler

ISG Winter Meeting 2022 Award Winners

Ms Sarah Gleeson

Dr Maeve Clarke

ISG Winter Meeting 2022 Award Winners

Ms. Rebecca Fitzgerald

Dr Tiarnán Fallon Verbruggen

Photo Gallery

Dr Nadeem Iqbal & Dr Danny Cheriyan

Pfizer stand

Photo Gallery

Dr David O'Sullivan and Dr Emma McDonnell with Ambu stand

Dr Thomas Matthewsm, Dr Sandeep Sihag & Dr Caroline Walker

Abstract Submissions selected for Other GI E-Poster Presentation

Thursday 22nd June 2023, Baird Suite

Abstract No.	Ref:	Title	Author	Time
31	23S126	Review of the Efficacy of Teduglutide, a Novel Treatment for Patients with Intestinal Failure	Aimee Drudy	11.30
32	23S178	H. pylori	Conor Costigan	11.36
33	23S113	Clearing the path for Advanced Endoscopy Training in Ireland	Eoin Keating	11.42
34	23S166	Facilitators And Inhibitors To First Adult Care Visits In The Transition From Paediatric To Adult Orientated Inflammatory Bowel Disease Healthcare	Joanna Rea	11.48
35	23S154	An observational study to determine association of Streptococcus Bovis infection with colorectal cancers and other gastrointestinal pathologies	Ambily Tony	11.54
36	23S153	Early Outcomes Following The Establishment Of A Pilot High-Risk Pancreatic Cancer Surveillance Clinic	Darragh Storan	12.00
37	23S157	The Incidence Of Coeliac Seropositivity In The West of Ireland	Gillian Madders	12.06
38	23S118	Interplay between IBS phenotype, hydrogen and methane breath test (HMBT)status, symptom severity and presence of neuropsychological conditions in an Irish setting.	Lillian Barry	12.12
39	23S111	Patient perspectives about treatment preferences for obesity with complications an IMI2 SOPHIA study	Hilary Craig	12.18
40	23S105	Nitrous Oxide Sedation for Endoscopy in Irish Hospitals	Edmond Morrissey	12.24

OTHER GI POSTER PRESENTATIONS

ABSTRACT 31 (23S126)

Review of the Efficacy of Teduglutide, a Novel Treatment for Patients with Intestinal Failure

Author(s)
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Introduction
Teduglutide (Revestive) is a recombinant human GLP-2 analogue. It is currently approved for adult and paediatric patients (>1 year) with short bowel syndrome (SBS) who are dependent on parenteral nutrition (PN).

Aims/Background
To report the Irish experience with teduglutide since its introduction 2 years ago

Method
A total of 10 patients were prescribed teduglutide at St James' Hospital and Children's Health Ireland at Crumlin between January 2021-April 2023. A retrospective chart review was conducted.

Results
The audited population, included five adult patients and five paediatric patients. 80% (n=8) of patients were male. Upon commencement of teduglutide, patient ages ranged from age 4-65 years. Causes of SBS included gastroschisis (30%), volvulus (20%), intestinal ischaemia (20%), Crohn's disease (10%), necrotising enterocolitis (10%) and extensive surgical resection (10%.) Mean duration of treatment with teduglutide was 10 months (1-27 months.) Teduglutide was discontinued in 33% patients (n=2) due to weight loss and an increase in PN requirements after at least 6 months of treatment. Overall, 60% (n=6, 3 adults, 3 children) of patients had a substantial reduction in weekly PN requirements (≥20% reduction in PN volume from baseline), while remaining nutritionally stable. The average reduction in weekly PN was 47% (14-100%) or 3,703 mL/week (1000-7786 ml/week) or additional 2 nights/week off PN (1-4 nights/week.) 20% of patients (n=2) attained PN independence. Overall, teduglutide was well tolerated. Adverse events of note included acute cholecystitis (n=1), pseudo-obstruction (n=1) and line sepsis (n=2).

Conclusions
Our data provides further real-world evidence for the efficacy of teduglutide in patients with IF.

ABSTRACT 32 (23S178)

H. pylori

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Introduction
In recent years, H.pylori eradication have fallen, likely due to increasing antibiotic resistance. Previously our team showed Clarithromycin Triple Therapy(CTT) failure in 123/482(26%) of people, suggesting high prevalence of clarithromycin-resistant H.pylori in Ireland.

Aims/Background
There are few therapeutic options available in Ireland. Maastricht VI guidelines recommend in areas of high clarithromycin resistance that High Dose Amoxicillin(HDA) can be considered, subject to evidence for local efficacy. We aimed to assess efficacy of HDA therapy for H. pylori.

Method
All patients testing positive for H. pylori in a Tertiary Centre were treated with HDA(Amoxicillin 1g TDS & Esomeprazole 40mg BD x2/52). Eradication was confirmed with UBT 4 weeks after therapy. A delta-over-baseline>4 was considered positive. Patient demographics were collected from the EPR. CTT Eradication rates between 2019-2022 were reviewed from the GI lab/TCD Research database for comparison.

Results
To date, 110 patients were included. 7 were excluded due to penicillin allergy. 17 declined or DNA follow up testing.(N=87) 57%Patients were identified on UBT, 43% on OGD. No patients had H. pylori culture & sensitivity available. 53/87(58%) were female, mean age 46 years. 53 patients(62%) were treatment-naïve (57% Female, mean age 45). Currently, post-eradication results are available for 86 patients Eradication was achieved in 53(62%) cases. In the naïve group, 37(70%) had successful eradication. Age & Gender were not significant predictors of eradication. There was no statistically significant difference in eradication between HDA and CTT groups (p=0.5093)

Conclusions
Overall eradication rates were disappointingly low. 17 (15%) patients declined post-eradication UBT. This represents a re-testing bias towards those with symptoms and persistent infection. While not a direct comparison with our previous standard of care, HDA appears non-inferior to CTT as first line therapy for H pylori for our cohort. It is cheaper, has a better side effect profile & fewer drug interactions & could be considered as first line therapy for H. pylori when quadruple therapy is unavailable.

ABSTRACT 33 (23S113)

Clearing the path for Advanced Endoscopy Training in Ireland

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Introduction
Endoscopy training for SpRs is evolving with the STEPS program in conjunction with the NEQI. Access to structured therapeutic endoscopy training remains at an earlier stage of development.

Aims/Background
To characterise current GI trainee's interest in, exposure to and barriers to training in advanced endoscopy.

Method
An anonymous survey was distributed to all current GI SpRs via weblinks. Results were analysed using SPSS.

Results
23 trainees responded (52.3% of SpRs), with all years of training represented. All trainees had exceeded 200 OGDs and colonoscopies by 3rd year of HST. Procedural volume correlated strongly with increased years of training for OGD (R=0.63, p=0.001) and colonoscopy (R=0.708, p=<0.001). Advanced endoscopy is a primary or secondary interest of 78.3% of trainees, with EMR being the most popular technique. 76.8% of SpRs had minimal observational exposure to advanced endoscopy in the current training year. Fewer trainees received practical exposure, with 84.6% reporting minimal exposure to hands-on training. GIM commitments were perceived as a major barrier to training by 50% of trainees. Other moderate barriers included unavailability of advanced endoscopy (45%), competition with fellow trainees (45%) and diagnostic endoscopy commitments. Time pressures impacting training were also cited by multiple SpRs. 60.9% (n=14/23) of trainees indicated an interest in completing a fellowship in advanced endoscopy.

Conclusions
Early year trainees are currently meeting STEPS volume requirements. Barriers to endoscopy training are consistent and remain challenging. It may be possible to restructure GI training, favouring endoscopy over GIM for senior trainees to facilitate advanced endoscopy. This may have additional utility in staffing for diagnostic endoscopy service provision.

ABSTRACT 34 (23S166)

Facilitators And Inhibitors To First Adult Care Visits In The Transition From Paediatric To Adult Orientated Inflammatory Bowel Disease Healthcare

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Naas General Hospital Munster Technological University

Introduction
The successful transition of Inflammatory bowel disease (IBD) patients from paediatric to adult services is essential to prevent disruption in care. The attendance at the first adult care visits are a pivotal phase of a successful transition process.

Aims/Background
The aim of this study is to explore the inhibitors and facilitators to first adult care visits.

Method
An exploratory, descriptive, qualitative approach was employed, underpinned by a transition theory (Meleis, 2010). A purposive sample of seven participants with IBD, who transitioned in the last four years, were recruited, through two clinical sites in Ireland, and an IBD support organisation. Online semi-structured interviews were conducted, and data were analysed using content analysis.

Results
Three themes were identified which illuminated various inhibitors and facilitators. The theme perception of transition revealed that joint care visits and adult healthcare teams that actively engaged with adolescents were facilitators, whereas difficulties contacting the adult services and the change in language were inhibitors. More than one joint visit with the adult and paediatric teams and active promotion of independence facilitated the second theme knowledge and preparation. A limited focus on disease management and significant parental involvement inhibited the development of knowledge and preparation. Addressing adolescent specific topics, such as sexual health, and the availability of IBD supports, such as an IBD psychologist, supported the final theme being an adolescent with IBD.

Conclusions
Identifying the inhibitors and facilitators provide insights for healthcare professionals in supporting a successful transition process and highlights the need for structured transition programmes.

ABSTRACT 35 (23S154)

An observational study to determine association of Streptococcus Bovis infection with colorectal cancers and other gastrointestinal pathologies

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Introduction
The association of Streptococcus Bovis (S.Bovis) bacteraemia with colorectal cancer was first described in the late 1970s. Streptococcus Bovis is a non-enterococcal group D Streptococcus. As per a Canadian study by Little et al (2019) in patients who underwent colonoscopy for streptococcus bacteraemia, 10% were found to have an adenocarcinoma and 37% had adenomas in comparison to the baseline population rate of 0.5% and 32%, respectively.

Aims/Background
To determine if Streptococcus Bovis infection has a close association with colorectal cancer incidence and also to assess other related gastrointestinal pathology.

Method
A retrospective observational study was performed. All Streptococcus Bovis cultures recorded in the hospital microbiology lab database over the last 10 years from January 2012 to December 2022 were included in the study. Culture reports were collected for analysis from the hospital lab database, colonoscopy records from the Endoscopy database (ENDORAAD) and Cross-sectional imaging of abdomen and pelvis for radiology.

Results
Fifty four patients were included in study who have grown S.Bovis. Out of the 54 patients, 21/54 (38.89%) only had colonoscopy done and 24/54 (44.4%) patients had abdominal imaging performed. Total colon cancer diagnosed were 6/21 patients with colonoscopy (28.57%). Out of them, 4 (19%) were left sided tumours. Others were colon adenomas (2), diverticular disease (10) and Crohn's disease (2). Mean age at diagnosis was 77.3 years (range 67-96). Out of the 54 patients included in the study, 20 had S.Bovis in blood cultures, 20 had positive urine cultures and 12 of them had positive swabs. 4/11 (36.36%) had colorectal cancer diagnosed and 2/11 (18.18%) had colon polyps (adenomas).

Conclusions
As per our study, only 55 % of patients with Streptococcus Bovis positive blood cultures were referred for a colonoscopy. S.bovis infections are closely associated to Colon cancer and other GI pathologies.A significant proportion of patients diagnosed with colon cancer in this group were left sided as per our study. Large studies are warranted to determine surveillance modality and benefits.

ABSTRACT 36 (23S153)

Early Outcomes Following The Establishment Of A Pilot High-Risk Pancreatic Cancer Surveillance Clinic

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Introduction
Pancreatic carcinoma (PC) usually presents at an advanced stage where surgery is not possible. Screening high-risk individuals (HRIs) for PC is recommended by several international groups to identify precursor lesions (intraductal papillary mucinous neoplasms (IPMNs) and PanINs). A pilot surveillance clinic for HRIs was recently established.

Aims/Background
Investigate outcomes from a high-risk pancreatic cancer surveillance clinic.

Method
Patients with familial pancreatic cancer (FPC) or those with a known PC predisposing germline variant (PC-PV) and associated family history (CAPS guidelines) were assessed and those eligible offered annual surveillance with alternating EUS and MRI/MRCP +/- genetic testing. Data were collected prospectively.

Results
Of 62 patients referred, 51 (82%) met eligibility for surveillance (mean age 53 years, 71% female). 30 patients (59%) had a confirmed germline PC-PV while 25 (49%) had FPC (4 met both criteria). Of the latter cohort, germline testing performed in 10/21 (48%), identifying a significant mutation in 2 (20%). 40 (78%) eligible HRIs commenced surveillance (median follow-up of 2 years). All patients had EUS, 25 (63%) also had alternating MRI/MRCP. IPMNs were identified in 11 patients (28%) and were discussed at MDT and entered reinforced surveillance. 1 patient had resection of a 3cm pancreatic IPMN (low grade dysplasia). PC was detected in 1 patient (3%) at scheduled follow-up 2 years into surveillance.

Conclusions
In HRIs, surveillance detected a high rate of cystic precursor lesions (>25%). Only one had a PC within programme thus far. Further longitudinal data are awaited to determine screening effectiveness and whether nationally applicable.

ABSTRACT 37 (23S157)

The Incidence Of Coeliac Seropositivity In The West of Ireland

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Introduction
A 1973 study from our institution demonstrated one of the highest incidences of biopsy-proven Coeliac Disease (CD) in the world. Guidelines now recognise that positive serology alone may be sufficient for diagnosis given the high sensitivity and specificity of Anti-Endomysial Antibody (EMA) for CD.

Aims/Background
This study aims to calculate the incidence of coeliac seropositivity and re-evaluate the incidence of CD in the west of Ireland.

Method
Galway University's Immunology lab is the sole provider of EMA testing for the west of Ireland. All patients with positive/borderline positive anti-TTG (≥5iu/ml) are referred for once-off EMA testing. Serological and histopathological data of newly positive EMA tests over a 2-year period were reviewed. "Serology-proven CD" was defined as positive EMA with anti-TTG ≥50iu/ml. "Biopsy-proven" CD was characterised by positive serology and ≥Marsh3a on biospy. Population statistics were based on 2016 Irish Census Data.

Results
Between 2018-2019, 505/692 EMA tests were positive. 417 patients were included. The incidence of coeliac seropositivity was 39.72 per 100,000 person-years. CD was diagnosed in 280 patients (incidence of 26.99 per 100,000 person-years). Among those, 118 patients had serology-proven CD and 162 patients had biopsy-proven disease.

Conclusions
The calculated incidence of coeliac seropositivity is high in the west of Ireland and incidence of coeliac disease itself remains high.

ABSTRACT 38 (23S118)

Interplay between IBS phenotype, hydrogen and methane breath test (HMBT)status, symptom severity and presence of neuropsychological conditions in an Irish setting.

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Introduction
Factors which predict severity of disease In IBS populations are not clearly defined but neuropsychosocial conditions have been reported to be associated with higher health care utilization in this group of patients. Early studies suggest that gut microbiome dysbiosis may be associated with select neuropsychological symptoms. Interplay between IBS symptoms, burden of disease and alterations in gut microbiota is not clearly defined.

Aims/Background
To determine if burden of disease measured using IBS-SSS, IBS-QoL, HADS correlate with presence of Small Bowel Bacterial Overgrowth (SIBO) or Intestinal Methanogen Overgrowth in Irish IBS patient cohort

Method
All patients referred for HMBT over 6 month period were invited to complete self reported questionnaires IBS-SSS, IBS-QoL and HADS.(May 2022 –December 2022) Patients were classified according to dominant phenotype. Kruskal-Wallis test was used to correlate subgroups of patient with clinical findings

Results
Data from 102 (78F, 24M) consecutive patients were reviewed. 50 (51%) patients (37F,13M) were found to have abnormal HMBT. Of the abnormal studies 7 (14%) had SIBO and 43(86%) had IMO. The patients who were positive for IMO on breath testing were found to have a strong association with the IBS-C phenotype (V=0.317, P=0.047). Those with IBS-C phenotype scored significantly worse in IBS-SSS and HADS score (IBS-SSS; p=0.036, HADS=0.038). There was no correlation between SIBO or IMO and worse symptom severity scores (P=0.679) quality of life (P=0.073) or HADS (P=0.423) among our patients.

Conclusions
In our cohort IBS-C phenotype appears to have the most significant burden on patients quality of life The prevalence of abnormal breath tests in IBS patients is high, however there is no correlation between an abnormal HMBT and worse IBS symptom severity.

ABSTRACT 39 (23S111)

Patient perspectives about treatment preferences for obesity with complications an IMI2 SOPHIA study

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Introduction
Incorporating patients' perspectives in obesity treatment planning may achieve greater buy-in from the patient and is likely to result in better health outcomes.

Aims/Background
To ascertain the perspectives of patients regarding what treatment options they would prefer to control their obesity and its complications

Method
Participatory action research, using purposeful sampling, was used to recruit 33 patients with obesity complications. Recruitment took place in specialist clinics for non-alcoholic fatty liver disease, diabetes and chronic kidney disease. None of the participants were formally referred to an obesity specialist clinic. Sixteen males and seventeen females ranging in age from 18-70 years, all with a BMI >35 kg/m2 were recruited. Data was collected in one-to-one semi-structured interviews. Prior to the interview, participants were asked to watch a 60-minute video explaining nutritional therapies, pharmacotherapies, and surgical therapies.

Results
Four themes emerged 1) structural factors of healthcare setting, 2) autonomy, 3) interaction with formal care, and 4) emotional and physical consequences of obesity. 49% of participants preferred nutrition therapy with support from medical professionals. 24% chose bariatric surgery, but access to surgery was a challenge. 18% chose pharmacotherapy alone and 6% chose pharmacotherapy combined with nutrition therapy. Cost was a theme associated with pharmacotherapy. 3% of participants wanted no intervention.

Conclusions
Factors that influence decisions around treatment options for obesity complications included access, cost, lack of knowledge and not being heard. These challenges can be addressed by giving better support to health care professionals, increasing their knowledge and improved health literacy of patients.

ABSTRACT 40 (23S105)

Nitrous Oxide Sedation for Endoscopy in Irish Hospitals

Author(s)
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Introduction
A 50:50 mixture of nitrous oxide gas(N2O) and oxygen is commonly used as analgesia during labour. There appears to be a trend towards utilisation of this gas mixture for sedation for endoscopic procedures in Ireland. This is of concern because N2O is a super-potent greenhouse gas. One kilogram of N2O contributes to atmospheric over-heating in the same amount as 298 kilograms of CO2. After carbon dioxide and methane, N2O is the third largest contributor to global warming.

Aims/Background
To determine the prevalence of N2O sedation in endoscopy units Irish hospitals.

Method
Phone survey of nursing staff.

Results
60 public and private Irish hospitals were contacted. 50 of them had endoscopy units. It was not possible to obtain responses to the survey despite phone and email communications from three hospitals. Of the 47 endoscopy units that responded to the survey 11 used N2O sedation to facilitate endoscopy procedures and all used it for colonoscopy only. Two units had plans in place to introduce N2O sedation. Of the 11 units that used N2O for sedation: 7/11 estimated they used it for less than 10 patients per week; 3/11 reported using it for 10-20 patients per week and one said they used it for more than 20 patients per week. 7/11 survey respondents were unaware of the greenhouse gas effect of N2O. All N2O sedation was administered using portable cannisters.

Conclusions
Among the non- anaesthesia community there is little knowledge around the environmentally harmful effects of N2O. We hope that statutory training bodies such as the Royal College of Physicians of Ireland and organisations such as the Irish Society of Gastroenterology will increase their consideration and focus on the environmental effects of healthcare. The adoption of environmentally harmful new practices in healthcare, where there are less harmful alternatives available is difficult to justify.

Y-ISG Case Presentations
Thursday 22nd June

Tara Suite, Main Meeting Room

Abstract No.	Title	Author	Time
1	Chasing Our Tail	Dr Barra Neary St. James's Hospital, Dublin	16.00
2	From Cyst To SPEN-did Surprise!	Dr Ciaran Mc Closkey Galway University Hospital	16.07
3	"A rare indication for liver transplant"	Dr Eileen Shannon St. Vincent's University Hospital, Dublin	16.14
4	"Colonic CLL; An unusual finding in a patient referred with anaemia and abnormal radiology"	Dr Clare Foley Beaumont Hospital, Dublin	16.21
5	To give anti-TNF or not to give anti-TNF?' that is the question?	Dr Roisin Corcoran St. Luke's General Hospital, Kilkenny	16.28
6	"Upa the creek without a paddle"	Dr Conor Palmer St. James's Hospital, Dublin	16.35
7	A Hair Out Of Place	Dr Barra Neary St. James's Hospital, Dublin	16.42

Abstract Submissions selected for Best Clinical Abstracts

Friday 23rd June 2023, Tara Suite - Main Meeting Room

Abstract No.	Ref:	Title	Author	Time
41	23S109	Subcutaneous Infliximab – A Real World Experience	Edmond Morrissey	9.00
42	23S139	Poor Correlation Between Anti-TTG IgG and Mucosal Recovery in the IgA-Deficient Coeliac	John Campion	9.10
43	23S147	Bariatric tourism complications and its burden on Irish health system	Qasim Rasheed	9.20
44	23S158	A multicentre survey of Helicobacter pylori antimicrobial resistance in Ireland	Thomas J. Butler	9.30
45	23S123	The Introduction of Biologics has Altered the Disease Phenotype Observed on Surgical Resections for Crohn's disease: Trends in Ileocaecal Histopathology over a Twenty-Two-Year period	Dr. Anne Fennessy	9.40
46	23S133	Outcomes Following Endoscopic Treatment of Barrett's Neoplasia: A Single-Centre Study	Dana Alsharqi	9.50

BEST CLINICAL PRESENTATIONS

ABSTRACT 41 (23S109)

Subcutaneous Infliximab – A Real World Experience

Author(s)
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Introduction
Infliximab is an important treatment option in the management of inflammatory bowel disease (IBD). It has traditionally been administered as an intravenous(IV) infusion but is now available as a subcutaneous (SC) injection. There is limited real world data around SC infliximab use and drug levels. In Ireland, IV medications are paid for from the hospital budget and SC medications are paid for from the community health budget.

Aims/Background
1. To assess the trough levels of infliximab when given in SC formulation compared to IV formulation 2. To faecal calprotectin pre and post switching drug route 3. To assess patient's attitudes to SC therapy 4. To examine the cost savings associated with switching to SC infliximab

Method
Proactive therapeutic drug levels are routinely performed in our clinic and we routinely offer SC switch to patients on IV infliximab. Patients currently receiving infliximab were identified using the departmental IBD database. Inclusion and exclusion criteria were applied. infliximab trough levels from when patient was receiving IV infliximab were compared to the most recent trough level while using SC infliximab. Response to SC infliximab was assessed using faecal calprotectin. Health related quality of life was also measured using the IBD Disk Questionnaire. A subset of patients completed a questionnaire about attitudes to SC therapy. The financial cost of providing IV infliximab to each patient was assessed. Data was analysed using Excel.

Results
In total 103 patients receiving SC infliximab for >3 months were identified. 0 were excluded. 55 (53%) were female and 48 (47%) were male. The median age was 39 (19-79). 57 (55%) had Crohn's disease (CD), 46 (45%) had ulcerative colitis (UC). Infliximab trough levels improved by an average of 14.98ug/mL (188.6%) after switching to SC ($P<0.05$). Faecal calprotectin fell by an average of 74.45ug/g (-18.8%) after switching from IV to SC formulation ($P<0.05$). Average IBD disk score while on SC infliximab was 36.96/100 reflecting these are patients with ongoing disease activity. The IBD disk score correlated with faecal calprotectin r 0.22 ($P<0.05$). In a subset of patients surveyed 90% (n=10) preferred SC to IV infliximab. Switching from IV to SC infliximab for the 103 patients included in this study has saved our department 523,137 euro per annum. There are also significant savings in terms of infusion suite capacity. In total our unit saves 670 infusion suite appointments per year due to these patients switching to SC therapy.

Conclusions
Switching from IV to SC Infliximab is not associated with a deterioration in infliximab drug levels or faecal calprotectin levels. Switching from IV to SC infliximab saved significant amounts of money for our hospital budget and has improved our infusion suite capacity.

ABSTRACT 42 (23S139)

Poor Correlation Between Anti-TTG IgG and Mucosal Recovery in the IgA-Deficient Coeliac

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Introduction
Selective IgA deficiency occurs in 0.3% of the population but is observed in 3% of people with coeliac disease (CD). Measurement of anti-TTG IgG provides an alternative screening test to anti-TTG IgA in such a cohort. However there is a paucity of data regarding the correlation between the decline in the anti-TTG IgG levels and mucosal healing following initiation of a gluten-free diet in IgA-deficient coeliac disease.

Aims/Background
We set out to (1) assess the rate of decline of anti-TTG IgG following gluten elimination in patients with IgA deficient coeliac disease and (2) assess the correlation between anti-TTG IgG and mucosal healing following gluten elimination.

Method
IgA-deficient patients were identified retrospectively from the coeliac database. Clinical, laboratory and histologic data were retrieved from the electronic patient record and patient symptoms were recorded from the contemporaneous clinical notes.

Results
19 patients with IgA-deficient CD were identified. Eight patients (42%) were male and 11 (58%) female. Median (IQR) age at diagnosis was 25 years (15, 39). Symptoms reported included bloating (34%), abdominal pain (21%), diarrhoea (21%) and fatigue (21%). Five patients (26%) had at least one other autoimmune condition. Three patients (15.7%) had normal tTG igG on first testing, having been diagnosed on the basis of duodenal biopsy at another centre. Of those who reported adherence to gluten free diet after diagnosis, 40%, 25% and 25% of IgA deficient coeliacs normalised their IgG anti-TTG levels at 1, 3 and 5 years respectively. Of those patients whose duodenal histology normalised after elimination of dietary gluten, only 21.4% had concurrent normalisation of anti-TTG IgG.

Conclusions
The decline in IgG anti-TTG following gluten elimination does not correlate with mucosal healing. IgA-deficient coeliacs can be reassured that a persistently positive IgG anti- TTG does not signify ongoing gluten ingestion and physicians can be reassured by histologic recovery in such patients irrespective of the anti-TTG titre.

ABSTRACT 43 (23S147)

Bariatric tourism complications and its burden on Irish health system

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Introduction
Bariatric surgery is an effective intervention for severe obesity. An unmet need for bariatric surgery in many countries has stimulated the growth of bariatric tourism worldwide.

Aims/Background
In Ireland, the lengthy waiting list for this surgery is the main reason patients embark on bariatric tourism. The risks to patients and the impact of this decision on the Irish Healthcare system are unknown.

Method
Data has been prospectively collected since January 2020 from patients who have presented to St. Vincent's University Hospital with complications related to bariatric surgery performed abroad. Patient demographics, place and date of surgery abroad, complications and therapeutic interventions required are recorded. Cost of care provided was estimated from HIPE data

Results
Thirty patients (26 female and 4 male) presented with bariatric surgery related complications over 34 months related to Sleeve gastrectomy (n=22, 73%), gastric bypass (n=2, 6.6%), intragastric balloon placement (n=2, 6.6%) and gastric band (n=1). The most frequent surgery destination was Turkey (n=17, 56%), among 7 other countries (Malaysia, Brazil, Spain, Poland, Prague, Belgium and UK). 24 patients required admission, with average length of stay (LOS) 18.6 days. A longer LOS was noted in patients with staple line leak, average 55.5 days. Nine patients underwent gastroscopy (30%) with 3 patients requiring OVESCO clip (10%) and 4 requiring oesophageal stent (13%). Five patients required complex revisional surgery. Cost of treatment data was available for 19 patients - € 356,545.

Conclusions
The volume of patients undertaking bariatric tourism is unknown, so it is not possible to calculate the morbidity rate. However, bariatric tourism with postoperative complications carry a significant burden on patients and the healthcare system. Services that provide this emergency care to patients should be adequately resourced.

ABSTRACT 44 (23S158)

A multicentre survey of Helicobacter pylori antimicrobial resistance in Ireland

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Introduction
Antibiotic resistance is one of the main reasons for Helicobacter pylori (H. pylori) treatment failure. The Maastricht VI/Florence consensus report highlighted the importance for local resistance surveys in order to guide clinicians in their choice of therapy.

Aims/Background
To assess the rates of primary and secondary antibiotic resistance for H. pylori in Ireland.

Method
Following ethical approval and receipt of informed consent, H. pylori was cultured from corpus and antral biopsy samples of patients attending Tallaght University Hospital, Letterkenny University Hospital, Mayo University Hospital and St. James's Hospital. Antibiotic susceptibility testing was performed via E-test (Biomerieux) and resistance classified according to the European Committee on Antimicrobial Susceptibility Testing (EUCAST) breakpoints.

Results
In total, 126 isolates were successfully cultured and antimicrobial susceptibility assessed. 103 of these were isolates of treatment-naïve patients (50±16 years old, 59% male) and 23 were of previously treated patients (48±12 years old, 61% female). Primary resistance rates for clarithromycin, metronidazole and levofloxacin were 37.9%, 44.7% and 21.4%, respectively. Secondary resistance rates for clarithromycin, metronidazole and levofloxacin were 65.2%, 73.9% and 30.4%, respectively.

Conclusions
Antibiotic resistance rates have reached significant levels for all major classes of antibiotics for the treatment of H. pylori and reach nearly double the rate of resistance in the previously treated group. Of note, first-line clarithromycin triple therapy can no longer be recommended in Ireland.

ABSTRACT 45 (23S123)

The Introduction of Biologics has Altered the Disease Phenotype Observed on Surgical Resections for Crohn's disease: Trends in Ileocaecal Histopathology over a Twenty-Two-Year period

Author(s)
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Introduction
Crohn's disease affecting the terminal ileum often requires surgery for treatment of fibro-stenotic disease, complex fistulizing disease and abscesses.

Aims/Background
With the increasing use of anti-TNF in the treatment of penetrating disease, we hypothesised that the disease phenotype seen at ileocaecal resection (ICR) would increasingly show stricturing, non-inflammatory behaviour.

Method
This was a retrospective study of the histological specimens from patients with Crohn's disease undergoing ICR over a twenty-two-year period in a single tertiary referral centre. Patients undergoing their first ICR between 2000 and 2021 were identified using our prospectively maintained inflammatory bowel disease (IBD) database and hospital pathology records. These patients were included for statistical analysis using SPSS.

Results
Between 2000 and 2021, there were 430 Crohn's disease surgical resections in our centre. Of these, 316 were ICRs; with 254 first time ICRs. The patients undergoing ICR were older in the 2011-2021 period, with a median age of 38 (IQR 29-49) compared to 31 years of age in the period 2000-2011 (IQR 24-42). Stricturing disease was more commonly found on histological specimens from 2011-2021 (66.2% of ICRs) compared to 43.7% of ICRs from 2000-2010 ($p<0.001$). Surgical specimens reporting the presence of an inflammatory mass and fistulas reduced in incidence over this period (11.7% to 3.3% and 31.1% to 19.2%) with an overall reduced proportion of penetrating disease.

Conclusions
The percentage of patients undergoing ileocaecal resection for penetrating Crohn's disease decreased between the two time periods, suggesting that with increased anti-TNF use, non-inflammatory, stricturing disease became the more common indication for surgery.

ABSTRACT 46 (23S133)

Outcomes Following Endoscopic Treatment of Barrett's Neoplasia: A Single-Centre Study

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Introduction
Endoscopic treatment of Barrett's neoplasia includes endoscopic mucosal resection (EMR) and radiofrequency ablation (RFA). Data on recurrence of high grade dysplasia (HGD) or intramucosal adenocarcinoma (IMA) following endoscopic treatment are relatively limited.

Aims/Background
To assess the rate of recurrence of neoplasia following endoscopic treatment of Barrett's lesions with HGD or IMA.

Method
Records of patients with HGD and IMA who underwent EMR and/or RFA from 2018 to 2021 were reviewed to evaluate recurrence. Recurrence was defined as HGD or IMA at the same site of a previously treated Barrett's lesion on surveillance endoscopy.

Results
A total of 48 patients were included. 17 patients had EMR alone, 18 had EMR + RFA, and 13 had RFA. The mean follow up time was 33 months (range 12-58). 43 (89.6%) did not have recurrent lesions, however 5 (10.4%) had recurrence. The mean time to recurrence of neoplasia was 19 months (range 12-24). All 5 recurrences had initial treatment with EMR, but only 2/5 had subsequent RFA as well. 3/5 (60%) of recurrence patients had IMA at initial diagnosis, compared to 2/5 who had HGD. None of the recurrences were invasive cancer and all were managed endoscopically.

Conclusions
Data on the rates of recurrence of HGD and IMA following endoscopic treatment of Barrett's-related lesions are limited. Our study shows a relatively low rate of recurrence, which can be managed endoscopically. Eradication of dysplastic barretts with RFA following EMR is important, and may be related to recurrences in our cohort.

Abstract Submissions selected for Best Scientific Abstracts

Friday 23rd June 2023, Graham Bell Suite

Abstract No.	Ref:	Title	Author	Time
47	23S148	HLA-DQA1*05 Allele Carriage and ANTI-TNF Therapy Persistence in Inflammatory Bowel Disease	Jayne Doherty	9.00
48	23S135	Exploring the potential role of Caspase-4 as a novel biomarker for colorectal cancer screening	Neil O'Morain	9.10
49	23S152	Rapid Detection of Refractory Coeliac Disease Type II (RCDII) Using Flow Cytometry – Review of a Newly Developed Service	Siofra Bennett	9.20
50	23S159	Clinical utility of anti-gp210 and anti-sp100 in chronic cholestasis work-up	Jack Scully	9.30
51	23S170	HLA-C*06 Genotype and Ustekinumab Therapy Persistence in Inflammatory Bowel Disease	Roisin Corcoran	9.40
52	23S144	Evaluation of Molecular-based Clarithromycin Resistance Testing in Helicobacter pylori compared to Culture-based Testing.	Stephen Molloy	9.50

BEST SCIENTIFIC PRESENTATIONS

ABSTRACT 47 (23S148)

HLA-DQA1*05 Allele Carriage and ANTI-TNF Therapy Persistence in Inflammatory Bowel Disease

Author(s)
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Introduction
Carriage of HLA-DQA1*05 allele is associated with development of antidrug antibodies (ADA) in Crohn's Disease (CD) patients receiving anti-TNF therapy. The presence of ADA is not uniformly associated with treatment failure.

Aims/Background
To determine the impact of carriage of HLA-DQA1*05 allele on outcome of biologic therapy, identify other risk factors impacting loss of response (LOR) to therapy and develop a risk-score to predict LOR to anti-TNF therapy.

Method
A multi-centre retrospective study of IBD patients treated with biologic therapy was performed. HLA-DQA1*05 genotypes were generated by imputation from whole genome sequence using HIBAG. All patients treated with anti-TNF therapy were biologic-naïve.

Results
877 patients were treated with ant-TNF therapy. 543 had no copy, 281 one copy and 53 two copies of HLA-DQA1*05 allele. Mean time to anti-TNF therapy discontinuation due to LOR in patients with 2 copies of HLA-DQA1*05 allele was significantly shorter compared to patients with 0 or 1 copy over 700day follow-up: 418 versus 541 versus 513 days, p=0.012. Factors independently associated with LOR included: carriage of HLA-DQA1*05 allele OR 1.2, p=0.02; female gender OR 1.6, p=4.2 x 10 ; CD OR 0.7, p=0.009; and infliximab therapy OR 1.5, p=0.002. We developed and validated the GPS-IBD risk-score to predict patients at higher risk of LOR to anti-TNF therapy using risk factors identified above. Mean time to LOR of anti-TNF therapy in patients with a score of 4-5 was significantly shorter compared to patients with a score of 2-3 or 0-1: 406 versus 496 versus 580 days ($p < 0.001$). 98 patients were treated with vedolizumab. Mean time to vedolizumab discontinuation in patients with 1/2 copies of HLA-DQA1*05 was significantly shorter compared to 0 copies ($p = 0.02$). 146 patients were treated with ustekinumab. No difference was seen in mean time to discontinuation of ustekinumab therapy dependent on HLA-DQA1*05 status ($p = 0.33$).

Conclusions
Carriage of two copies of the HLA-DQA1*05 alleles is associated with a less favourable outcome of anti-TNF therapy with shorter time to LOR. We have developed and validated a risk-scoring system to help predict LOR to anti-TNF therapy. Further prospective studies are required to validate the usefulness of this risk score in clinical practice.

ABSTRACT 48 (23S135)

Exploring the potential role of Caspase-4 as a novel biomarker for colorectal cancer screening

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Introduction
Caspases are a group of proteolytic enzymes involved in the co-ordination of cellular processes, including inflammation and apoptosis. Selective epithelial expression of caspase-4 has previously been identified in malignant colorectal tissue, suggesting its possible utility as a biomarker . Whether this altered expression can be detected in serum and how early in the development of neoplastic tissue this occurs, remains unknown.

Aims/Background
To examine the expression of caspase-4 in serum as a potential biomarker for colorectal cancer (CRC).

Method
Serum samples were collected from FIT +ve BowelScreen (BS) and CRC patients from July 2021 to January 2023. Biobanked serum from other cancers (lung, ovarian, cervical, oesophageal) was accessed. Serum levels of caspase-4 were measured by ELISA and results were matched to colonoscopy findings.

Results
Serum was collected from 200 BS participants (male n=120 (60%); median age 68) and 50 CRC patients (male n=28 (56%); median age 68). Within the BS group, adenoma (n=111, 55.5%), SSL (n=30, 15%) and CRC (n=8, 4%) were identified. Caspase-4 levels from CRC patients was significantly higher than healthy controls ($p<0.01$) and patients with other cancers ($p<0.05$). Immunohistochemical studies revealed that caspase-4 was expressed in all SSLs, with higher expression in polyps with HGD compared to LGD ($p=<0.01$). There is a trend towards increased serum caspase-4 levels in patients with advanced polyps (>10mm) and higher polyp burden (>3 polyps), but did not reach statistical significance, possibly due to low sensitivity of ELISA.

Conclusions
These results suggest that caspase-4 represents a selective biomarker for CRC and may have a role in detection of advanced polyps.

ABSTRACT 49 (23S152)

Rapid Detection of Refractory Coeliac Disease Type II (RCDII) Using Flow Cytometry – Review of a Newly Developed Service

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Introduction
Approximately 1.5% of coeliacs have RCD, defined as villous atrophy and ongoing symptoms despite adherence to a gluten free diet(GFD). RCDI mimics untreated coeliac disease whereby a normal population of IELs are observed. RCDII is characterised by an abnormal(aberrant) population of IELs(surfaceCD3 - , surfaceCD8 - and cytoplasmicCD3 +). RCDII can be diagnosed by immunohistochemistry(reduced CD8 staining), molecular analysis(TCR gene rearrangement studies) or flow cytometry. Flow cytometry provides a rapid, quantitative assessment of the degree of aberrancy(% of abnormal IELs/total number IELs) in patients with non-healing CD and may help predict the risk of future development of EATL in such patients.

Aims/Background
The aim of this project was to evaluate the impact of a newly developed flow-cytometry service on the diagnosis and management of RCDII in a tertiary referral centre.

Method
The results of all flow cytometry assays performed on duodenal biopsies since commencement of the service were reviewed in addition to patient records.

Results
55 assays were performed on 38 patients. RCDII was identified in 10, all of whom had clonality on molecular testing. 3/10 had normal staining for CD 3/CD 8 and would have been misdiagnosed on immunohistochemistry alone. Median age 63yrs, (64% female). Mean and median %aberrant IELs were 73% and 79%. The mean/median aberrancy of those who died (n=5, 4EATL, 1 neuro-coeliac) and of those who survived was 75%/80% and 66/60%, respectively. RCDI and non-healing coeliac had aberrancy <20%.

Conclusions
Flow cytometry is an efficient and reliable method to asses for RCDII. Mortality risk appears to correlate with the degree of aberrancy.

ABSTRACT 50 (23S159)

Clinical utility of anti-gp210 and anti-sp100 in chronic cholestasis work-up

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Introduction
Primary biliary cholangitis (PBC) is the most common chronic cholestatic liver disease. Antimitochondrial antibodies (AMA) are the hallmark of PBC and present in >90% of patients. Antinuclear antibodies (ANA), including anti-gp210 and anti-sp100, can be positive in up to 30% of PBC patients and are highly specific (>95%). Crucially, a diagnosis of PBC can now be established using these antibodies in AMA-negative patients without the need for a biopsy.

Aims/Background
Assess the clinical utility of PBC-antinuclear antibodies in patients with previous diagnosis of PBC and in patients with chronic cholestasis since its introduction in SVUH.

Method
Retrospective review of data on all patients checked for anti-gp210 and/or anti-sp100 since 2018. SPSS analysis was performed.

Results
88.6% of the 35 patients studied were female, mean age of 57.3 (SD±13.7). 25.7% of the tests were sent after a PBC diagnosis and 74.3% for diagnostic purposes. 2 (5.7%) patients were positive for AMA. 2 patients (5.7%) tested positive for anti-gp210 and 8 (22.8%) for anti-sp100, with a median ANA titre of 1:400 (80-6400). Median TE was 7kPa (3.8-73kPa), with no difference in TE between the positive and negative groups. Patients positive for either antibody had higher IgM values (1.8g/L vs 1.25g/L; p. 0.04). 8 patients (88.9%) had a liver biopsy in the subgroup of previous PBC diagnosis while just 12 (46.2%) in the cholestatic work-up patients.

Conclusions
28.5% (n:10) of the patients tested positive for anti-gp210 or anti-sp100 and just one was AMA positive. Hence their importance as a diagnostic tool in PBC, while avoiding liver biopsies.

ABSTRACT 51 (23S170)

HLA-C*06 Genotype and Ustekinumab Therapy Persistence in Inflammatory Bowel Disease

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Department(s)/Institutions
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Introduction
Ustekinumab (USTK) is an anti-IL12/23 IgG1 kappa monoclonal antibody that is approved for use in both psoriasis and inflammatory bowel disease (IBD).

Aims/Background
HLA-C*06 allele carriage has been associated with higher rates of response to USTK in psoriasis patient populations. The association between HLA-C*06 carriage and USTK response in IBD has not been previously evaluated.

Method
A multi-centre retrospective study of IBD patients treated with USTK was performed. Baseline demographics for the entire cohort were collected. HLA-C*06 genotypes were generated by imputation from whole genome sequence using HIBAG. USTK therapy persistence, was considered a proxy for treatment response, and was expressed as time to discontinuation of USTK therapy. The study primary endpoint was USTK therapy persistence segregated by HLA-C*06 allele genotype. Statistical analysis was performed using survival analysis and multivariate cox logistic regression with effect of covariates on outcome expressed as odds ratios (OR).

Results
146 IBD patients were identified and included in the study population. In the study population, 32 patients (22%) carried at least one HLA-C*06 allele. There was no significant difference in median time to USTK therapy discontinuation comparing HLA-C*06 carriers to non-carriers at 2000-days follow-up, p=0.4. In a multivariate regression neither HLA-C*06 allele carriage (OR 1.2, p=0.5), male gender (OR 1.2, p=0.6), CD phenotype (OR 1.6, p=0.44), nor concomitant immunomodulator use (OR 1.1, p=0.8) were independently associated with time to USTK therapy discontinuation.

Conclusions
HLA-C*06 allele carriage is not associated with increased USTK therapy persistence in IBD. Larger studies of USTK therapy outcome in IBD patients with characterised HLA-C*06 genotype are required to confirm this finding

ABSTRACT 52 (23S144)

Evaluation of Molecular-based Clarithromycin Resistance Testing in Helicobacter pylori compared to Culture-based Testing.

Author(s)
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Introduction
Molecular methods offer a more rapid alternative for the detection of H. pylori (Hp) resistance to antibiotics than traditional culture-based methods.

Aims/Background
To evaluate the diagnostic accuracy of molecular-based clarithromycin susceptibility testing compared to culture and E-test.

Method
Following ethical approval and informed consent, adults were recruited prospectively from Tallaght and Letterkenny University Hospitals, regardless of Hp treatment history. During routine gastroscopy, subjects had 1 antrum and 1 corpus biopsy taken for Hp culturing and DNA extraction. Clarithromycin susceptibility testing was performed by the Etest method. The RIDA®GENE Helicobacter pylori assay (R-Biopharm AG, Germany) was used for detection of Hp and clarithromycin resistance-associated point mutations (A2146C, A2146G and A2147G).

Results
In all, samples from 191 culture-positive patients (mean age 48.4 ± 15.3 years; 45.0% (N=86) female) were analysed. The rates of clarithromycin resistance detected by culture-based and molecular methods were 49.2% (N=94/191) and 38.7% (N=74/191), respectively (P=0.05; Fisher's exact test). Results were in agreement between both methods in 84.3% (N=161/191) of cases. The sensitivity and specificity of the Ridagene assay compared to culture for the detection of clarithromycin resistance were 74.2% (95% CI: 64.4-82.6%) and 94.7% (95% CI: 88.0-98.3%), respectively. The positive predictive value was 93.5% (95% CI: 85.5-97.9%) and the negative predictive value was 78.1% (95% CI: 69.4-85.3%).

Conclusions
While the Ridagene assay was easy to use and more rapid than Hp culture, the low sensitivity compared to culture in our cohort may limit its use to cases where culture-based methods are unsuccessful.

Sincere thank you to the Scientific Committee for their time and energy.

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AUDIT PRESENTATIONS

ABSTRACT 53 (23S112)

Can Baveno-VI criteria for varices screening be safely used for better utilisation of limited endoscopic resources?

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Introduction
To evaluate variceal screening requirement using Baveno VI criteria (BC), chronic liver disease patients with Liver Stiffness Measurement (LSM)<20 kPa and platelet count (PLT)>150k are unlikely to develop high-risk varices that requires endoscopic intervention. Hence, endoscopic screening can be safely avoided. To maximise healthcare delivery, BC application can reduce unnecessary workload by prioritising high-risk cases, thus, utilising limited resources effectively.

Aims/Background
Can Baveno-VI criteria for varices screening be safely used for better utilisation of limited endoscopic resources?

Method
A retrospective analysis of hepatology patients at St James's Hospital (between September 2019 and October 2022) with liver stiffness compatible to liver cirrhosis as well as upper endoscopy and blood tests within 12 months from elastography.

Results
119 (78%) were excluded from 153 scoped patients: (a) no FibroScan (n=80), (b) longer than 12 months duration between FibroScan and gastroscopy(n= 17), (c) beta-blockers treatment history (n= 21), (d) Hepatocellular Carcinoma (n=1). In remaining included 34 patients, n=27 (79%) had no varices, n=5(15%) had grade 1 varices and n=2 (6%) had grade 2 varices, with only one requiring variceal band ligation. Within this cohort, 12 (36%) patients fulfilled BC, where none had high-risk varices and could have avoided endoscopy. 22(65%) patients did not meet the criteria (PLT <150k and/or LSM >20 kPa), and endoscopy screening is recommended. Of these, 16(73%) did not have varices, while 3 had varices(18%) requiring beta-blockers and 1 requiring banding. Given variceal prevalence of 30%, BC has 100% specificity and 43% sensitivity, providing 100% positive and 70% negative predictive values.

Conclusions
Baveno VI criteria has demonstrated high reliability in identifying cirrhotic patients with low-risk varices in whom endoscopic screening can be safely avoided. Ultimately, enabling more appropriate utilisation of limited healthcare resources.

ABSTRACT 54 (23S168)

Endoscopy Timing – Are We Meeting The Bleeding Standards!?

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Introduction
GI bleeding is a common medical emergency. Causes can be classified into 'upper' and 'lower' sources of bleeding. There are well established guidelines regarding standards of care in the management of both.

Aims/Background
To evaluate the outcomes of patients presenting to UHG with signs and symptoms of GI bleeding over a 3-month period from 10th June – 10th September 2022.

Method
We looked at Medical and Surgical on call admission lists from 10th June – 10th September 2022. Patients with signs and symptoms of GI bleeding were included. Data was then retrospectively collected from electronic medical records.

Results
There were 107 admissions over 3 months; 90 medical and 17 surgical. 50% were male. Median Glasgow-Blatchford score (GBS) was 4 at presentation. Median length of stay (LOS) was 4 days. 1.9% underwent surgery and no patient required IR intervention. 27 % were on a DOAC, 19% aspirin and 5% on DAPT prior to admission. Just 27% of those getting an OGD, had one within 24 hours. 67 patients (63%) were deemed to be 'upper' GI bleeds on the basis of their presenting signs and symptoms. 47/67 (70%) of patients had an OGD. 89% got PPI during admission, with 54% being on a PPI prior. Just 9/20 patients not getting an OGD had documented reasons why. 7/67 patients (10.4%) had variceal bleeds. All of these received terlipressin, 86% got antibiotics, with a 9 day median LOS and 14% mortality. 40/67 (59.7%) presented on a weekday. Of these, just 32% had an OGD within 24 hours, with a median time to endoscopy of 37 hours, a 3.5 day median LOS and 5% mortality. 27/67 patients presented at the weekend. Just 10.5% of those had an OGD within 24 hours. Median time to endoscopy was 91 hours, with a 6.5 day median LOS and 7.4% mortality.

Conclusions
Patients admitted to our institution do not receive international best standards of care when presenting with a GI bleed; particularly with respect to timely access to endoscopy. We have also identified issues with weekend admissions leading to higher mortality, longer hospital stay, and longer wait to endoscopy. Local changes such as prioritization of bed allocation for these patients and the introduction of a GI bleeding pathway would likely help. However, it is likely that similar issues are occurring throughout the Irish hospital system given the current admission pathways. Further work is needed nationally to quantify the level of the problem. A coordinated national approach to the management of these patients is urgently required.

ABSTRACT 55 (23S145)

Surveillance in Inflammatory Bowel Disease – an audit of adherence to current surveillance guidelines

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Introduction
Inflammatory bowel disease(IBD) patients have an increased risk of

developing colorectal cancer compared to the general population. International guidelines have aligned in recent years through the European Crohn's and Colitis Organisation(ECCO) and Surveillance for Colorectal Endoscopic Neoplasia Detection and Management in Inflammatory Bowel Disease Patients (SCENIC) guidelines on surveillance colonoscopies to detect early colorectal dysplasia. The adaptation and adherence to these guidelines in clinical practice remains challenging.

Aims/Background
To determine if surveillance practices in our institution are in line with international guidelines.

Method
We retrospectively audited a cohort of IBD patients attending the outpatient clinic in November 2022. A second methodology was used to evaluate IBD patients attending the endoscopy department. Adherence to surveillance guidelines was compared to ECCO guidelines. Clinical parameters were used to identify the appropriate surveillance interval for patients.

Results
166 patients in total attended the outpatient clinic in the studied period. 40 [22(55%) CD, 17(42.5%) UC and 1(2.5%) IBD-U] were included. Median disease duration was 7 years in CD and UC patients. 14/22(63.6%) CD patients and 12/17(70.6%) UC patients had appropriate surveillance colonoscopies. Dysplasia was detected in 1 patient in total. The endoscopic cohort included 40 [18(45%) CD, 21(52.5%) UC and 1(2.5%) IBD-U patients. Median disease duration was 13 years in CD and 13 years in UC patients. 14/18(77.7%) CD patients and 14/21(66.6%) UC patients had appropriate surveillance in line with guidelines. Dysplasia was detected in 1 patient in total.

Conclusions
Adherence to surveillance guidelines was similar and suboptimal in both cohorts. The rate of dysplasia was the same in both groups. Incorporating a surveillance interval assessment tool into the outpatient clinic could improve adherence to surveillance guidelines in IBD patients.

ABSTRACT 56 (23S155)

Endoscopic Examination of The J pouch (ileo-anal pouch anal anastomosis) in IBD patients: are we doing it correctly? A single centre experience.

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Introduction
Endoscopic examination of the Ileal pouch anal anastomosis (IPAA) in inflammatory bowel disease is important both for symptom investigation and cancer surveillance. The European Crohn's and Colitis Organsiation (ECCO) guidelines recommend that pouchoscopies be performed by experienced IBD endoscopists and that a pouchoscopy report should describe the pre-pouch ileum, the pouch and the rectal cuff, with biopsies taken from each area.

Aims/Background
We reviewed the reports to assess if they met the standard proposed by ECCO guidance.

Method
We retrospectively reviewed endoscopy reports for all IPAA patients undergoing pouchoscopy at our centre since 2011.

Results
131 pouchoscopies were performed in patients with an IBD-related IPAA. 36.6% were performed by surgeons, 62.6% by gastroenterologists and 0.8% did not report the name or speciality of the endoscopist. 54.1 % described the pre-pouch ileum, 94.6% described the body of the pouch and 40.4 % described the rectal cuff. 52.6% had a picture of the pre-pouch ileum, 88.5% of the pouch body and 48.8% of the rectal cuff. The pre-pouch ileum was biopsied in 27.4%, the pouch body in 61.8% and the rectal cuff in 21.3%. Only 10 procedures (8.3%) meet all the ECCO recommendations for pouch examination.

Conclusions
These data show that the recommended standards for reporting and performing endoscopic examination of ileal pouches in IBD patients are not consistently applied in our unit. Education regarding these standards is important for all endoscopists involved in IBD care.

ABSTRACT 57 (23S150)

Time To Endoscopy: A Single Center Analysis On The Non-Variceal Upper GI Bleeding ESGE Guidelines

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Introduction
In 2021, the European Society of Gastrointestinal Endoscopy (ESGE) issued updated guidelines on the pre-endoscopic, endoscopic, and post-endoscopic management of patients with nonvariceal upper gastrointestinal hemorrhage (NVUGIH), however, data on adherence to the ESGE guidelines remains scarce.

Aims/Background
We assessed the extent of use of the Glasgow-Blatchford Score and the time taken to Upper GI Endoscopy for patients presenting to Letterkenny University Hospital with NVUGIH.

Method
Patients presenting to Letterkenny-University-Hospital ED between the dates of 1-January-2022 and 31-July-2022 with suspected NVUGIH were included in our study. Patients with a variceal upper GI bleed and patients found to have a lower GI bleed were excluded. 36 patient records were retrospectively analyzed for documentation of the Glasgow-Blatchford Score and time to Endoscopy.

Results
Pre-endoscopic risk stratification with the Glasgow-Blatchford Score (GBS) was conducted in 15/36 (41.7%) patients. Endoscopy was performed within 24 hours in 46% of cases, with the greatest delays in endoscopy occurring for patients admitted on Fridays (Median, 74 hours), and in those admitted over the weekend. Furthermore, only a quarter (25%) of low-risk patients (GBS 0 or 1) were discharged from the ED.

Conclusions
We observed low adherence to ESGE 2021 NVUGIH guidelines. 75% of very low risk patients received inpatient endoscopy. Endoscopy was delayed (>24 hours) for patients presenting on Friday, Saturday and Sunday due to the lack of weekend availability of endoscopists trained in the management of UGIB. Further education on the GBS Risk Stratification Score and provision of a weekend endoscopy service is required to minimize endoscopy delays.

ABSTRACT 58 (23S164)

Streamlining Inpatient Endoscopy In The Post COVID-19 Era

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Introduction
Inpatient endoscopy occurs on an ad-hoc basis. Significant delays occur from time of request to date of completion. In times of bed crises, endoscopy units may be used as overflow wards, limiting patient flow, further exacerbating delays. If inpatient endoscopy can be streamlined, this may reduce length of stay.

Aims/Background
To identify if delays to endoscopy are prolonging admissions. To assess the number of procedures suitable for urgent outpatients. To assess compliance with international guidance on timing for urgent UGIB.

Method
Sampling of all patients referred for inpatient endoscopy in the reference dates with retrospective analysis including reason for endoscopy, time to endoscopy, procedure outcome, and date of discharge.

Results
A 6-week period including 101 procedures (77 OGDs) was reviewed. GI bleeding and anaemia was the indication for 46% of all procedures. >50% of cases referred were deemed non-urgent, ~60% were deemed suitable for outpatient investigation. Average waiting time was 3.36 days for all indications, 2.53 days for UGIB. 33% of UGIBs had an OGD <24 hours from referral; 75% <72 hours. 17% of UGIBs were discharged same day; 48% discharged <48 hours. 17% had a normal endoscopy, 16% with UGIB had unremarkable OGDs. Procedures of non-GI teams occurred within 3.62 days.

Conclusions
A significant number of procedures may be better facilitated through a scheduled rapid access outpatient list with the knock-on effect on the average waiting time being >3 days. The inpatient referral pathway has been revised to include the Glasgow-Blatchford Bleeding score to streamline referrals more efficiently.

ABSTRACT 59 (23S171)

Impact of a Clinical Nurse Specialist in Inflammatory Bowel Disease Service

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Introduction
Introduction Inflammatory Bowel Disease has been described as an umbrella term for a group of diseases within the gastrointestinal tract, namely Crohn's disease and ulcerative colitis. Given the growing number of patients presenting with IBD at UHK a need for a dedicated IBD Nursing Service was identified. In 2020 the IBD nursing service was established and now provides support and advice to over 500 patients.

Aims/Background
Aims To optimise IBD patient care avoiding escalation to hospital admission and urgent OPD visits.

Method
Methods Patient data was collected between January 2022 and December 2022 from the local IBD database highlighting calls received by the IBD CNS from patients. Data included patient queries solved, referred to OPD, emergency department or any other outcomes.

Results
Results In 2022, 1560 calls were received by the IBD CNS. 964 queries (62%) were resolved either by the IBD CNS or through MDT, 106 (11%) were referred for urgent OPD (Rapid access IBD clinic) and 5 patients (0.5%) required admission. The remaining 596 queries (38%) were mainly for prescriptions which were also dealt with by the IBD CNS.

Conclusions
Conclusion Our results have clearly shown that having a dedicated IBD service has a very positive impact on the delivery of quality and timely clinical care. Most of the queries were dealt by IBD CNS and MDT (62%). A Significant number of urgent OPD visits were avoided (89%). The large volume of calls to the IBD service provides evidence of patient acceptance and appreciation of the IBD CNS as their point of contact to access the services.

ABSTRACT 60 (23S117)

An Audit Of DEXA Completion And The Prevalence Of Metabolic Bone Disease In Intestinal Failure And HPN Patients

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Introduction
Metabolic bone disease (MBD) is a possible complication of intestinal failure (IF), with a multi-factorial pathogenesis. Several studies have reported MBD such as osteopenia and osteoporosis is common in patients on Home Parenteral Nutrition (HPN). The EPSEN guidelines on chronic intestinal failure in adults recommend yearly dual-energy X-ray absorptiometry (DEXA) for monitoring of bone mineral density.

Aims/Background
To assess if DEXAs were completed on: 1. Patients who transitioned from Children's Health Ireland (CHI) Crumlin to the adult IF service at St. James's Hospital (SJH). 2. IF patients on HPN at SJH

Method
A retrospective review of patients reviewed by the IF team who were on HPN or who had transitioned from adolescent to adult services at SJH from 2020 to 2022 was undertaken.

Results
Seven of the ten IF patients who transitioned from adolescent to adult services had a DEXA completed in SJH. Of the seven, five had bone mineral density below expected (71%), three of which were classed as having osteopenia (43%) and two of which had osteoporosis (29%). Of the adult IF patients in SJH on HPN (n= 30), nineteen did not have a DEXA completed at all (64%). Of the eleven patients who did have a DEXA, eight had bone mineral density below expected (73%), two of which were classed as having osteopenia (18%) and six of which had osteoporosis (55%).

Conclusions
Only 36% of IF patients who were on HPN had a DEXA completed, therefore not complying with ESPEN recommendations. 70% of the transitioned IF patients had a DEXA done. Where a DEXA was completed, bone disease was present in most of the patients on HPN (73%) and most IF patients transitioning to adult services from CHI (71%).28% of the transition IF patients had osteoporosis, and 55% of the IF HPN patients.

ABSTRACT 61 (23S124)

Colonic Biopsies Compliance For Chronic Diarrhoea And Resulting Prevalence Of Microscopic Colitis At University Hospital Kerry

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Introduction
Microscopic Colitis (MC) is an inflammatory bowel disease presenting with chronic, non-bloody watery diarrhoea, associated risk factors are age, female gender and smoking. BSG guidelines recommends that patients undergoing colonoscopy for chronic diarrhoea should have right and left colonic biopsies to look for histological features of MC. It has previously been reported that up to 10% of all patients undergoing colonoscopy for chronic diarrhoea will have a diagnosis of MC.

Aims/Background
The primary aim of this audit was to assess the compliance of taking colonic biopsies in patients with chronic diarrhoea undergoing colonoscopy in UHK. Secondary aim was to assess the prevalence of MC according to gender and age in this population.

Method
Data was extracted from the Endoscopy Reporting System in UHK. All colonoscopies carried out for chronic diarrhoea over 2022 was retrospectively analysed.

Results
In total, 430 patients had a colonoscopy as part of the workup for chronic diarrhoea. 89.8% (386/430) had biopsies taken (all the biopsies were taken from right and left colon). In 19 cases, histological features of MC was found. In those, 52% were female with mean age of 60.1 years [18-83]. Looking at histological classification, 18/19 showed characteristics of lymphocytic colitis and 1/19 showed collagenous colitis.

Conclusions
This audit has shown the UHK endoscopy unit was compliant with taking colonic biopsies for chronic diarrhoea as per BSG guidelines. It found that the prevalence of MC within this cohort was 4.4%.

ABSTRACT 62 (23S160)

Post Colonoscopy Colorectal Cancer Incidence: A single tertiary centre review

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Introduction
PCCRC is the diagnosis of colorectal cancer within 3 years of a colonoscopy that did not show cancer. BSG and JAG advise that endoscopic units have a target of PCCRC rate of <5% at 3 years.

Aims/Background
To review PCCRC's occurring within 3 years of a colonoscopy that did not show cancer.

Method
A retrospective analysis of colonoscopies within 36 months prior of a colorectal cancer diagnosis in Beaumont Hospital between 2020-2022(inclusive) was performed. Endoscopy, pathology and cancer network databases were used to identify patients. Endoscopy reporting software (Endoraad) from the RSCI network was cross referenced to identify cancers that were diagnosed outside of our hospital. Patients without a complete data set with the above modalities were excluded from analysis.

Results
339 patients were diagnosed with a colorectal cancer in Beaumont Hospital between 2020-2022. 60 patients were excluded from analysis. 279 patients were included for review of possible PCCRC. A PCCRC rate of 1/279 (0.35%) was calculated.

Conclusions
A recent review of 3 year PCCRC rates in the published literature showed an unadjusted PCCRC rate of 7.6%. Beaumont hospital is meeting the BSG and JAG PCCRC target of <5%. However, it is important to acknowledge the limitation of patient exclusion due to incomplete data, and the possibility that patients may have had PCCRC diagnosed outside of the RCSI group.

ABSTRACT 63 (23S181)

Audit of photo documentation of bowel during colonoscopy.

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Introduction
Colonoscopy is a diagnostic and therapeutic procedure that has become an ideal tool to assess and manage various medical conditions involving bowel1.Photodocumentation is a necessary part of the procedure and helps confirm completion of procedure also provides visual evidence of any abnormality and even to suggest that the examination was normal.

Aims/Background
The aim of this audit was to assess the endoscopy department for its phtodocumentation of the bowel during colonoscopy. There is a significant variation for the number of photos taken since various guidelines suggests different anatomical landmarks to be photographed however among these for colonoscopy, the ESGE recommends photo documentation of up to 10 anatomical landmarks.

Method
Random selection of scopes was done, from the list of colonoscopies performed at the department from the beginning of January 2023 to end of March 2023. Total 209 colonoscopies were assessed for the photo documentation. The photos were analyzed from the Endorad software and Microsoft excel was then used for data entry and analysis.

Results
The mean age was 59 years. There was a slightly male predominance with 55% males and 45% females. The most commonly taken photo was caecum with ileo-caecal valve (91.9% of the scopes had this photo taken). Although taking this photo is optional but still, the photo that was most commonly not taken was that of the terminal ileum (72.2 % of scopes had no terminal ileal photo. The second most commonly missed photo was of rectum in the retro flexion view (50.2% of scopes had no rectal retro flexion photo taken.

Conclusions
According to the standards set by BSG and ASGE the endoscopy department at Mayo University Hospital Castlebar is almost there since in this audit we found that the photo of caecum with ileo-caecal valve was taken in 91.9% of the scopes. This audit however was done in accordance to the recommended photo documentation as per European society of gastroenterology guidelines9 where they recommends more rigorous photo documentation, here however there is room for improvement. Endoscopists in Mayo University Hospital should aim to schedule and participate in regular internal meetings that highlight the importance of systematic photo documentation during colonoscopy. Re-audit should be done.

ABSTRACT 64 (23S172)

Audit Of Referral Outcomes From A CNS-led Diarrhoea Clinic in University Hospital Waterford

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Introduction
In 2019 at University Hospital Waterford, a clinical nurse specialist (CNS)-led pathway was established. Referrals for low-risk patients with chronic diarrhoea were triaged by the Consultant Gastroenterologist to the CNS-led clinic. The purpose of this pathway was to consider onward referral for endoscopy, review in a consultant-led clinic or to discharge back to GP. If successful, the CNS-led clinic would reduce the burden of inappropriate referrals to both of the aforementioned services, with significant time and financial savings.

Aims/Background
To review patient outcomes, including onward referrals, from the CNS-led Diarrhoea Clinic.

Method
Data was collected from the paper-based proforma completed at the CNS-Led clinic between February 2019 and February 2023. Assessment included a review of any red flag symptoms (including weight loss, PR bleeding, Family history of Bowel Ca/ IBD), FBC, biochemistry profile, coeliac markers, stool microbiology, FOB and faecal calprotectin.

Results
Of 277 referrals triaged for this clinic, 213 patients presented for review. 175 patients (82.2%) completed all requested investigations. 11 patients (6.3%) were referred directly onwards to consultant-led GI OPD for further assessment. Only 42 patients (24%) were forwarded directly for endoscopy. Of the 35/42 patients to date who have obtained colonoscopies, 14 have subsequently been referred to GI OPD for follow up. 122 patients (69.7%) were discharged back to their GP without requiring further investigation. Notably, 6 of those discharged later obtained colonoscopies in UHW, all of which were reassuring for sinister findings.

Conclusions
The data emphasises the benefits provided by a CNS-led clinic in terms of reducing the burden of GI/ Endoscopy referrals, expediting time sensitive referrals, and reassuring patients with functional symptoms. These benefits are reflected in both time and cost savings.

ABSTRACT 65 (23S125)

Audit on the Management of Iron Deficiency Anemia in the Mater Hospital April 2023

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Introduction
Symptomatic iron deficiency anemia without overt bleeding is a common cause of medical admission in our institution.

Aims/Background
In 2021 The British Society of Gastroenterology published updated guidelines on the management of iron deficiency anemia. We audited the management of this inpatient group against the recommendations set out in the guidelines and whether management occurred as inpatient or outpatient.

Method
Patients were identified retrospectively by analysing daily handover documents January 1st and April 1st 2023.We collected Coeliac serology, urinalysis , performance of endoscopic or radiological investigations, administration of blood and iron. We identified which medical specialty the patient was admitted under, length of hospital stay and whether investigations were completed as an inpatient or outpatient.

Results
We identified 24 patients meeting the inclusion criteria. 4/24 had Coeliac serology , 3/24 had urinalysis. 5/24 did not receive any iron replacement. 13/24 had an OGD, 10 as an inpatient. 8/24 had a colonoscopy. 15/24 were admitted under the GI service, 7 in the medical assessment unit. Average length of hospital stay was 5 days. Hospital stay was shorter for those admitted in the medical assessment unit versus the gastrointestinal service (2.3 days versus 4.3 days)

Conclusions
We identified deficiencies in the management of inpatients presenting with symptomatic iron deficiency anaemia against the set guidelines. Iron deficiency anaemia was associated with a significant hospital stay. We propose that a dedicated iron deficiency anaemia pathway incorporating rapid access to outpatient endoscopy would improve compliance with guidelines and may reduce length of hospital stay.

ABSTRACT 66 (23S162)

An Audit of Tattooing Practices in the Endoscopy Units of Louth County Hospitals

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Introduction
Placement of tattoos during colonoscopy facilitates accurate identification of colon cancer sites at surgery. The 2020 National GI Endoscopy Quality Improvement (QI) Program guideline recommends tattooing all suspicious neoplastic lesions outside the rectum and caecum.

Aims/Background
To assess compliance of our endoscopy unit with National GI Endoscopy QI Programme guidelines on tattooing of cancers.

Method
We used a prospectively maintained database of colorectal cancers diagnosed at Our Lady of Lourdes Hospital, Drogheda and Louth County Hospital in 2022. Electronic endoscopy reports (EndoRAAD) were used to collect relevant data: Name, age, sex, colonoscopy date, tumour location and record of tattoo placement.

Results
47 patients with endoscopically detected colorectal cancer were identified: median age 68 years (IQR 62-79.75), 17 (36%) female. Anatomical distribution was as follows: one (2%) caecum, seven (15%) ascending, four (8%) transverse, two (4%) descending, 25 (53%) sigmoid and eight (18%) rectum. Of 38 (80%) cancers occurring outside the caecum or rectum, 31(82%) were tattooed according to endoscopy reports. Of the 7 (18%) tumours not tattooed, all proceeded to successful surgical resection.

Conclusions
Our data shows suboptimal compliance with national guidance on endoscopic placement of tattoos in relation to colonic tumours. We will present our findings at our local Endoscopy Users Group meeting with a view to implementing QI practices and repeating the audit cycle. We acknowledge limitations of our data, including its retrospective nature, and lack of access to surgical records to confirm whether visible tattoo was present at the time of surgical resection.

ABSTRACT 67 (23S115)

Improving Triage For Inpatient Colonoscopy At University Hospital Kerry: A Successful Quality Improvement Initiative

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Introduction
An audit was carried out at UHK to measure the volume of inpatient colonoscopies, their indications and quality. We found that a large volume of inpatient colonoscopies were undertaken, the majority of which could have been triaged as an outpatient procedure according to the HSE triage guidance. Additionally, we confirmed the well-established challenges relating to inpatient colonoscopy quality and the need for repeat investigation. To improve endoscopy capacity utilisation and colonoscopy quality, an inpatient triage form was implemented.

Aims/Background
The aim of this study was to evaluate the impact of the inpatient triage form at UHK on colonoscopy triaging.

Method
Inpatient colonoscopy data over the 16-weeks after the implementation of the inpatient triage form was collated and compared to the results of the original audit. The primary outcome was the weekly number of inpatient colonoscopies carried out. The secondary outcome was the distribution of indication for the inpatient colonoscopies carried out.

Results
Over the 16 weeks, the mean weekly colonoscopies was 1.25 compared to 3.21 pre-form implementation ($p<0.001$, student t-test). 35% of inpatient colonoscopies carried out met indication for emergency colonoscopy, 20% met indication for flexible sigmoidoscopy only and 45% did not meet indication for inpatient procedure (vs 22.22%, 20.51% and 57.26% respectively).

Conclusions
Following the implementation of the form, a significant reduction in the volume of inpatient colonoscopies carried out was observed. The changes in indication distribution reflects improved triage. The change in attitude at UHK in relation to inpatient colonoscopy triaging has allowed for better endoscopy capacity utilisation and improved colonoscopy quality.

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Dr Anne Fennessy, Dr Brian Egan & Dr Neil O'Morain

Dr Kevin Ward & Dr James Turvill

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