Irish Society of Gastroenterology

Winter Meeting

7th & 8th December 2023
Killashee Hotel,
Naas, Co. Kildare

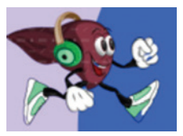
Welcome Message

A Chairde,

It gives me great pleasure to welcome you all to the Winter Meeting of the ISG, to be held in the beautiful and newly renovated Killashee House Hotel.

We have a busy and exciting programme ahead with a gathering of very distinguished speakers from Ireland and further afield. I am delighted that we all hope to be there in person, which will allow for greater interaction, learning and networking, a feature of the ISG meeting that I think we all agree will be warmly welcomed.

We will kick off on Wednesday evening with a hepatology session for the SpRs and an interhospital quiz that will surely get the ball rolling. Our main sessions on Thursday will feature modern approaches to bariatric surgery and obesity followed by some stimulating talks in the afternoon on the benefits of exercise for patients and ourselves.



I am excited about the enthusiasm shown for our 'Activity hour', which will give everyone a chance to take a deep breath and get active before our social activities and gala dinner. There will be an opportunity for yoga, spinning, or to experience the fantastic gym and pool at Killashee. Board games will be available for those who prefer a more relaxed hour and it is also very acceptable to just chill and recharge our batteries.

We will all be fresh for Friday morning with what looks like a brilliant line up of speakers on IBD, followed by time to discuss and debate some challenging cases. I would like to highlight in particular our most important group and our future, our trainees, who have submitted an excellent range of abstracts that will be presented throughout the meeting. Out educational subcommittee will also announce the winners of the new educational bursaries.

I extend my sincere thanks to all my colleagues on the ISG board who have been of great assistance bringing this programme together. In advance I would like to thank our distinguished speakers for giving up their time and sharing their experiences with us here at the ISG. I also thank our industry partners for their ongoing support and presence. None of this would be possible without the tireless work that goes on behind the scenes by Michael Dineen and Cora Gannon and team, my heartfelt thanks to you both from all of us.

I hope you all have a valuable, educational and enjoyable meeting and an opportunity to catch up with old friends and make a few new ones.

Sincere best wishes

Professor Orla Crosbie
President, Irish Society of Gastroenterology
Consultant Hepatologist
Cork University Hospital

ISG MEETING, Winter 2023

Irish Society of Gastroenterology Winter Meeting

7th & 8th December 2023
Killashee Hotel, Naas, Co. Kildare

Day 1 — Thursday 7th December – Morning

08.00 - 09.00	**Registration / Coffee / Visit Stands**
09.00 - 10.00	**Top 7 Abstracts - President's Choice**
10.00 – 11.00	**Symposium 1: Part 1** **Modern approach to Obesity and Bariatric Surgery**
10.00 – 10.30	***Home and Away-the Bariatric Surgery Episode*** **Professor Helen Heneghan** Professor of Surgery University College Dublin
10.30 - 11.00	***How the gut talks to the brain*** **Professor Carel le Roux** Metabolic Medicine University College Dublin
11.00 - 11.30	**Coffee / Visit Stands**
11.30 - 12.00	**Symposium 1: Part 2** ***Endobariatrics – Endoscopic Sleeve Gastroplasty (ESG) and beyond*** **Mr Jamie Kelly** Bariatric and Cancer Surgeon Spire Southhampton Hospital, UK
12.00 – 13.00	**Themed Oral Presentations** Hepatology and Other GI - Rathaskar Suite (Main meeting Room) Endoscopy and IBD - Fountain Suite
13.00 – 14.15	**Lunch / Visit Stands**

ISG MEETING, Winter 2023

Day 1 Thursday 7th December Afternoon

14.15 - 15.45 **Symposium 2:**
Exercise and Movement for All

14.15 - 14.45 ***Lifestyle and Liver Disease; worth spending energy on?***
Professor Mike Trenell
Professor of Metabolism and Lifestyle Medicine
Newcastle University, UK

14.45 - 15.15 ***Being Active with Inflammation; should we be prescribing lifestyle medicine in GI?***
Professor Karen Boland
Consultant Gastroenterologist
Beaumont Hospital, Dublin

15.15 - 15.45 ***Ergonomics for the Endoscopist***
Dr Keith Siau
Consultant Gastroenterologist
Royal Cornwall Hospitals NHS Trust, UK

15.45 - 16.15 **Coffee / Visit Stands**

16.15 - 17.15 **Pfizer Sponsored Symposium**

JAK inhibitors for Ulcerative Colitis: From clinical trials to real world experience
Professor Peter Irving
Consultant Gastroenterologist
Guy's and St Thomas Hospital, London, UK

17.30 -18.30 **Activity Hour**

19.30 **Reception and Conference Dinner**

Day 2 Friday 8th December

09.30 – 10.30 **Symposium 3: Part 1**
Emerging approaches in Inflammatory Bowel Disease

09.30 - 10.00 ***Intestinal Ultrasound in IBD: what's all the hype about?***
Dr Kerri Novak
Consultant Gastroenterologist
University of Calgary, Canada

10.00 – 10.30 ***Changing concepts in managing dysplasia associated with IBD***
Professor Marietta Iacucci
Professor in Gastroenterology
University College Cork

10.30 – 11.00 **Coffee / Visit Stands**

Symposium 3: Part 2

11.00 –11.30 ***De-escalation of treatment in IBD, biologics or immunosuppressants***
Professor Peter Irving
Consultant Gastroenterologist
Guy's and St Thomas Hospital, London, UK

11.30- 12.45 **Meet the Experts**
IBD Difficult Case Presentations

Panel
Dr Kerri Novak
Professor Peter Irving
Professor Marietta Iacucci

12.45 – 13.00 **Award Presentations**

13.00 **ISG Close of Meeting**

14.00 - 15.00 **AbbVie Medical Education Symposium**

"Endoscopic Outcomes – From Clinical Trials to Clinical Practice"
Dr David Gibson
Consultant Gastroenterologist
Alfred Hospital, Melbourne

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Dr Caroline Lavery, Dr Conor Braniff,
Dr Ciaran Magee, Dr John McGoran

Dr Barra Neary, Prof Subhasish Sengupta

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ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Ms Louise Rooney Abbvie, Mr Colla Cunneen Abbvie,
Dr Lakshman Kumar

Dr Matthew McKenna-Barry,
Dr Thomas Mathews, Dr Robert Varley

Biographical Sketches

Professor Helen Heneghan
Professor of Surgery
University College Dublin

Professor Helen Heneghan (MB BCh BAO, PhD, FRCS) is a Consultant Bariatric Surgeon at St. Vincent's University Hospital, Dublin and Professor of Surgery at University College Dublin. She is a graduate of NUI Galway medical school, was awarded a PhD from NUI Galway in 2012. She completed the RCSI Higher Surgical Training scheme in General Surgery in 2016. During her training, she spent two years on Fellowship in the Bariatric & Metabolic Institute in Cleveland Clinic, Ohio. She then completed her training with a Bariatric Fellowship in the UK. She has co-authored >120 publications in peer-reviewed journals and has written several book chapters on the topics of bariatric and endocrine surgery. Her research interests include obesity and cancer, fatty liver disease and bariatric surgery mechanisms.

Professor Carel le Roux
Metabolic Medicine
University College Dublin

Professor Carel le Roux graduated from medical school in Pretoria South Africa, completed his specialist training in metabolic medicine at St Bartholomew's Hospitals and the Hammersmith Hospitals. He obtained his PhD from Imperial College London where he later took up a faculty position. He moved to University College Dublin for the Chair in Chemical Pathology and Metabolic Medicine and he is now a Director of the Metabolic Medicine Group. He also holds the position of Professor of Metabolic Medicine at Ulster University and Extra-ordinary Professor of Chemical Pathology at University of Pretoria. He currently coordinates an Innovative Medicine Initiative project on obesity. He previously received a President of Ireland Young Researcher Award, Irish Research Council Laurate Award, Clinician Scientist Award from the National Institute Health Research in the UK, and a Wellcome Trust Clinical Research Fellowship for his work on how the gut talks to the brain.

Mr Jamie Kelly
Bariatric and Cancer Surgeon
Spire Southhampton Hospital, UK

Mr Jamie Kelly is a specialist in Laparoscopic, robotic and endoscopic surgery, focused on weight loss and cancer surgery of the upper gastrointestinal tract. He was appointed lead upper GI surgeon at University Hospital Southampton in 2012.
From a weight loss perspective, he performs the routine procedures (band, sleeve, bypass, and revisional procedures) but also performs incisionless weight loss procedures. He was the first to perform POSE in Europe and the first to perform Endoscopic Sleeve Gastroplasty (ESG) in the UK (2015). Was involved in all the UK based Endobarrier trials. He was part of the original advisory board for Apollo to help understand and develop ESG. He is published, lectures, teaches, and proctors nationally and internationally. Has taken ESG from inception through to NICE approval in the UK and has performed over 400 cases.
Currently involved in developing new endoscopic antireflux procedures.

Professor Mike Trenell
Professor of Metabolism
and Lifestyle Medicine
Newcastle University, UK

Mike Trenell is a clinical scientist, specialising in digital health and innovation. He holds a PhD in Neurogenetics from Sydney University (Australia) and MBA in Strategy and Innovation from Durham University (UK). A former Diabetes UK RD Lawrence Fellow and NIHR Senior Fellow, Mike is a Founder of Changing Health, a digital health company, and an Honorary Professor of Digital Medicine at Newcastle University. Having published widely in metabolic medicine and ageing, Mike is passionate about translating science into practice. He was the founding Director of the NIHR Innovation Observatory, the largest non-commercial horizon scanning facility globally, and former Deputy Director of the MRC Centre for Ageing and Vitality.

Professor Karen Boland
Consultant Gastroenterologist
Beaumont Hospital, Dublin

Karen graduated with an honours degree from the School of Medicine at RCSI in 2007 and is currently appointed as a Consultant Gastroenterologist at Beaumont Hospital with an interest in inflammatory bowel disease and clinical nutrition. She completed an advanced fellowship in microbiome analysis, diet analysis and inflammatory bowel disease at Mount Sinai Hospital Toronto. Her current research interests include therapeutic drug monitoring in IBD, microbiome analysis in recurrent Crohn's disease and the impact of diet and exercise programmes on outcomes in moderate to severe IBD and cirrhosis. Karen is a member of the board of IrSPEN and chair of their Scientific Committee.

ISG MEETING, Winter 2023

Dr Keith Siau
Consultant Gastroenterologist
Royal Cornwall Hospitals NHS Trust, UK

Dr Keith Siau is a consultant gastroenterologist from Cornwall, UK. He has broad research interests including endoscopy training, quality in endoscopy and has developed the ERGONIMICS framework on ergonomics in endoscopy. He has co-authored endoscopy training and certification guidelines for upper and lower GI endoscopy, ERCP and EUS. He is a current committee member for BSG Endoscopy and is lead for the national quality improvement programme for upper GI bleed management, editorial board member for Endoscopy, Endoscopy International Open and UEG Journal, and serves on the ESGE working groups for Social Media and for Green Endoscopy.

Professor Peter Irving
Consultant Gastroenterologist
Guy's and St Thomas Hospital, London, UK

Peter Irving is Consultant Gastroenterologist at Guy's and St Thomas' Hospital in London and is Professor of IBD at King's College London. Professor Irving studied medicine at Cambridge University and The London Hospital Medical College, UK. He trained in gastroenterology in London before undertaking an IBD fellowship in Melbourne, Australia. He has a large IBD practice and a number of active research interests in translational research, clinical IBD and clinical trials. He has published widely in IBD including several books and book chapters, and over 200 peer-reviewed articles. He formerly served as Chair of the Education Committee of ECCO and e-Learning Ambassador for ECCO and now sits on the Education Committee of UEGF.

Dr Kerri Novak
Consultant Gastroenterologist
University of Calgary, Canada

Kerri is an academic faculty at the University of Calgary, practising an IBD-focused practice at the Foothills Medical Center. She was the first IBD physician in Canada to introduce routine use of intestinal ultrasound in clinic in North America in 2012 and has been a passionate advocate and champion ever since. She is a founding member of the International Bowel Ultrasound Group (IBUS), their current Secretary on the Governing Board, and is the Chair of the Canadian interest group (CAN BUS) and a co-chair of the American-Canadian joint group (iUSCAN). She is an enthusiastic trainer of all those interested in IUS and has visitors to Calgary from all over the world. Most importantly, Kerri has 2 wonderful teenage daughters and a patient husband who all love to camp in the Alberta mountains. She almost loves her dog Iggy most of all.

Professor Marietta Iacucci
Professor in Gastroenterology
University College Cork

Prof Marietta Iacucci is a leading researcher in the field of AI and a pioneer in 'endo-omics' that fuses endoscopic and histologic information with 'multi-omics data in Inflammatory Bowel Disease. The application of precision medicine to predict disease course and outcomes in gastrointestinal diseases has been recently published in Gastroenterology 2021,2023 Gut 2022 with cover illustrations and editorials.
Prof Iacucci qualified in Medicine from the University of Rome and obtained her PhD in 2009. She trained and did research in Germany, the United Kingdom, and Japan and previously held permanent faculty positions at the Universities of Calgary, Canada and Birmingham, UK. She was a key investigator at the National Institute of Health Research in Birmingham. She led transdisciplinary work that predicted disease courses and outcomes in colonic neoplasia and inflammatory bowel disease, bridging engineering, bioinformatics, and imaging/omics.
She has been nominated for leadership positions in multiple international organisations. She is a fellow of the American Society of Gastrointestinal Endoscopy. American Gastroenterological Association Fellow, the member of e-Learning Taskforce of the European Crohn's and Colitis Organisation (ECCO), member of International Inflammatory Bowel Disease Organisation (IOIBD), member of the Global interventional Inflammatory Bowel Disease Group, sits on the ESGE advanced imaging in colorectal neoplasia guidelines committee and IBD quality improvement committee working group.
She has delivered key plenary talks at prestigious international conferences such as the American Gastroenterology Association/ American Society of Gastrointestinal Endoscopy, International Organisation for Study of IBD, European Crohn's and Colitis Organization and European Society of Gastrointestinal Endoscopy.Her goal is to drive transdisciplinary precision medicine research in IBD and colon cancer.

ISG Board Members

Professor Orla M Crosbie,
President ISG
Consultant Hepatolologist
Cork University Hospital

Prof. Orla Crosbie is a 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 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.

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.

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 2020, following training in Northern Ireland and a research endoscopy fellowship at University Hospitals of Leicester. He has recently taken up the post of training programme director for gastroenterology in Northern Ireland and continues to direct JAG accredited courses at Altnagelvin. In addition to training and education, John's professional interests include upper GI disorders and therapeutic endoscopy. He is learning to play the piano and remains a work in progress.

Ms Claire Donohoe
Consultant Resectional Oesophagogastric Cancer and General Surgeon
Trinity St James' Cancer Institute, Dublin

Claire Donohoe is a consultant resectional oesophagogastric cancer and general surgeon at Trinity St James' Cancer Institute, Dublin. She provides endoscopic, laparoscopic, robotic and open approaches for treating OG cancers. Her research interests include the immune contexture of oesophageal adenocarcinoma, federated real world evidence and formative assessment for learning in medical education.

Professor Anthony O'Connor
Consultant Gastroenterologist
Tallaght University Hospital

Prof. Anthony O'Connor is clinical associate professor in Gastroenterology at Trinity College Dublin and Head of the Department of Gastroenterology at Tallaght University Hospital. He graduated in medicine from University College Cork in 2004. He completed BST training in Limerick before undertaking higher specialist training in Gastroenterology and General Medicine in Tallaght and St. James's Hospitals in Dublin. He was awarded an MD by Trinity College Dublin in 2012 for a thesis on Stomach Cancer supervised by Professor Colm O'Morain. Upon completion of his training in Ireland he worked at Beth Israel Deaconess Medical Center/ Harvard Medical School in Boston, USA before taking up an appointment as Consultant Gastroenterologist at Leeds Teaching Hospitals NHS Trust in June 2014 and returning to Ireland in 2016 to an appointment at Tallaght University Hospital. His interests are Inflammatory Bowel Diseases especially Quality of Life for patients with IBD, functional GI diseases, Helicobacter pylori infection and Gastric Cancer prevention. Is gaeilgeoir é.

Professor Suzanne Norris
Consultant Hepatologist/
Gastroenterologist at St James's Hospital and Professor in Gastroenterology & Hepatology, Trinity College Dublin.

Prof Norris has a lifelong interest in education and raising awareness about liver disease. She is a former member of the governing board of the European Association for the Study of the Liver (2007-2008), EASL Scientific Committee (2005-2008), and AASLD Education Committee (2007-2009). She was National Specialty Director for gastroenterology/hepatology registrar training in Ireland from 2007-2012 at the Royal College of Physicians in Ireland, and Vice-Dean of Postgraduate Specialist Training 2012-2016. Prof Norris was the inaugural HSE Clinical Lead to the National Hepatitis C Treatment Programme in Ireland 2016-2017. A founding member and chair of the Irish Hepatitis C Outcomes Research Network (2012-2016), she has participated into several national and international collaborative projects on epidemiology and public health issues related to viral hepatitis.

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.

ISG MEETING, Winter 2023

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide


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Ms Carole Schilling IBD, Ms Sini George IBD,
Ms Brenda Fee, Ms Tincymol Lukose IBD

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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

ISG MEETING, Winter 2023

Top Abstracts - Presidents choice

7th December - Rathaskar Suite (Main Meeting Room)

Abstract No.	Ref:	Title	Author	Time
1	23W107	Combined EUS and ERCP Procedures; The Urgent Need For Enhanced Sedation	Dr Eoin Keating	9.10
2	23W113	Hepatitis C community prevalence is over-estimated: a prospective birth cohort study.	Prof Aiden McCormick	9.17
3	23W123	Review Of HCC Recurrence Post Liver Transplant In The Irish Population And Assessing Validity of The Retreat (Risk Estimation of Tumour Recurrence After Transplant) Score Within Our Patient Cohort	Dr Julie Steen	9.24
4	23W139	Clinical Efficacy of Accelerated 4-weekly vs. Conventional 8-weekly Ustekinumab Dosing in Inflammatory Bowel Disease: A Single Centre Experience.	Dr Ashley Lloyd	9.31
5	23W153	Adding Branched-Chain Amino Acids to a Standard-of-Care Treatment Improves Muscle Mass and frailty of Cirrhotic Patients: A Randomised Controlled Trial	Dr Reza Saeidi	9.38
6	23W155	Effectiveness, Safety, and Cost of Combination Advanced Therapies in Inflammatory Bowel Disease	Dr Cathy McShane	9.45
7	23W158	Novel Budesonide Preparations for Refractory Coeliac Disease	Dr Caroline Walker	9.52

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Dr Zita Galvin and Dr Geraldine McCormack

TOP 7 ABSTRACTS

ABSTRACT 1 (23W107)

Combined EUS and ERCP Procedures; The Urgent Need For Enhanced Sedation

Author(s)
Eoin Keating (1, 2), Shane McGuinness (1), Harvey Martir (1), Gayle Bennett (1, 2), Barry Kelleher (1, 2), Stephen Stewart (1, 2), Navneet Ramlaul (1, 2), Jan Leyden (1, 2)

Department(s)/Institutions
1. Department of Gastroenterology, Mater Misericordiae University Hospital 2. School of Medicine, University College Dublin

Introduction
Completing advanced endoscopic procedures e.g. EUS and ERCP under conscious sedation is challenging.

Aims/Background
International recommendations favour enhanced sedation (e.g. propofol) for EUS and ERCP to optimise outcomes. Access to propofol sedation is limited in Irish endoscopy.

Method
A retrospective analysis of single-session combined EUS/ERCP procedures over 16 months, focusing on sedation use and technical success.

Results
697 ERCPs were analysed, 82.5% (n=547) direct ERCPs and 17.5% (n=122) combined EUS/ERCP procedures. 4.2% (n=29) of all procedures were completed using propofol. Overall ductal cannulation rate was 91.4% but was significantly lower for combined procedures vs direct ERCPs (83.6% vs 93%, p=0.001). Propofol-supported ERCPs achieved a cannulation rate of 100%. Matching by indication, failed cannulation rates for choledocholelithiasis was 13.2% for combined EUS vs 2.7% of direct ERCPs (p<0.001). Difficult ERCP cannulation rates (pre-cut sphincterotomy or pancreatic duct stenting) were higher in combined EUS cases vs direct ERCPs; choledocholelithiasis 17.6% vs 8%, p=0.022, and malignant strictures 29.4% vs 14.3%, p=0.045. Complication and successful stenting rates did not differ between the groups. Combined procedures required >5mg midazolam in 74.6% vs 52.1% of direct ERCPs (p<0.001). Similarly, >100mcg of fentanyl was required in 50.8% of combined procedures vs 21.4% of direct ERCPs (p<0.001). Sedation-related issues complicated 11.5% (n=15) of combined EUS/ERCP procedures. Sedation-related ERCP failure rates were significantly higher in combined EUS/ERCPs vs direct ERCPs (4.9% vs 1.7%, p=0.045).

Conclusions
Successful biliary cannulation is significantly more challenging in combined cases under conscious sedation. Propofol-supported ERCP is beneficial in facilitating completion of complex biliary endoscopy cases at first attempt.

ABSTRACT 2 (23W113)

Hepatitis C community prevalence is over-estimated: a prospective birth cohort study.

Author(s)
McCormick PA, O'Grady M, DeGascun CF, Lambert JS, Crosbie O, McKiernan S, Skelly M, Holder P, Courtney G, Hennessy B, Walsh K, Twohig R, Browne K, O'Gorman T, Crowley V, Costelloe S, O'Byrne R, Whitney E, Gildea O, Montgomery N.

Department(s)/Institutions
National Hepatitis C Treatment Program HSE, National Virus Reference Laboratory, Mater Hospital, Cork University Hospital, St James's University Hospital, University Hospital Limerick, St Luke's Hospital Kilkenny, University Hospital Waterford, Sligo University Hospital.

Introduction
Hepatitis C virus infection is often asymptomatic and many patients may be unaware they are infected. Community based, birth cohort screening has been advocated to identify these patients. It has been estimated that 0.7 - 1% of individuals born between 1965 and 1985 in Ireland are infected. The cost-effectiveness of screening is critically dependent on the population prevalence

Aims/Background
To determine the community prevalence of hepatitis C virus infection in the birth cohort 1965-1985.

Method
Residual serum samples from blood tests ordered by community general practitioners were anonymised and analysed for the presence of hepatitis C antibody + antigen. Twelve large general hospitals throughout the country participated.

Results
A total of 14,320 samples were tested, 9,347 of which were from the birth cohort 1965-1985. Seventy-two samples were positive for hepatitis C antibody of which 12 were positive for hepatitis C antigen (17%). The overall prevalence of hepatitis C antigen in the birth cohort was 0.09%. A higher prevalence (0.39%) was identified in males in two urban areas of Dublin.

Conclusions
Chronic hepatitis C virus infection prevalence was much lower than previously estimated. The proportion of antibody positive patients with hepatitis C antigen was also lower than expected suggesting the effects of treatment and/or high spontaneous viral clearance. Universal birth cohort screening is unlikely to be cost-effective. Targeted birth cohort screening in high prevalence areas could be considered.

ISG MEETING, Winter 2023

ABSTRACT 3 (23W123)

Review Of HCC Recurrence Post Liver Transplant In The Irish Population And Assessing Validity of The Retreat(Risk Estimation of Tumour Recurrence After Transplant) Score Within Our Patient Cohort

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Introduction
There is no international agreement on the role of post liver transplant (LT) surveillance for recurrent hepatocellular carcinoma (HCC) in patients who were transplanted for HCC. The Risk Estimation of Tumour Recurrence After Transplant (RETREAT) score, which incorporates α-fetoprotein (AFP) at liver transplantation (LT), presence of microvascular invasion, the sum of the largest viable tumour and number of tumours on explant, has been proposed as a risk-stratification tool to help predict recurrence and guide post LT surveillance.

Aims/Background
To determine the HCC recurrence rates post LT in our cohort and to externally validate the RETREAT score in an Irish population

Method
This single centre, retrospective cohort study included all patients who underwent liver transplant for HCC from 2014 to 2023

Results
Over the 9 year period, 103 patients (83% Male, 97% Cirrhotic, median age at diagnosis 59) underwent LT for HCC. All patients were transplanted within UCSF criteria and 94% (n=97) were within Milan criteria. 13% (n=13) had recurrence and the median time to recurrence was 37 months (6-62). Median survival post recurrence was 10 months (1-55). Median RETREAT in group with no recurrence was 1(0-6), median RETREAT in those with recurrence was 3 (1-7).

Conclusions
Similar to international data, higher RETREAT scores in an Irish population were associated with higher risk of HCC recurrence. The RETREAT score may be a useful tool to risk stratify patients and help guide post LT surveillance.

ABSTRACT 4 (23W139)

Clinical Efficacy of Accelerated 4-weekly vs. Conventional 8-weekly Ustekinumab Dosing in Inflammatory Bowel Disease: A Single Centre Experience.

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Introduction
European Crohn's and Colitis Organisation (ECCO) recommends 8-weekly dosing regimen of Ustekinumab in the treatment of moderate-to-severe inflammatory bowel disease (IBD) in patients who have failed conventional treatment. Accelerated 4-weekly dosing has been suggested to be efficacious, however not licenced, in 'non-responders'.

Aims/Background
To determine how 4-weekly accelerated dosing regimen in ustekinumab drug levels correlate with response to treatment in patients with inflammatory bowel disease.

Method
Patients for inclusion were identified utilising online prescription records at Mercy University Hospital, Cork. Inclusion criteria consistent of IBD patients with ustekinumab commencement within 6 months. Faecal calprotectin (FCP) levels/Ustekinumab drug levels were monitored at 12-week check in post initiation and at 2nd assessment. Symptoms were quantified using the Harvey Bradshaw Index for Crohn's Disease and the Partial Mayo Score for ulcerative colitis.

Results
101 patients at the Mercy University Hospital Cork were identified utilising a database of prescriptions and physical charts (4-weekly: 27; 8-weekly: 74). A statistically significant decrease in FCP levels at 2nd assessment was noted in patients with 4-weekly dosing (p=0.028). There was no statistically significant relationship between dosing interval and symptoms (p=0.735). Individual patient factors including age, gender, type of IBD, and concurrent IBD medications did not have a statistically significant effect on faecal calprotectin levels or symptoms.

Conclusions
The greater percentage decrease in faecal calprotectin provides objective evidence supporting the escalated dosing interval at the Mercy University Hospital IBD centre. However, further study is necessary to justify increasing the dosing interval for all patients treated with ustekinumab for IBD.

ABSTRACT 5 (23W153)

Adding Branched-Chain Amino Acids to a Standard-of-Care Treatment Improves Muscle Mass and frailty of Cirrhotic Patients: A Randomised Controlled Trial

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Introduction
Sarcopenia (low muscle mass, strength, and function) and frailty are associated with adverse outcomes in cirrhosis, including hepatic encephalopathy, ascites, infection, and increased hospitalisation. The effect of branched-chain amino acid (BCAA) supplementation on muscle mass and frailty in patients with cirrhosis and sarcopenia is unknown.

Aims/Background
Our aim is to the potential of BCAA in enhancing muscle mass and mitigating frailty among individuals with cirrhosis.

Method
Cirrhotic patients were recruited from a single center tertiary hospital for this prospective, randomized controlled trial. Consecutive patients with cirrhosis were randomized to receive either 30g/day BCAA orally (BCAA group) or continue with standard medical therapy (NBCA-group) for 3 months with initial assessment conducted during third week. Nutritional status, muscle and fat mass were assessed using BIA (SECA mBCA 525) as the reference. Sergi-sarcopenia-equation were employed for muscle mass/appendiceal muscle mass index (ASMI) measurements. Validated muscle strength and functional metrics {handgrip strength (HGS), sit-to-stand (STS) and short physical performance battery (SPPB)} and liver-frailty-index (LFI) were recorded. Statistical analysis was performed using Stata version 17.0. P value <0.05 was considered significant.

Results
Total of eighty-eight individuals recruited. 52 patients {mean age 58±10; males (52%) of predominantly alcohol (65%) and MASH (13%) were randomised. 36 healthy controls (HCs) {mean age 51± 11, 41% male} were also included. Compared to HCs, cirrhotic patients had lower muscle strength (HGS 36.6 ± 10 vs 25.3 ± 9, p<0.001; STS 8.9 ± 2.2 vs 14.4 ± 7.1, p<0.001), performance (SPPB 11.80 ± 0.47 vs 9.9 ± 2.41, p<0.001) and nutritional status (PhA 6.51 ± 0.9 vs 4.89 ± 0.97, p<0.001). In cirrhotic patients, supplement compliance was 81% (SD = 16) at week 12 and well-tolerated. Baseline clinical and demographic characters of patients were similar apart from more males (n=17 vs 10 ,p=0.02) and higher BMI (30.4±7 vs 26.4±4.8, p=0.01) in NBCA group and lower ASMI in BCAA group (6.59±1.22 vs 7.69±1.36, p=0.003). In patients receiving BCAA, there was high muscle mass (ASMI) at week 3 (Δ0.37, CI 0.06—0.71 with p=0.02) but not at week 12 (Δ0.14, CI -0.07—0.36, p=0.02). Eight (15%) patients (n=6 BCAA, n=2 NBCA) had sarcopenia at baseline. Overall, on week 12, 49% of patients showed improvement in ASMI, which were more frequent in BCAA group, 83% vs 59% in NBCA with p=0.02. Reduced frailty(LFI) was noted in BCAA group (Δ-0.32, CI -0.57—-0.08, p=0.008) and week 12 (Δ-0.21, CI -0.40—-0.01, p=0.03). Secondary outcomes including handgrip strength (p>0.13), STS (>0.16), SPPB (p>0.19) and serum albumin level (p=0.44) were similar in both arms at both time points.

Conclusions
Addition of BCAA to standard of care in cirrhotic patient leads to improvement in frailty and muscle mass of patient with cirrhosis. It is important to note that the improvements in muscle mass were primarily observed in the short term. Alongside BCAA supplementation, the incorporation of exercise may be necessary to effectively enhance and sustain muscle mass in patients with liver cirrhosis and will be evaluated as part of study evolution.

ABSTRACT 6 (23W155)

Effectiveness, Safety, and Cost of Combination Advanced Therapies in Inflammatory Bowel Disease

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Introduction
Despite significant progress in the management of inflammatory bowel disease (IBD), a proportion of patients fail to respond to therapy. Consequently there is increased interest in combining two advanced therapies targeting different inflammatory pathways to increase long term rates of response and remission. Limited data are available regarding the outcomes, safety, and cost-effectiveness of this treatment approach.

Aims/Background
To assess treatment outcomes, safety and cost-effectiveness of combination advanced therapies in IBD.

Method
Combination advanced therapy was defined as the concurrent administration of two biological agents, or one biological agent along with a small molecule therapy. Clinical data, including disease characteristics, treatment regimens, disease activity scores, and adverse events, were collected from electronic patient records. Clinical response rates, biochemical markers, persistence of combination therapy, and treatment costs were assessed.

Results
Our study comprised 109 IBD patients undergoing combination advanced therapies across nine academic medical centres in Ireland. The median [95% confidence interval] time to discontinuation of first therapeutic trial of combination therapy was 154.9 weeks (129.6 – 180.2 weeks). Corticosteroid-free (CSF) clinical response at 12 weeks was achieved in 39% of patients. At 52 weeks rates of CSF clinical response were 38%; with higher response rates observed in Crohn's disease (47%) compared with ulcerative colitis (17%). At 52 weeks, a combination of anti-IL23 and JAK inhibitor was the most effective with 67% of patients achieving CSF clinical response and 33% achieving CSF clinical and biochemical response. There was a significant reduction in serum CRP, faecal calprotectin, and clinical disease activity scores during the follow-up period. Adverse events were observed in 26% of therapeutic trials, with disease-related events being the most common. There were 3 cases of non-melanomatous skin cancer and 10 infectious complications. The annual cost of maintenance therapy for combination advanced therapies ranged from €12,426 to €30,724 per patient.

Conclusions
Combination advanced therapies demonstrated effectiveness and acceptable safety profiles in a cohort of treatment-refractory IBD patients. The high cost associated with this treatment approach requires consideration. These findings support the selective use of combination advanced therapies in patients with severe and refractory disease. Further large, prospective trials are required to definitively evaluate combination advance therapy in IBD.

ABSTRACT 7 (23W158)

Novel Budesonide Preparations for Refractory Coeliac Disease

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Introduction
Refractory coeliac disease(RCD) is a rare form of coeliac disease associated with high morbidity and mortality, in part, due to limited treatment options. Manipulation of budesonide preparations to ensure preferential release in the upper small intestine has demonstrated therapeutic benefit in patients with RCD, many of whom have failed conventional immuno-modulators. Thrice daily "open capsule budesonide(OCB)" 3mg, consumed in three different ways is one such therapeutic option for RCD.

Aims/Background
To describe the outcome of RCD patients treated with either OCB or a novel "naked budesonide(NB)" preparation encompassing 3mg of budesonide powder made up in a gelatin capsule.

Method
A retrospective review of RCD patients treated with either preparation over an 11-year period. Demographic, clinical, serological and histological variables were identified from review of electronic medical records.

Results
17 patients were identified, 53%(n=9) male, 47%(n=8) female, with a median age of 62 at RCD diagnosis. 65%(n=11) had RCD2 based on the presence of T-cell receptor gene rearrangements or an aberrant phenotype of IELs. 35%(n=6) had RCD1. Diarrhoea and weight loss were the commonest symptoms with the majority of patients demonstrating total or subtotal villous atrophy on D2 biopsy. Following treatment, all patients(100%) reported symptom improvement, while 77%(n=10/13) demonstrated improved villous morphology.

Conclusions
Both OCB and NB were associated with clinical and histological improvement in our cohort of patients with RCD. For a disease with few treatment options, these novel regimens of budesonide administration provide a safe and effective therapy and should be considered as a first line therapeutic approach.

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Dr Eoin Keating, Dr Niamh Mehigan Farrelly

Themed Oral Presentations - Hepatology and Other GI

7th December - Rathaskar Suite (Main Meeting Room)

Abstract No.	Ref:	Title	Author	Time
8	23W103	Age Added to MELD or ACLF Grade Predicts Survival in Patients with Severe Alcohol-Related Hepatitis Declined for Liver Transplantation	Dr Stephanie Rutledge	12.00
9	23W129	Advanced nurse practitioner-led Hepatology clinic for chronic liver disease: experience at one year.	Dee Noone	12.06
10	23W143	Should we Per-Cyst?: A real world experience comparing European and Canadian guidelines for pancreatic cyst surveillance	Dr Barra Neary	12.12
11	23W130	Clinical Impact of Urinary Ethyl Glucuronide and Ethyl Sulfate Testing in Liver Transplant Assessment	Dr Larissa Manojlovich	12.18
12	23W134	Screening For Hepatitis Delta Virus (HDV) In Patients Attending A Regional Hepatitis Service	Dr Brooke Layard	12.24
13	23W159	The Rising Burden Of Clostridium Difficile Infection In Ireland	Dr Ciaran Mc Closkey	12.30
14	23W137	Alcohol-related critical care admissions during the COVID-19 pandemic in Ireland: Uncontrolled interrupted time series analysis	Dr Tobias Maharaj	12.36
15	23W144	Higher neutrophil-to- lymphocyte ratio associates with poorer prognosis in advanced HCC treated with Transarterial Chemoembolization plus Immune Checkpoint Inhibitors	Dr Paul Armstrong	12.42
16	23W160	Large Language Model Chat GPT-4 Can Outperform Clinicians in Endoscopy Triage	Dr John Campion	12.48
17	23W152	Hepatic encephalopathy is a greater predictor of mortality than MELD scores in decompensated cirrhosis requiring admission	Dr Orna Waldron	12.54

ISG MEETING, Winter 2023

HEPATOLOGY AND OTHER GI

ABSTRACT 8 (23W103)

Age Added to MELD or ACLF Grade Predicts Survival in Patients with Severe Alcohol-Related Hepatitis Declined for Liver Transplantation

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Introduction
Severe alcohol-related hepatitis (AH) nonresponsive to corticosteroids is associated with high mortality, particularly with concomitant acute-on-chronic liver failure (ACLF). Most will not be candidates for expedited liver transplantation (LT, without 6 months of abstinence); their outcomes are largely unknown.

Aims/Background
Our aim was to determine the outcomes of declined candidates and derive practical prediction models for transplant-free survival applicable at the time of waitlist decision.

Method
We analysed a prospectively maintained database of severe AH patients hospitalised at Mount Sinai 1/2012–7/2021, utilising the National Death Index for those lacking follow-up. Clinical variables were analysed based on the endpoints of mortality at 30, 60, 90, and 180 days. Logistic and Cox regressions were used for model derivation.

Results
Over 9.5 years, 206 patients with AH were declined for LT, mostly for unfavourable psychosocial profiles, with mean MELD 33 (+/-8), 61% with ACLF. Over a median follow-up of 521 (17.5-1368) days, 58% (119/206) died at a median of 21 (9-124) days. Of 32 variables, only age added prognostic value to MELD and ACLF grade. CLIF-C ACLF score and two new models, MELD-Age and ACLF-Age, had similar predictability (AUC 0.73, 0.73, 0.72, respectively), outperforming Lille and Maddrey's (AUC 0.63, 0.62). In internal cross-validation, average AUC was 0.74. ACLF grade ≥2, MELD >35, and age >45 were useful cutoffs for predicting 90-day mortality.

Conclusions
Patients with severe AH declined for LT have high short-term mortality. Age added to MELD or ACLF scores enhances survival prediction at time of waitlist decision in patients with severe AH declined for LT.

ABSTRACT 9 (23W129)

Advanced nurse practitioner-led Hepatology clinic for chronic liver disease: experience at one year.

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Introduction
Chronic liver disease is one of the leading causes of death in Ireland and worldwide, now representing one of the top 5 killers of adults in the UK. With increasing rates of alcohol and non-alcoholic fatty liver disease (NAFLD), referrals for chronic liver disease have increased significantly, and account for almost 50% of all Gastroenterology referrals; limited availability of expertise has led to increased outpatient waiting times, with over 70% of 'long-waiter' GI referrals (> 9 months) relating to liver disease.

Aims/Background
A new Hepatology ANP clinic was established in order to reduce outpatient waiting list times, and to appropriately determine which patients referred with chronic liver disease could be discharged safely.

Method
Patients referred to the Hepatology/GI department were triaged by a consultant Hepatologist and deemed suitable for review in the Hepatology ANP clinic. Patients were reviewed in a weekly ANP led clinic, appropriate investigations were taken and depending on their diagnosis, patients were discharged for GP follow up, or deemed for continued review.

Results
Between August 2022 and August 2023, 279 patients were reviewed. The average age of patients reviewed in the clinic was 54yr (range 18yr-90yr); the most common reason for referral was abnormal liver blood tests (39%), followed by Haemochromatosis (22%) and fatty liver disease (14%). Using transient elastography (Fibroscan) and liver imaging, 18 cirrhotic patients (6%) were identified and a further 68 patients (22%) were found to have mild to moderate liver fibrosis. The most common diagnosis was NAFLD, representing 69% of patients reviewed. 177 patients (57%) were deemed suitable for community GP follow up and discharged from the service after a single visit.

Conclusions
The Hepatology ANP clinic is a successful method of reducing Hepatology waiting list times and has led to clinic discharge in 2/3 of cases, resulting in a significant reduction in the burden on the Hepatology service in our hospital.

ABSTRACT 10 (23W143)

Should we Per-Cyst?: A real world experience comparing European and Canadian guidelines for pancreatic cyst surveillance

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Introduction
Pancreatic cyst surveillance (PCS) places a significant burden on gastroenterology and radiology services, despite low risk of cancer progression for majority of patients. There are multiple international guidelines for PCS which differ in frequency of surveillance and cessation date.

Aims/Background
In MMUH, our current surveillance is based on the "European evidence-based guidelines on pancreatic cystic neoplasms" (ESGE). We examined how our practice would change with adoption of less 'aggressive' PCS, as per "Recommendations for the Management of Incidental Pancreatic Findings in Adults by the Canadian Association of Radiologists (CAR)"

Method
139 patients enrolled in our PCS programme were included. Records were evaluated for cyst size, duration and frequency of surveillance (ESGE), with findings compared to CAR guidelines to establish any differences.

Results
Median surveillance duration was 4 years. Median cyst size was 12mm with 105 (84.6%) having a cyst <25mm. 103/139 (83%) would have qualified for surveillance as per CAR guidelines. Of the 107 patients on active ESGE surveillance in MMUH, 58 (54.2%) would remain on CAR surveillance. 4/139 (3.5%) of patients had surgery, with no pancreatic cancers noted.

Conclusions
In our surveillance cohort, use of the CAR PCS guideline would have resulted in 31% fewer surveillance episodes per patient. (3.9 vs 2.7), with 26% fewer patients undergoing surveillance. Given the low risk of cancer progression during PCS, a 'less aggressive' surveillance strategy would seem practical. A national approach to pancreatic cyst surveillance, (taking account of resource limitations as well as international literature) would be feasible, with establishment of a pancreatic cyst working group.

ABSTRACT 11 (23W130)

Clinical Impact of Urinary Ethyl Glucuronide and Ethyl Sulfate Testing in Liver Transplant Assessment

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Introduction
Alcohol abstinence is a key eligibility criteria for orthotopic liver transplant (OLT). Self-reporting is the main method by which abstinence is monitored. Plasma ethanol levels are only elevated for a short period after alcohol consumption. Ethyl glucuronide (EtG) and ethyl sulfate (EtS) are ethanol metabolites present in urine for up to 80 hours after ethanol ingestion, and therefore play a role in identifying clandestine alcohol use.

Aims/Background
To assess the impact of analysing random urine samples for EtG and EtS in patients with liver disease being considered for liver transplant.

Method
The results of 61 urinary specimens sent for EtG/EtS analysis within our service from January 2018 - February 2023 inclusive were retrospectively assessed to identify the impact of the result on clinical decisions.

Results
53 of 61 urinary EtG/EtS specimens were collected from 48 pre-transplant patients. Mean age 56.0 years (range 36-76); 20 females, 28 males. 85% had alcohol-related liver disease, 8% non-alcoholic steatohepatitis, 2% autoimmune hepatitis, 2% hepatitis B, and 2% granulomatous hepatitis. 10 (21%) of these patients produced positive results, with only 3 (6%) self-reporting recent alcohol consumption. Positive results led to 6% (n=3) being withdrawn from the OLT assessment process, whilst 10% (n=5) had not yet started assessment, and were deemed ineligible for consideration.

Conclusions
These results highlight the value of urinary EtG/EtS testing in pre-transplant patients, particularly given the uncertainty surrounding self-reported abstinence in patients with alcohol use disorders. It is now established as a standard component of the OLT assessment process in our unit.

ABSTRACT 12 (23W134)

Screening For Hepatitis Delta Virus (HDV) In Patients Attending A Regional Hepatitis Service

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Introduction
EASL recommend HDV testing in all new HBV positive patients. Guidance for existing HBV patient cohorts is less clear.

Aims/Background
NICE recently approved Hepcludex (Bulevirtide) for selected patients with HDV. A recent cluster of HDV positive cases from Romania triggered a targeted review of chronic HBV patients thought to be at increased risk of having HDV, to determine the prevalence locally.

Method
We performed a retrospective review of all chronic HBV patients attending our regional hepatitis clinic to identify those on HBV treatment. Patients with persistently elevated ALT (thus deemed more likely to have HDV co-infection), were tested for HDV. Those testing positive for HDV with raised HDV RNA were considered for NICE approved treatment.

Results
182 patients in a database of €1600 were on oral antiviral therapy. 47/182 had raised ALT and were therefore considered high risk for HDV. 2/47 tested positive for HDV. Including the cluster (n=5), 7 HDV positive cases were identified and considered for treatment. • 2 patients successfully cleared HDV with peg-interferon. • 1 patient is currently on peg-interferon with reducing viral load. • 2 patients previously cleared HDV with peg-interferon and have relapsed. • 2 patients have recently been diagnosed and are due to commence treatment with peg-interferon. Only 1/5 treated patients fulfils criteria to be considered for Hepcludex presently.

Conclusions
Screening of chronic HBV patients on oral antiviral therapy with persistently elevated ALT yielded a 4.5% HDV detection rate in a low-prevalence area. All units with cohorts of such patients should screen for HDV, in addition to screening new HBV patients.

ABSTRACT 13 (23W159)

The Rising Burden Of Clostridium Difficile Infection In Ireland

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Introduction
Efforts to prevent Clostridium Difficile infection (CDI) have expanded over recent decades, through antimicrobial stewardship and infection control measures. Yet, the impact of these measures remains uncertain.

Aims/Background
To quantify the number of admissions to Irish hospitals with CDI. We sought temporal trends in age, gender, length of stay (LOS), admitting specialty, associated diagnosis and mortality.

Method
The Hospital In-Patient Enquiry (HIPE) dataset was used to identify all discharges with the ICD code of A04.7 (Enterocolitis due to Clostridium difficile) as either a primary or secondary diagnosis from 2009–2022.

Results
There were 20,956 admissions over the studied period with a 23-day median LOS. 10.7% were elective, with a 22-day LOS. 59% were female. There was an increase in hospitalisations with CDI from 1301 to 1962 per year since 2009, or an incidence of 29 to 39 admissions per 100,000, peaking at 43 in 2019. Despite this, mortality rates have decreased, from 21% (273 deaths) in 2009 to 11.8% (232 deaths) in 2022. 28% had CDI as a primary diagnosis. Other common primary diagnoses included respiratory infection (14.5%), malignancy (7%), urinary tract infection (4.5%), fracture (3.5%), CVA (2.4%), and IBD (1.4%). Overall mortality was 13.8%. Factors associated with increased mortality included male sex (15.3%), increasing age (80.5% of deaths were >65 years, and 40.3% were >80) and elective admission (20.1%). The most common primary diagnoses in patients that died were infection (33.5%), CDI (12.8%), malignancy (9.4%), CVA (5.1%), fracture (4.7%), and CHF (3.4%). The most common admitting specialties were General Medicine (50.6%), General surgery (10.4%), Geriatrics (8.7%), Haem/Onc (7.9%), GI (6.8%), Respiratory (4.4%), and Orthopaedics (3.1%).

Conclusions
The prevalence of CDI in hospitalised patients is rising, however, the COVID-19 pandemic appears to have had a mitigating effect. Despite decreasing mortality rates and LOS, CDI is associated with significant mortality, particularly in the elderly. Further work is needed to determine the impact of FMT access and recurrent infection.

ABSTRACT 14 (23W137)

Alcohol-related critical care admissions during the COVID-19 pandemic in Ireland: Uncontrolled interrupted time series analysis

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Introduction
The SAR-CoV-2 virus (COVID-19) placed a significant strain on intensive care units (ICUs), and alcohol is a frequent cause of admission to ICU which can add to this burden.

Aims/Background
To evaluate the impact of the SARS-CoV-19 (COVID-19) pandemic on trends in alcohol-related intensive care unit (ICU) admissions.

Method
Consecutive ICU admissions from 01 March 2019 to 28 February 2021 were prospectively screened for alcohol-involvement. Pandemic periods were determined by public health announcements and periods of increased COVID-19 activity at Beaumont Hospital. Uncontrolled interrupted time series analysis was used to determine changes in alcohol-related ICU admissions due to the pandemic.

Results
Of 1724 ICU admissions assessed, 11.7% (n = 202) were alcohol-related. Alcohol-related admissions increased by 97% during Hospital Phase 1 of the pandemic compared to if the pandemic never occurred (IRR 1.97; p = 0.01). Alcohol-related admissions were associated with greater median length of ICU stay (+2.0 days; p = 0.004), increased likelihood of requiring mechanical ventilation (OR 2.12; p < 0.001), and greater mean duration on mechanical ventilation (+2.1 days; p < 0.001) compared to non-alcohol admissions. For every one COVID-19 ICU admission we found one accompanying alcohol-related admission during the pandemic (108 COVID-19 versus 102 alcohol).

Conclusions
This study highlights that alcohol harms represent a significant burden in critical care and can place additional strain on critical care resources during vulnerable periods such as the COVID-19 pandemic.

ABSTRACT 15 (23W144)

Higher neutrophil-to- lymphocyte ratio associates with poorer prognosis in advanced HCC treated with Transarterial Chemoembolization plus Immune Checkpoint Inhibitors

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Introduction
Neutrophil-to-lymphocyte ratio (NLR) has been proposed as a barometer of the relationship between the tumour microenvironment and the systemic immune response. Higher NLR is associated with advanced disease stage and poor overall survival outcomes in a range of cancer types including hepatocellular carcinoma (HCC).

Aims/Background
To evaluate NLR as a prognostic biomarker in patients treated with Transarterial Chemoembolisation (TACE) plus tremelimumab and durvalumab in advanced hepatocellular carcinoma as part of a clinical trial.

Method
Patients with HCC (Childs Pugh A/B7; Barcelona Clinic Liver Cancer Stage B/C; ECOG 0/1; sorafenib-naïve or experienced) were enrolled in a clinical trial (UCDCRC/19/01 EudraCT no. 2019-002767-98) of tremelimumab in combination with durvalumab and subtotal TACE performed on week 6. Full blood count including differential sample assessments were performed at baseline and weekly. NLR was defined as absolute neutrophil count divided by absolute lymphocyte count. Patients were divided into groups according to evidence of clinical benefit.

Results
13 patients enrolled in the trial. 12 were evaluable for treatment response at 6 months and survival information followed up to date (two years). 6 (50%) patients were classified as responders. We saw an association between higher index NLR and poorer outcomes (p = 0.015, Spearman's Rho -0.725). The diagnostic performance of NLR for treatment response was assessed using receiver operated characteristic curves (ROC). The area under the ROC was 0.91 (95% CI: 0.76-1, p = 0.016). Four patients (31%) were alive at two years. Lower index NLR associated with overall survival at two years (p = 0.034, Spearman Rho 0.6).

Conclusions
Our pilot study suggests that pre-treatment NLR is a quantitative inflammatory biomarker which correlates with clinical and survival benefit in a clinical trial evaluating response to TACE plus immune checkpoint blockade.

ABSTRACT 16 (23W160)

Large Language Model Chat GPT-4 Can Outperform Clinicians in Endoscopy Triage

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Introduction
Large language models (LLMs) such as Chat GPT-4 utilise machine learning techniques to generate answers to queries, and could be harnessed to assist with the clerical burden that takes clinical staff away from front line duties.

Aims/Background
We sought to compare adherence to current national and international guidelines on triage and surveillance endoscopy between Chat GPT-4 and gastroenterology staff.

Method
64 fictional patient cases were generated by referencing national and international guidelines. The cases were divided across five categories: lower gastrointestinal symptomatic (LGI), upper GI symptomatic (UGI), family history of colorectal carcinoma (FHCC), polyp surveillance (PS) and Barrett's oesophagus surveillance (BS). Clinicians (doctors and nurses) and Chat GPT-4 were asked to triage the cases from memory (attempt 1), and again when given the relevant guideline for reference (attempt 2).

Results
20 clinicians and one LLM participated in the study. In attempt 1, the LLM median (IQR) score was higher than clinician in LGI [70 (60,70) vs 50 (37.5,60), p=0.008] and FHCC [82 (73,82) vs 36 (27,65), p = 0.003] while there was no statistically significant difference in BS [71 (64,71) vs 57 (43,64), p = 0.37)], PS [31 (23,46) vs 31 (21,48), p=0.84] or UGI [50 (50,62.5) vs 53 (50,57), p=0.81)]. In attempt 2, median clinician scores improved for LGI [80% (70,80)], FHCC [78% (52,91)], BS [79% (67,86)], PS [62% (42,71) and UGI [75% (74,81)].

Conclusions
LLMs may prove a useful tool for specific healthcare tasks but unsupervised decision-making cannot yet be delegated to LLMs. Specific models trained only on discrete inputs such as relevant guidelines may improve performance and become a reliable adjunct to conventional healthcare processes in the future.

ABSTRACT 17 (23W152)

Hepatic encephalopathy is a greater predictor of mortality than MELD scores in decompensated cirrhosis requiring admission

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Introduction
Mortality from liver disease has increased 400 fold over the past 40 years in Ireland. Admission mortality rates in cirrhosis range between 10-15% in Ireland, far greater than that of many other chronic conditions. Predictors of outcome are crucial to effective management. Predictive scores exist to determine the severity of liver disease and effectively assess the risk of mortality in cirrhosis. Data on this cohort in Ireland is lacking.

Aims/Background
To establish the main determinants of short-term mortality in patients admitted with decompensated cirrhosis to our institution.

Method
Emergently admitted patients with cirrhosis between 2018 and 2022 were identified retrospectively through the Hospital Inpatient Enquiry system using codes K703, K743, K746, and a prospectively maintained database of cirrhosis patients. Medical records were interrogated. Statistical analysis was performed using Jamovi 2.3.21. Ethical approval was granted by Ethics (Medical Research) Committee Beaumont Hospital (approval number 22/39).

Results
356 patients were identified from 589 admissions. Patients with a history of malignancy (47), on anticoagulation (37), post liver transplant (1), and with insufficient available data (62) were excluded. The remaining 209 patients comprised 330 admissions. Alcohol related liver disease was the most common aetiology, 73.9%. Lower mortality rates were seen in those admitted with NASH cirrhosis and variceal bleeding. At multivariable analysis, hepatic encephalopathy (HR 2.07, CI 1.19–3.62, p=0.011), age (HR 1.03, CI 1.01–1.06, p=0.010), and MELD 3.0 (HR 1.10 CI 1.07–1.15, p<0.001) were associated with 90-day mortality. 101 patients were encephalopathic on presentation conferring a 22.7% mortality rate on admission and 26.7% rate at three months.

Conclusions
Emergently admitted patients with cirrhosis have a high admission and 90-day mortality, with alcohol accounting for the vast majority of admissions. Although MELD scores may be useful, the presence of hepatic encephalopathy in particular is an ominous sign, with 1 in 4 patients dying within 3 months. In order to reduce mortality from liver disease in Ireland, target screening for cirrhosis and the identification and early treatment of its complications is crucial.

ISG MEETING, Winter 2023

Message from Michael Dineen

As we turn into the home straight for Christmas with a new year approaching, we can look back on a very good year for ISG. We have a new President in the chair, Professor Orla Crosbie and we offer our best wishes and thanks to Professor Deirdre McNamara for her contribution and support during her two years as President.

One of the great benefits of our two-year Presidency is that the system works. Every President brings something new to the table and they give freely of themselves, especially their time and expertise.

Sometimes it may take a little while to get everybody on the same wavelength but when we do it is always full steam ahead. We all have the same aim to make our Society the best and the most progressive that it can be, an organisation that we can be proud of.

The Society has several stakeholders. Obviously, our Consultants and NCHD's are vital components, our nurses and other HCP's also play vital roles. There is however one group whose contribution is often not fully recognised and that is the pharma industry. Without this continued financial support, the Society would not have reached the level that it is presently at.

Enhanced venues, best of AVC companies Top International Speakers Travel and Honoraria, Bursaries and Observationships, Prizes and awards for best abstract submissions, Lifetime Achievement Awards. Training Grants for SpR's.

All these cost money and would not be possible without the constant financial support that we receive every year from these companies and all that they ask for is that we stop and say hello during coffee breaks or lunch time. The last message that every delegate sees on leaving the meeting room is 'Please visit the Stands'. Of late I keep getting the same comments from Pharma -

'Nobody is interested in talking to us anymore' **Please don't kill the goose.**

Merry Christmas

Michael Dineen
Chief Executive ISG

Themed Oral Presentations - Endoscopy and IBD

7th December - Fountain Suite

Abstract No.	Ref:	Title	Author	Time
18	23W106	Adjunctive methotrexate in the management of anti-infliximab antibodies in paediatric IBD	Dr Ali Raba	12.00
19	23W135	Point of Care Testing for Drug levels in IBD - The Initial CUH Experience	Dr. Natasha Irfan	12.06
20	23W118	Back-to-Back Colon Capsule Endoscopy And Colonoscopy In A Mixed Population	Dr Eimear Gibbons	12.12
21	23W133	The Effect of Depression and Anxiety on IBD Activity is Mediated by Psychosocial and Economic Disability	Dr Aimee Drudy	12.18
22	23W163	Analyses Of Peripheral Eosinophil Levels As A Predictor Of Response To Treatment In Patients Receiving Vedolizumab For Inflammatory Bowel Disease	Dr Shane Elwood	12.24
23	23W136	Complicated Barrett's lesions and subsequent endoscopic eradication therapy: A single centre Irish experience.	Dr Ashley Lloyd	12.30
24	23W156	Serum amyloid A – A Novel Biomarker of Ulcerative Colitis Disease Activity	Dr Cathy McShane	12.36
25	23W119	Upper GI Endoscopic Submucosal Dissection in Ireland: An Update	Dr. Danny Cheriyan	12.42
26	23W154	Artificial Intelligence-Based Quantification of the Mesentery in Acute Crohns Disease	Dr Paul Lynch	12.48
27	23W127	Colon Capsule Endoscopy as an Alternative to CT Colonography in those with an Incomplete Colonoscopy	Dr Caroline Walker	12.54

ENDOSCOPY AND IBD

ABSTRACT 18 (23W106)

Adjunctive methotrexate in the management of anti-infliximab antibodies in paediatric IBD

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Introduction
Anti-TNF therapy is a highly effective therapy for inflammatory bowel disease (IBD) but anti-drug antibodies (ADAs) limit its durability and effectiveness.

Aims/Background
The aim of this study is to investigate whether adding methotrexate co-immunosuppression following antibody development abrogates titre progression and averts secondary loss of response in children diagnosed with IBD.

Method
We analysed the data of participants of the DOCHAS study of children with IBD who commenced on infliximab between January 2020 to December 2022. Clinical characteristics, disease phenotype, clinical activity indices, infliximab dose/kg, infusion frequencies and corresponding trough and anti-drug antibody levels and titres were analysed. Outcomes including secondary loss of response, medication durability and ADA titres were compared between groups with and without adjunctive methotrexate therapy.

Results
Between January 2020 to December 2022, 373 patients were newly diagnosed with IBD; 184 (50%) patients commenced infliximab (median age at diagnosis 13 years; 108 (59%) male) and 33/184 (18%) developed ADAs (14 (42%) within 6 months of starting infliximab, 7 (21%) between 6months and 1 year and 2 (6%) after more than 1 year). Adjunctive methotrexate was commenced in 20/184 (11%) patients: 18/20 for positive ADAs, and 2 for suboptimal therapeutic response to infliximab. Reduced ADAs were seen in 11/18 (61%), infliximab dose was increased in 3/18 (17%), 1 had infliximab reinduction (6%)), but no improvement was seen in 7 (39%). By comparison, of the 15 patients with ADAs who did not start methotrexate, 3/15 (20%) lost infliximab response, ADAs improved in 2/15(13%) spontaneously, in 3/15 (20%) after infliximab dose increases, and 1/15 following reinduction of infliximab.

Conclusions
Anti-infliximab antibodies developed in less than 1 in 5 patients treated with infliximab within 2 years following a proactive therapeutic drug monitoring regimen. A modest benefit of adjunctive methotrexate in sustaining infliximab response was observed. Larger scale protocolised studies would help determine which patients may benefit from this approach.

ABSTRACT 19 (23W135)

Point of Care Testing for Drug levels in IBD – The Initial CUH Experience

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Introduction
Infliximab (IFX) and Adalimumab (ADA) therapeutic drug monitoring in IBD via Enzyme-Linked Immunosorbent Assay (ELISA) is the gold standard for monitoring levels. This test is not widely available, with samples sent externally with a turn-around time of approximately three weeks which significantly impacts patient care.

Aims/Background
To investigate the validity of IFX and ADA trough levels by a new single point of care test (POCT) ProciseDx against standardised ELISA measurements.

Method
24 patients on IFX and 16 on ADA were recruited from June-September 2023. Samples were taken at infusion or OPD by trained nurses. Results were available within 5 minutes of sampling. Serum samples were also sent to the lab to compare results with ELISA methods.

Results
15 patient samples were suitable for comparing POCT with ELISA. Regression analysis on the combined results of ADA and IFX show strong correlation, r=0.829(P<0.000236). Results for ADL and IFX show strong correlation, r=0.982(P<.000476) and r=0.809(P<0.00825) respectively. Data were not available for 25 patients due to samples being rejected or test results outstanding. Invalid POCT results occurred only at the start of analysis representing staff learning.

Conclusions
There is a strong correlation with POCT and ELISA. Rapid turnaround (5minutes v ~3weeks) allows timely dose adjustment, improving patient care. Moreover, we have 16 IFX and 15 ADA valid results from POCT testing, while 9 IFX and 7 ADA results still awaited from ELISA highlighting the delays in the current method.

ABSTRACT 20 (23W118)

Back-to-Back Colon Capsule Endoscopy And Colonoscopy In A Mixed Population

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Introduction
Colon capsule endoscopy (CCE) has been demonstrated to be comparable to traditional colonoscopy and better than CT colonography (CTC) for the detection of colonic pathology. It has been shown to have a high incremental yield after incomplete colonoscopy. It is a safe test with good patient acceptability.

Aims/Background
To assess the role of colon capsule endoscopy as a non-invasive, diagnostic tool in both symptomatic and screening populations attending Connolly Hospital.

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Ronan Dodd, Ann Marie O'Reilly and David Shanahan Athena Pharmaceuticals.

Ms Marnie Lawrie Advanz Pharma, Dr Julia Sopena Falco, Dr Jack Scully

ISG MEETING, Winter 2023

Method
Prospective participants are identified from endoscopy waiting list office. Consenting participants undergo CCE the day prior to their scheduled colonoscopy. CCEs are read by two expert readers, blind to results of colonoscopy. Primary outcomes are polyp detection rates (PDR). Secondary outcomes include complications and technical issues.

Results
60 back-to-back procedures have been completed to date between January 2023 and September 2023 (M: F 37:23, mean age 59, range 35-73). Most common indications for colonoscopy were surveillance 38%, PR bleeding 21% and diarrhoea/ IBD assessment 15%. PDR for all CCE was slightly higher than colonoscopy but not statistically significant (56.5% versus 48%, p =0.46). PDR for complete CCE was higher at 65%, trending toward significance (p =0.14). Excretion rate was 80%. 15% cases were incomplete due to belt being moved/ removed. There were no complications.

Conclusions
Despite drawbacks, CCE is a viable diagnostic alternative to colonoscopy. The increasing demand on colonoscopy waiting lists raises valid concerns regarding the ability of health services to deliver endoscopy in a timely fashion. Alternative diagnostic and surveillance modalities are necessary and CCE has a central role to play.

ABSTRACT 21 (23W133)

The Effect of Depression and Anxiety on IBD Activity is Mediated by Psychosocial and Economic Disability

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Introduction
IBD patients experience relatively rates of anxiety and depression, and both have been causally associated with disease recurrence by driving mucosal inflammation via immune-mediated pathways and the microbiome. Anxiety and depression are also closely related to "disability", a broad measure of functional impairment relating to the disease, its treatments, psychological, social and economic circumstances, and also known to be related to disease recurrence.

Aims/Background
To determine if anxiety and depression were independently related to disease recurrence, or whether their association with disease activity was explained by their close link with disability.

Method
329 IBD patients completed a questionnaire that assessed anxiety (Beck's Anxiety Inventory), depression (Beck's Depression Inventory) and disability (IBD Disability Index). Subjects were followed up for a median of 7.5 years to assess clinical recurrence. Statistical analysis was performed using causative mediation analysis.

Results
Both anxiety (P<.001) and depression (P<.001) correlated closely with disability. In addition, long-term disease activity was related to baseline anxiety (P=.02), depression (P<.001) and disability (P<.001). However, when entered into multivariate Cox proportional hazards models with disability, neither anxiety (P<.18) nor depression (P=.557) were independently related to outcome, while disability remained a significant factor in both the anxiety (P<.001) and depression (P=0.014) models.

Conclusions
The relationship between anxiety, depression and IBD recurrence may be overstated and can be explained by their association with generalised disability. This indicates the importance of a comprehensive biopsychosocial paradigm of IBD recurrence rather than a model that concentrates on psychological dysfunction alone.

ABSTRACT 22 (23W163)

Analyses Of Peripheral Eosinophil Levels As A Predictor Of Response To Treatment In Patients Receiving Vedolizumab For Inflammatory Bowel Disease

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Introduction
Vedolizumab is a gut-selective integrin antagonist used for the induction and maintenance of remission in patients with moderate to severe inflammatory bowel disease (IBD). Eosinophils are increasingly implicated in chronic intestinal inflammation. We noted an association between raised serum eosinophil levels and use of vedolizumab therapy.

Aims/Background
To examine a rise in peripheral eosinophil count above the upper limit of normal as a potential predictor of response to treatment in IBD patients receiving vedolizumab.

Method
We retrospectively reviewed the clinical records and blood results of 62 IBD patients on vedolizumab attending Beaumont Hospital. Serum eosinophil levels before and after induction of therapy were documented, where the post treatment eosinophil count was taken as the peak level within the first 24 months of treatment. Chi-Square Test of Independence was used with p-value <0.05 donating statistical significance.

Results
Preliminary data includes 62 patients. 66.1% (n=41) had ulcerative colitis, 30.6% (n=19) Crohn's disease, 3.2% (n=2) IBDU. 86.4% (n=53) had mucosal response to vedolizumab. Of those who responded to treatment, 40%% (n=21) had an eosinophil count above 0.4x109 /L (0.42-1.1x109 /L) post-induction, p=0.03. Onset of the peak in eosinophil level was variable, ranging between 1- and 16-months after delivery of first dose. The average change in eosinophil level was seen to be higher amongst responders (0.18745) when compared to non-responders (0.09375).

Conclusions
A high eosinophil count following initiation of treatment may be an early predicter of response in patients receiving vedolizumab therapy for IBD. Serum eosinophilia has been reported in natalizumab-treated patients with MS. We are expanding analysis to study this pattern and its potential use as a biomarker of response to anti-integrin therapy.

ISG MEETING, Winter 2023

ABSTRACT 23 (23W136)

Complicated Barrett's lesions and subsequent endoscopic eradication therapy: A single centre Irish experience.

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Introduction
Endoscopic eradication therapy (EET), combining endoscopic mucosal resection (EMR)/submucosal dissection (ESD) with ablation, is the preferred treatment for complex Barrett's lesions, aiding diagnosis, staging and potential eradication of mucosal dysplasia/neoplasia. ESD offers lateral margin data but has associated procedure risks. EMR demonstrates comparable EET efficacy to ESD with an increased safety profile.

Aims/Background
We aim to review deep margin clearance post EMR for Barrett's related lesions and subsequent histological clearance post EET.

Method
Retrospective review (January 2019 - October 2023) included Barrett's patients undergoing initial EMR for visible lesions. The study assessed EMR method, histology, margin clearance, nature of ablation, EET clearance and complications. Patients with prior EMR/EET were excluded.

Results
398 patients were identified with Barrett's diagnosis via "Follow up: dysplasia" filter on 'Endoraad' endoscopic software. 63 patients (58 male; 5 female; mean age: 67) were eligible. 100% had dysplastic/neoplastic histology (4.7% low-grade dysplasia (LGD); 44.4% high-grade dysplasia (HGD); 49.2% intramucosal carcinoma: pT1a: 42.8%; pT1b: 6.3%). 93.7% of EMR achieved negative deep margin clearance. 6.3% had positive deep margins (4 patients: HGD: 1; pT1a: 2; pT1b: 1). 65.1% of patients underwent endoscopy post-EET. EET-clearance was 73.2%. Median time from EMR to EET clearance was 18 months. Procedure-related complication rate was 23.8% (Stricture: 9.5%; Acute bleeding: 7.9%; 3.2% ablation ulceration; 1.6% mucosal tear). No statistical association was identified between ablation voltage and stricture formation/multi-piece EMR and bleeding.

Conclusions
EMR with subsequent ablation provides high deep margin clearance rates, leading to complete Barrett's eradication for the majority of patients in <20 months from index treatment.

ABSTRACT 24 (23W156)

Serum amyloid A – A Novel Biomarker of Ulcerative Colitis Disease Activity

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Introduction
Despite recent advancements in the treatment of ulcerative colitis (UC), a substantial number of patients fail to achieve long-term remission. Persistent histological activity has been linked with poorer treatment outcomes. Histological remission is now an accepted treatment target; however, there remains significant variability in the interpretation of UC histology. As such, there is a need for novel biomarker identification to aid assessment and ultimately predict disease relapse. Serum amyloid A (SAA) is an acute-phase protein, of which serum levels have shown promise as a biomarker in IBD.

Aims/Background
This study aims to explore the utility of SAA levels in UC colonic tissue as a diagnostic biomarker for disease activity and progression.

Method
Two cohorts were prospectively recruited, including healthy controls and UC patients. Sigmoid biopsies were collected and tissue explants generated. Tissue-conditioned media from these explants was collected and secreted SAA quantified using 54 V-plex ELISA. Demographic information, disease characteristics, endoscopic Mayo scores and disease progression were documented. P values < 0.05 were considered significant in analyses.

Results
The two cohorts included 11 healthy controls and 16 UC patients (endoscopic remission n=6). Active UC patients demonstrated significantly higher SAA concentrations than healthy controls (p=0.0013) and those in remission (p=0.02). There was no significant difference in SAA concentrations between healthy controls and UC patients in remission (p=NS). UC patients in the lowest SAA concentration quartile had a significantly longer time to disease progression (p=0.0462).

Conclusions
Quantification of SAA secretion in IBD ex-plants has potential as a biomarker of UC activity and progression. Further investigation of SAA as a biomarker in IBD is warranted.

ABSTRACT 25 (23W119)

Upper GI Endoscopic Submucosal Dissection in Ireland: An Update

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Introduction
Endoscopic submucosal dissection (ESD) allows for potentially curative en-bloc resection of GI tract lesions, and provides the most accurate endoscopic staging modality for early cancer.

Aims/Background
To present the outcomes of ESD performed for upper GI neoplasia in Beaumont Hospital, Ireland.

Method
Upper GI ESD procedures performed from January 2020 to date were evaluated.

Results
29 patients (18 male) underwent ESD under general anaesthesia. 17 gastric and 12 oesophageal lesions underwent ESD. 27/29 (93%) of patients had a complete ESD. 2 procedures were terminated early due to challenges faced with (1) lesion position (converted to EMR and successfully resected) and (2) suspicion for deep invasion (had surgery). The mean age was 67 years (range 47-83). The median lesion size was 32mm (range 25-69). The median procedure time was 80 min (range 60-180). 24/27 (89%) with a completed ESD had an 'R0' resection. 2/29 (6.8%) had a complication (oesophageal perforation), both of which were managed conservatively without surgery. 25/27 (93%) were discharged with 2 days of the procedure. 0/18 (0%) of patients who have undergone endoscopic surveillance post ESD have had evidence of disease recurrence at a median follow up of 20 months. En-bloc resection upstaged pathology in 18/27 (63%) of patients.

Conclusions
ESD is an effective and safe technique in the management of upper GI neoplasia. Our data and outcomes are very promising when compared to centres of similar volume in Europe. Further training and collaborative efforts are required to ensure the ongoing success of ESD in Ireland.

ABSTRACT 26 (23W154)

Artificial Intelligence-Based Quantification of the Mesentery in Acute Crohns Disease

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Introduction
Recent advances in our understanding of mesenteric anatomy and function have led to increased recognition of its role in diseases including Crohns. In severe, acute Crohns disease mesenteric tissue may not be safe to resect, and thus temporary defunctioning ileostomy may be formed.

Aims/Background
We aimed to examine the effect of defunctioning ileostomy on mesenteric tissue in Crohns disease.

Method
A retrospective case-series review was performed. Eligible patients had their biochemical, operative and CT imaging reviewed, with CTs then reconstructed using an Artificial Intelligence software. Tissue volume and total surface area was then quantified from pre-defunctioning and pre-resection CT imaging using this model.

Results
A total of 13 patients underwent defunctioning for acute, complicated Crohns disease. 10 patients had interval resection, with 5 of this subgroup undergoing AI analysis. The 10 patients who had defunctioning and interval resection showed statistically significant reduction in mean White Cell Count (P – 0.02) and CRP (P - 0.01) between pre-defunctioning and pre-resection bloods. Furthermore, albumin was significantly increased over the same period in this cohort (P – 0.001). Using AI it was found that both Volume and Total Surface Area of total tissue, mesentery and greater omentum was reduced between interventions.

Conclusions
Artificial Intelligence can be used to quantify mesenteric tissue. Defunctioning decreased both volume and total surface area of mesenteric tissue in Crohns disease, rendering interval resection safe.

ABSTRACT 27 (23W127)

Colon Capsule Endoscopy as an Alternative to CT Colonography in those with an Incomplete Colonoscopy

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Introduction
Alternatives to colonoscopy need to be considered following failed colonoscopy. Colon capsule endoscopy(CCE) has been shown to have comparable, and for certain indications, higher diagnostic yields than CT colonography(CTC). However, it has lower completion rates, thus careful patient selection is vital. CTC waiting lists nationally exceed 12months and were over 18months in University Hospital Galway.

Aims/Background
Examine CCE as an alternative to CTC for failed colonoscopy

Method
We reviewed clinical indications and patient history for all 100 patients on the CTC waiting list. We included patients with a preceding incomplete colonoscopy. We applied our exclusion criteria: age >70years, diabetes, poor bowel prep at colonoscopy, dialysis dependent CKD, or known strictures. The remaining patients were offered CCE as an alternative to CTC and listed on agreement.

Results
Overall, 42 were eligible. Of these, 4 had already undergone colonoscopy, and 1 a right hemi-colectomy. A further 11 declined due to the extra litre of prep(4), dysphagia(6), and new technology concerns(1). The remaining 26 were listed. To date, 15 patients have undergone CCE. 87%(n=13) were successful and subsequently removed from the CTC waiting list. Of the 2 failed CCEs, 1 was unable to swallow the capsule and 1 had poor prep. Based on the CCE findings, 40%(6) have been referred for attempted repeat colonoscopy, 20%(3) OGD or dedicated SBCE, and 7%(1) surveillance CCE. 20%(3) require no further endoscopic investigation.

Conclusions
CCE is a useful diagnostic alternative to CTC. Careful patient selection should be performed to boost its completion rates, and in turn reduce unnecessary CTCs and colonoscopies.

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Prof Eoin Slattery, Dr Orla Craig, Prof Anthony O'Connor, Dr Audrey Dillon

Professor Colm O'Morain and Mrs Marcelle O'Morain

ISG MEETING, Winter 2023

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Dr Syafiq Ismail and Niall Molloy

Professor Deirdre McNamara and Dr Neil O'Morain - getting it right

POSTER PRESENTATIONS

Abstract No.	Ref:	Title	Author
28	23W101	Quality improvement project; Assessing sensitivity of CLO tests in the endoscopy unit of Midlands Regional Hospital Tullamore	Mícheál Brennan
29	23W102	Opportunistic Transient Elastography Increases Readiness for Change in Inpatients with Alcohol Use Disorder: A Prospective Pilot Study (ELISA)	Stephanie Rutledge
30	23W104	Hepatocellular Carcinoma Screening in Cirrhosis: Experiences of an Irish Peripheral Hospital	Thomas Matthews
31	23W108	Post ERCP Pancreatitis; Changing Risk Profiles	Eoin Keating
32	23W109	Conscious of Demand; Sedation Practice for Irish ERCP Services	Eoin Keating
33	23W110	Patient recall of endoscopy results: A tale of diminishing recollections	William Shanahan
34	23W111	Colitis on CT vs Endoscopy; A Single Centre Audit	Leo Phelan
35	23W112	Photo-documentation during upper GI endoscopy in Letterkenny University Hospital, compared with European Society of Gastrointestinal (ESG) endoscopy recommendation.	Maryam Sakinah Binti Jeffrey
36	23W114	Ascitic Tap Delays: For Better or Worse?	Alan Marrinan
37	23W115	Mean Nocturnal Baseline Impedance in a cohort of patients with mild oesophagitis	Julie O Neill
38	23W116	Absent contractility: Consequence or cause of Supragastric Belching.	Lucy Quinlivan
39	23W117	The Impact Of The Introduction Of Castor Oil On Excretion And Completion Rates At Colon Capsule Endoscopy	Eimear Gibbons
40	23W120	NAFLD, MASLD or what? The Irish impression of the recent change in NAFLD nomenclature	Ciarán McHale
41	23W121	The Impact of a Community Development Worker on The Hepatitis C Virus (HCV) Service in Cork.	Lorraine O Connor
42	23W122	Compliance With Percutaneous Endoscopic Gastrostomy (PEG) Tube Insertion Guidelines and Associated Complications in Endoscopy Unit at St Vincent's University Hospital (SVUH): A Clinical Audit	Chuhadry Khuram Shahzad
43	23W124	Time to ERCP on Referral Receipt in a Tertiary Hospital	Laura Neilan

ISG MEETING, Winter 2023

POSTER PRESENTATIONS

Abstract No.	Ref:	Title	Author
44	23W126	Sláintecare in action: Transitioning IBS care to the community, a pilot study of a new IBS pathway.	Kelvin Lynch
45	23W128	A retrospective study to assess if polypectomy technique and type of cut impacts recurrence rate after large colonic polypectomy.	Ambily Tony
46	23W131	Bismuth Quadruple Therapy as first line eradication regimen; experience in an EU border county Hospital.	Ronan Whitmarsh
47	23W132	Report On The Indications And Outcomes Of Urgent (P1) Gastroscopy In An Irish Affiliated Hospital.	Ahmed Al-Aloosi
48	23W138	Review of Percutaneous Endoscopic Gastrostomy (PEG) insertion – indications, efficacy and safety.	John Peacock
49	23W140	A Snap Shot Of Waiting Times For Admitted GI Patients In The Era Of Speciality Redistribution Should We Be Doing More?	Cathal Clifford
50	23W141	How well are we treating PBC? A service review	Helen O'Donovan
51	23W142	Design, Delivery and Evaluation of Specialist Inflammatory Bowel Disease Educational Programme: An Irish Perspective	Dawn Farrell
52	23W145	Early inpatient management of Inflammatory Bowel Disease Flare in Galway University Hospital	Siew Ting Ooi
53	23W146	What Makes a Difference in Capsule Endoscopy Training? - Experience From a Newly Established Capsule Endoscopy Unit	Dana Al-Sharqi
54	23W147	Inflammatory Bowel Disease (IBD) nurses knowledge practice and attitudes to Microscopic colitis (MC)	Cathy Walsh
55	23W149	Impact Of The Adoption Of Novel Oral Anticoagulants On Endoscopy Pre-Assessment	Hisham Magdeldin
56	23W150	Gut vs Guidelines – Evaluating Post-Polypectomy Surveillance In Endoscopy In Accordance With National Guidelines	Fionn Nally
57	23W151	Rising Rates Of Iron Deficiency Anaemia - Are Anticoagulants To Blame?	Hisham Magdeldin
58	23W161	Pathology identified at colonoscopy in a cohort of patients with cystic fibrosis	Anna Corby
59	23W162	A Single-Centre Review of Repeat Upper Endoscopy After Diagnosis of Gastric Ulcer	Aimee Drudy

POSTER PRESENTATIONS

ABSTRACT 28 (23W101)

Quality improvement project; Assessing sensitivity of CLO tests in the endoscopy unit of Midlands Regional Hospital Tullamore

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Introduction
The Campylobacter like organism test (CLO test) is a simple test available for the detection of H. Pylori with Sensitivity of 78-97% and specificity of 94-100%. The CLO test can provide rapid diagnosis at endoscopy and allows for early prescription of eradication therapy.

Aims/Background
To assess the sensitivity of CLO tests In MRHT. The aim was to assess how CLO tests were being undertaken and reviewed and to identify any potential practices that could contribute to higher false negative rates; highlight potential practice improvements to optimize the sensitivity of testing.

Method
The Patient list was obtained from pathology. Quantitative data collected included Gross appearance at OGD, Histology result, CLO result, whether the patient was taking a PPI, Time of day of OGD and Team performing OGD. Qualitative data included a Review of practice to explore potential operational factors contributing to false negative results. Nursing staff and endoscopists were reviewed regarding the process of biopsy taking, number of bites, and practices around reading CLO results.

Results
130 patients examined from January – March. 19/130 (14.6%) patients had positive hitology. 9/19 (47%) positive CLO test (sensitivity). Specificity – 98%

Conclusions
Based on recent guidelines from the Irish h. Pylori working group, there are some simple steps that could help improve the sensitivity of CLO testing 1. Stop PPI where appropriate. 2. Implement standardized method of reporting CLO. 3. Education to highlight the importance of taking two bites for CLO sample. Hopefully, these changes will help maximise the sensitivity of CLO tests. Improvement should be reaudited after 6 months.

ABSTRACT 29 (23W102)

Opportunistic Transient Elastography Increases Readiness for Change in Inpatients with Alcohol Use Disorder: A Prospective Pilot Study (ELISA)

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Introduction
The prevalence of alcohol use disorder (AUD) and alcohol-related liver disease is rising, especially since the onset of the COVID-19 pandemic. Teachable moments (TMs) are health events that can motivate individuals to adopt risk-reducing behaviours.

Aims/Background
Our aim was to evaluate the impact of vibration-controlled transient elastography (VCTE) interpretation as a TM on psychological scores (PS) in people with AUD.

Method
Patients without known liver disease were enrolled from an inpatient addiction unit. At baseline, four validated PS assessing alcohol use, insight, and readiness to reduce drinking were administered: AUDIT-C, revised Readiness Ruler (RR; range –5 to +5), Stages Of Change Readiness And Treatment Eagerness Scale (SOCRATES-8A), and Hanil Alcohol Insight Scale (HAIS). VCTE was performed, and results given. PS were repeated immediately after and at follow-up phone calls. The primary endpoint was a change in PS at any timepoint.

Results
Between April 2022 and May 2023, 23 subjects were enrolled, with mean age of 51.0 years (+/- 12.1), 73.9% male and 60.9% white, 17.4% Black, 8.7% Hispanic, 13.0% “Other”. All had severe AUD, with a mean of 20.4 (+/- 9.1) daily drinks for a median of 14.0 (10-21.5) years. SOCRATES-8A and HAIS scores did not significantly change after VCTE (p=0.4, 0.8 respectively), but revised RR score increased by 3.6 points (+/- 2.1) (p<.001). VCTE identified cirrhosis in 4/23 (17.4%).

Conclusions
In this pilot study, delivering results of VCTE to alcohol rehabilitation inpatients increased readiness for change. This population had a high prevalence of undiagnosed cirrhosis, representing an opportunity for linkage to hepatology care.

ABSTRACT 30 (23W104)

Hepatocellular Carcinoma Screening in Cirrhosis: Experiences of an Irish Peripheral Hospital

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Introduction
2018 European Association for the Study of the Liver guidelines suggest a six-month HCC surveillance interval for Child-Pugh A and B cirrhotic patients (or C awaiting transplantation).

Aims/Background
We aimed to audit our compliance with guidelines.

Method
Our hepatology clinic, liver elastography and radiology databases were cross referenced to yield 91 patients attending with cirrhosis over the years 2013 to 2022.

Results
Child Pugh C cirrhotics (n=24, 18%) were excluded. 167 studies were analysed. The median number of months between studies was 9.77 (IQR:5.9-17.8). 40% were carried out at an interval of greater than 12 months. The average number of months between imaging pre- and post-COVID were 12.8 and 8.26 months respectively (95% CIs:10.9-14.8, 6.4-10.1). 5% (n=5) were diagnosed with HCC. Median age at diagnosis was 74 years (IQR:66-74). Median AFP at diagnosis was 10.9 (IQR:5.4-756). 60% of diagnoses were made in the absence of a known history of cirrhosis. Two Child-Pugh C patients had HCC diagnosed. One was a male in his 60s who had a diagnosis made on ultrasound 10.5 months after prior surveillance at another site. Another male in his late 70s had a diagnosis made 35 months after a prior ultrasound identified cirrhosis, though his performance status had made surveillance inappropriate.

Conclusions
5% of our cohort were diagnosed with HCC, with none in the setting of a failure to follow surveillance guidelines. Surveillance intervals post March 2020 fell significantly ($p < 0.01$). This may be attributable to an increase in radiology resources in the latter part of the decade.

ABSTRACT 31 (23W108)

Post ERCP Pancreatitis; Changing Risk Profiles

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Introduction
Post-ERCP pancreatitis (PEP) was often associated with young females, especially with Sphincter of Oddi dysfunction.

Aims/Background
As ERCP is increasingly solely therapeutic, the risk profile for PEP, in our unit, is changing.

Method
Retrospective analysis of a PEP rates in a prospectively-maintained database over 16 months. Passive complication follow-up (PCF) was completed for the initial 3 months, followed by active complication tracking (ACT) for the remainder.

Results
697 ERCPs were completed during the study period, 20.7% (n=144) during PCF and 79.3% (n=553) with ACT. During ACT, follow-up was achieved in 94.4% (n=522/553). Reported PEP rate was 3.57% (n=5/144) during PCF and 4.8% (n=25/522) in ACT with an overall PEP rate of 4.3% (n=30/697). Patients <50 years have higher rates of PEP, 11.1% vs 4.6% (p=0.032), driven by higher rates of PEP in young males, 19.4% vs 2.8% of males >50, p=0.001. ERCP indications (Choledocholelithiasis vs Other) were not significantly different between groups (p=0.109) Though no significant difference was observed for females >50 vs <50, female patients >70 had significantly higher rates of PEP than females aged <70, 9.7% vs 3.4%, p=0.048. Endoscopic documentation of diclofenac administration (or intentional omission) for PEP is significantly higher for younger, female patients, 87.7% of <50 vs 67.5% of >50, p=0.002.

Conclusions
Risk profiles for PEP are changing, responding to shifts in ERCP indication. Younger male and older female patients appear at increased risk of PEP. Diligent attention to risk reduction for PEP in all groups, rather than traditional groups is warranted. ACT defines a true ERCP complication rates.

ABSTRACT 32 (23W109)

Conscious of Demand; Sedation Practice for Irish ERCP Services

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Introduction
ERCP is performed under propofol/anaesthesia in the majority of developed countries. ERCP is performed under conscious sedation in Ireland and the UK. However, our sedation practice is notably different to recently published UK practice of >27,000 ERCPs.

Aims/Background
As sedation becomes an ERCP key performance indicator (KPI), Irish endoscopy may need to adapt its own sedation KPI.

Method
Retrospective analysis of sedation practice in a prospectively-maintained database (Mater ERCP Roadmap) over 16 months.

Results
547 direct ERCPs (excluding combined EUS procedures and propofol cases) were recorded over 16 months. 57% (n=312) of patients were aged ≥70. Median sedation doses for patients ≥70 years was 4mg midazolam (range 1-10mg) and 50mcg fentanyl (0-200mcg). 36.2% (n=113) of ≥70 year old patients received ≥5mg midazolam, compared to 1.9% of UK >70 year olds. 13.5% (n=42) of Mater >70 year olds received ≥100mcg fentanyl vs 2.5% of similar UK patients. For patients <70, median sedation dose was 6mg midazolam (1-15mg) and 75mcg fentanyl (0-125mcg). 73.2% (n=172) received ≥5mg midazolam vs 9.8% of UK patients. 31.9% (n=75) received ≥100mcg fentanyl vs 10.7% of similar UK patients. Propofol support was available for 5% of ERCPs (n=29) vs 10.4% of UK patients. Direct sedation-related failure (inability to sedate or sedation safety concern) occurred in 1.8% of ERCPs (n=10/547). Sedation reversal was required in a single patient (<0.2%). There were no sedation related deaths.

Conclusions
In the absence of enhanced sedation, conscious sedation for ERCP remains a necessity. Adopting future BSG sedation KPIs for ERCP sedation will be challenging for Irish endoscopy.

ABSTRACT 33 (23W110)

Patient recall of endoscopy results: A tale of diminishing recollections

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Introduction
The British Society of Gastroenterology position statement on patient experience of GI endoscopy states that results should be communicated to patients on the day of the procedure to empower patients and promote ownership of their healthcare.

Aims/Background
To determine the effectiveness of hand-written endoscopy summaries presented to patients at GUH GI endoscopy unit.

Method
In this prospective study, a random selection of patients who underwent endoscopy in autumn 2023 were phoned one week post procedure to answer a series of questions regarding their endoscopy results and recommendations. This was approved by the GUH clinical audit committee. Statistical analysis was performed using Jamovi 2.3.21.

Results
Attempted phone contact was made with 119 patients. 35 did not answer. 6 declined to take part. 3 were excluded. 75 patients partook and were included. 93.3% (70) correctly identified the endoscopy type. 16% (12) said they were not informed of results; there were no significant differences in midazolam ($p = 0.214$) or fentanyl ($p = 0.138$) dosing. 77.3% (58) correctly recalled at least one result from their procedure. Of those with ≥2 findings (33), 18.2% (6) correctly recalled a second result. Of those with ≥3 findings (12), 8.3% (1) correctly recalled a third result. 82.7% (62) correctly recalled recommendations. Of those for whom medication was recommended (15), all who received a script had filled it. 80% (12) reported taking the recommended medication.

Conclusions
Most patients correctly identify the endoscopy, recommendations, and one result. Recall of anymore than one result is poor. A standardised computer-generated summary may improve patient recall.

ABSTRACT 34 (23W111)

Colitis on CT vs Endoscopy; A Single Centre Audit

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Introduction
Patient's presenting with GI symptoms commonly undergo cross-sectional imaging. Colitis on CT frequently leads to further investigation with endoscopy, often an out-patient procedure but, particularly in patients with IBD, this may be performed during the admission.

Aims/Background
Assess if in-patients with evidence of colitis on CT have consistent features on endoscopy.

Method
Retrospective, single-centre study. Data was collected from all in-patients with colitis in a 12-month period between October 2021 - September 2022. Patient charts were reviewed along with imaging, endoscopy, and histology reports.

Results
307 patient episodes reviewed. 145(47%) underwent CT abdomen-pelvis during admission. 90(29%) had colitis reported on CT. Of this 90, 27(9%) had endoscopy and 21(7%) had features of colitis. That is, in this study, colitis on CT correlated with endoscopic findings in 78% of patients who underwent both. On further analysis, known/new diagnosis of IBD was the cause in 44%. This was by far the largest subgroup. Many "indeterminate" results went on for further out-patient investigation.

Conclusions
Colitis on CT correlated with endoscopic findings of colitis in 78% of patients in this study. However, only 23% of patients with the diagnosis "colitis" had lower GI endoscopy with congruent features. Unsurprisingly, the majority of patients did not have endoscopy during their admission, those that did tended to have IBD in their history. Also of note, 22% of patients with CT reported colitis went on to have entirely normal endoscopy. Colitis on CT does not necessarily imply findings on endoscopy, but is more likely to represent positive endoscopy in patients with IBD

ABSTRACT 35 (23W112)

Photo-documentation during upper GI endoscopy in Letterkenny University Hospital, compared with European Society of Gastrointestinal (ESG) endoscopy recommendation.

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Introduction
This audit compares whether the endoscopy service at Letterkenny University Hospital complies with the ESGE guideline's recommendation of photo documentation during Gastroscopy.

Aims/Background
The adherence to the ESGE recommendation ensures a complete exploration of the relevant section of the upper GI. To conduct this audit, review the endoscopy reports performed in Letterkenny University Hospital from 1st May 2023 to 31st July 2023 and compare the images with the ESGE guideline

Method
827 upper GI endoscopies were reviewed from 1 May 2023 to 31 July 2023 from the Endorrad server. 23 of the procedures reviewed were excluded as they were found not to require photo documentation of the 8 prescribed anatomical locations.

Results
76/804 (9%) Upper GI Endoscopies audited had images of the 8 prescribed anatomical sites. The following list shows the images taken as recommended by the ESGE guidelines and their frequency. Second Part of the Duodenum, 705/804 (88%). 2cm above the Squamocolumnar, Junction (Z Line) 693/804 (86%), Cardia in Inversion 683/804 (85%), Antrum 413/804 (51%), Duodenal Bulb 324/804 (40%), Upper Oesophagus 290/804 (36%), Upper Part of the Lesser Curvature 252/804 (31%), Angulus in Partial Inversion 140/804 (17%).

Conclusions
This audit shows that the photo documentation during upper GI endoscopy must meet the guidelines ESG suggested. The findings of this audit have been presented to the endoscopists in the hospital, and we will promptly carry out the necessary quality improvement project.

ISG MEETING, Winter 2023

ISG Gallery, Summer Meeting 2023, Grand Hotel Malahide

Dr Shreyashee Sengupta, Dr Mary Hussey, Professor Deirdre McNamara, Dr Neil O'Morain, Dr Cathy McShane

Dr Manus Moloney, Professor Orla Crosbie, Professor Colm O'Morain

ISG MEETING, Winter 2023

ABSTRACT 36 (23W114)

Ascitic Tap Delays: For Better or Worse?

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Introduction
Spontaneous Bacterial Peritonitis (SBP) is one of the most common bacterial infections in patients with cirrhosis. SBP is associated with poor outcomes, with survival after the first episode of 40% at one year. It is known that ascitic fluid analysis that occurs <12 hours from time of hospitalization is associated with improved short term survival.

Aims/Background
• To review the time from presentation to ascitic tap being conducted. • To assess the prevalence of SBP among hospitalized patients with cirrhosis admitted via A&E • To assess whether outcomes were affected when the ascitic tap was delayed >12 hours.

Method
All ascitic fluid samples received by microbiology in the Mater Hospital over a 12 month period from January 2022 to January 2023 were reviewed. From 256 entries, only patients with ascites secondary to cirrhosis, admitted via A&E, with samples sent up to 5 days/122 hours from time of presentation were included. Patients with malignant ascites, ascites sampled intra-operatively, ascitic tap >5 days of admission were excluded. A total of 65 data entries from 39 different patients met the inclusion criteria.

Results
Average time to ascitic tap: 27.59 hours, median: 18 hours (IQR 8-28.25). Prevalence of SBP in our study was 3.07% (2/65). Mortality within study period: 17.94% (7/39). Cause of death: HCC (2), IC bleed (1), GI bleed (1), not documented (3). Ascitic tap conducted >12 hours: 39/65 (60%). In this group, average length of stay: 9.16 days, median 6 (IQR 3-12) vs average 13.1 days, median 6 (IQR 2-13.25), for patients with ascitic tap <12 hours. Death in the group >12 hours: 10.25% (4/39) vs 11.52% (3/26) in the <12 hour group. Readmission within 30 days in the >12 hours group: 30.77% (12/39) vs 50% in the <12 hour group (13/26).

Conclusions
In our study, a delay in obtaining the ascitic tap did not equate to worse outcomes for patients. However, the follow up period was short, with a median follow up period of 3 months for the >12 hour group, and 4 months for the <12 hours group. By extending the follow up period, a difference may have been observed.

ABSTRACT 37 (23W115)

Mean Nocturnal Baseline Impedance in a cohort of patients with mild oesophagitis.

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Introduction
Oesophagitis is characterized by inflammation of the oesophageal mucosa. More recently, the relatively novel metric, mean nocturnal baseline impedance (MNBI), has been proposed as a surrogate marker of oesophageal mucosal integrity.

Aims/Background
To compare MNBI with DeMeester score (DMS), acid exposure time (AET), total number of reflux episodes (TNORE) and LOS resting pressure in a cohort of patients with confirmed oesophagitis on gastroscopy.

Method
Patients with confirmed oesophagitis (LA scale- grade A/B) on gastroscopy (N=33,M=19,F=14) attended the GI function lab (2022-2023) for testing. Oesophageal manometry (Manoscan, Given Imaging) data were analysed using the Chicago Classification v4.0 and 24hrpHz and impedance data (Sandhill, Diversatek and Digitrapper, Given Imaging) were analysed using the conventional method and the Lyon consensus. Data were analysed using 'part of whole' distribution and 95% confidence interval (CI) was established using Prism, Graphpad.

Results
Abnormal MNBI(<2292kohms) was evident in 66%(95%CI:47-81%) of patients. In contrast, an abnormal total AET(<4.2%/24hr) was only evident in 16%(95%CI:5%-33%), an abnormal TNORE(<73/24hr) was only evident in 34%(95%CI:19-53%) and an abnormal DMS was only evident in 28%(95%CI:14-47%) of patients. Normal LOS resting pressure(13-43mmHg) was evident 67%(95%CI:48-82%) of patients. Abnormally low MNBI was evident in 75%(95%CI:48-93) of patients with a normal LOS resting pressure.

Conclusions
Abnormal MNBI is more widely distributed in a cohort of oesophagitis patients than other more conventional metrics, such as AET, DMS and TNORE. The majority of patients with abnormal MNBI have a normal LOS resting pressure, which may indicate that low MNBI in this patient cohort is likely to be related to an inflamed oesophageal mucosa.

ABSTRACT 38 (23W116)

Absent contractility: Consequence or cause of Supragastric Belching.

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Introduction
Absent contractility(AC) is a motility disorder characterised by 100% aperistalsis. In the GI Lab at the Mercy Hospital it has become apparent that AC occurs in a cohort of patients who present with supragastric belching(SGB), which is behavioural in nature.

Aims/Background
To examine the relationship between AC, SGB and acid reflux.

Method
High resolution impedance manometry(Manoscan, Given Imaging) reports(2018-2023) were examined, those that met the Chicago classification(v3.0 and 4.0) for AC were selected for this restrosepctive study,(N=22),(N=10 Male, N=12 Female). 24hr pHz and impedance data(sandhill, Diversatek)from patients with AC was examined and the threshold for excessive SGB was taken as >13 episodes/24 hrs. Data were analysed using 'part of whole' distribution and 95% confidence interval(CI) was exstablished using Prism, Graphpad.

Results
Excessive SGB was evident in 82% of patients with AC(95% CI: 60-95%). Normal DeMeester score(<14.7/24hrs) was evident in 50% of patients with AC and SGB(95% CI: 26-74%). Normal acid exposure time(<4.2%/24hrs) was evident in 67% of patients with AC and SGB(95% CI: 41%-87%). Normal total number of reflux episodes(<73/24hrs) was evident in 44% of patients with AC and SGB(95% CI: 21-69%).

Conclusions
This study identifies a cohort of patients in which AC is linked with SGB. This raises the question as to whether SGB is a consequence or cause of AC. It is possible that SGB is a subconscious reflex used to attempt oesophageal clearance. Future studies should extend these findings to determine whether the current therapeutic treatment of SGB with diaphragmatic breathing is sufficient to improve oesophageal motility in patients with AC

ABSTRACT 39 (23W117)

The Impact Of The Introduction Of Castor Oil On Excretion And Completion Rates At Colon Capsule Endoscopy

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Introduction
A good bowel preparation protocol will achieve adequate colonic cleanliness and aid timely capsule excretion. The quality of the preparation protocol is dependent on many factors, including, laxative used, timing and volume of laxative, types of boosters used, use of prokinetics and patient tolerability. Great variability exists between studies with regards to excretion and completion rates.

Aims/Background
To assess the impact of the introduction of 15ml of castor oil to the bowel preparation protocol for colon capsule endoscopy (CCE) at Connolly Hospital

Method
All reported CCEs performed in Connolly Hospital since the introduction of the service were initially reviewed. 11 CCEs were excluded where castor oil was used as an alternative to gastrograffin. All included patients received Moviprep A+Bx2 prior to capsule ingestion, with 1L Moviprep and 50ml Gastrograffin used boosters (n=131). 15ml castor oil was added to this protocol from November 2022 (n=38). The cohort who attended for CCE prior to November 2022 have been used as comparison (n=82).

Results
There was no statistically significant difference with regards to demographics/indications for CCE between the groups. Excretion rates improved significantly after the introduction of castor oil from 68% to 89%, p <0.01. Completion rates improved from 57% to 76%, p=0.06. There was no statistically significant improvement in polyp detection rate, 36.5% to 39.5%.

Conclusions
The introduction of castor oil has had a positive effect on excretion and completion rates in this department. There is widespread variation in preparation protocols used in clinical practice and a need for large, prospective studies comparing these protocols remains.

ABSTRACT 40 (23W120)

NAFLD, MASLD or what? The Irish impression of the recent change in NAFLD nomenclature

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Introduction
NAFLD (now termed MASLD) is reported to be the most common hepatic disorder in western countries today with 17-46% of adults affected. At the 2023 EASL Congress, the multinational NAFLD Nomenclature Initiative announced a change to the nomenclature surrounding NAFLD as well as a diagnostic algorithm.

Aims/Background
We sought to determine the Irish impression of this significant change in nomenclature.

Method
This data was collected anonymously via an online, twelve-point questionnaire with a mix of close-ended and open-ended questions. This was distributed to the Irish Society of Gastroenterology membership via email as well as other clinical groups.

Results
There were 60 respondents to our questionnaire. 46 of these were members of the ISG. Of these, 50% (n=23) were Consultants and 50% were SpR/Registrars. A further 5 histopathology consultants responded. The majority of respondents were working in the Dublin area (n=33), however other larger centres were well represented (Galway n=8, Cork n=8). 62% of people had been aware of a change

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Dr Zita Galvin, Professor Orla Crosbie, Dr Audrey Dillon

Dr Ciaran Magee, Dr Kyle O'Donovan, Dr Eugene Campbell

ISG MEETING, Winter 2023

to the nomenclature. 65% agreed that a change was needed and 57% agreed with the changes implemented. On average, the group were only 56% confident the changes will be beneficial. The most frequently cited concern was that these changes were complicated and confusing (23%). The benefits of these changes most frequently included improving the clarity of the diagnosis and helping disease awareness. 76% of respondents will use the new nomenclature going forward.

Conclusions
Whilst this group were not particularly confident that these changes will have a positive impact on clinical practice, the majority will begin to use this new nomenclature.

ABSTRACT 41 (23W121)

The Impact of a Community Development Worker on The Hepatitis C Virus (HCV) Service in Cork.

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Introduction
It is well documented that testing and treatment of HCV in people who inject drugs (PWIDs) and the homeless is a challenge. An audit carried out in CUH in 2019 identified that referrals from addiction and homeless services were low. This emphasised the need for increased screening in the addiction and homeless services. In late March 2023 a Community Development Worker (CDW) was recruited to the Cork HCV community team.

Aims/Background
The aim of the study was to evaluate the impact of the CDW on the HCV service in Cork.

Method
A retrospective review of contemporaneously collected data on individuals screened and treated for HCV who were also engaged in the addiction or homeless service in Cork from late March to October 2023.

Results
The CDW has screened 50 patients opportunistically to date across a range of settings. 24% (n=12) of these were HCV antibody positive. 58% (n=7) of these were positive for current HCV infection. 4 of these have commenced treatment to date. In addition, the CDW has participated in some of the scheduled 'pop-up' screening days in the addiction and homeless centers where 70 patients were screened. 8.6% (n= 6) of these were HCV antibody positive. 66.67% (n=4) of these were positive for current HCV infection.

Conclusions
The CDW has proven to be highly effective in the detection of HCV in hard to reach groups and also in assisting those in the homeless and addiction services to engage with HCV treatment.

ABSTRACT 42 (23W122)

Compliance With Percutaneous Endoscopic Gastrostomy (PEG) Tube Insertion Guidelines and Associated Complications in Endoscopy Unit at St Vincent's University Hospital (SVUH): A Clinical Audit

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Introduction
Enteral tubes offer nutritional support for patients struggling to meet their requirements due to neurological or acute/chronic conditions . Serious complications occur in 1.5% to 4% of PEG placements, including aspiration, bleeding, perforation, and infections . Procedure-related 30days mortality is below 1% .

Aims/Background
Guidelines suggest PEG insertion requires a multidisciplinary approach, referral pathway, pre-procedure assessment, documentation of indication and photo documentation of satisfactory placement in the stomach . In the UK, around 17,000 PEGs are placed yearly, while Ireland lacks both a database and guidelines. This audit aims to assess enteral tube procedures carried out in SVUH endoscopy unit comparing to international standards.

Method
We included patients with PEG placements in SVUH endoscopy unit's from January 2022 to July 2023. Patients were identified through endoscopy reporting systems. Charts were reviewed for complications.

Results
In 2022, 15 PEG procedures were performed, with 2 unsuccessful due to anatomical variations. No complications or 30-day mortality recorded. Only 3 had the indication noted in reports, and 50% met satisfactory placement photo-documentation. Patient suitability was not formally documented pre-procedure. In 2023 (till July), 13 PEGs were placed. One patient experienced bleeding, necessitating a transfusion. No 30-day mortality was recorded. 82% met PEG placement criteria. Only 2 procedures mentioned indications, and no formal patient assessment was documented.

Conclusions
The complication rate and mortality are in line with international guidelines. However the volume of PEG placement is small and documentation is poor. We recommend formal assessment pathway, mandatory inclusion of indications in reports and database for PEG tube insertion as per guidelines.

ABSTRACT 43 (23W124)

Time to ERCP on Referral Receipt in a Tertiary Hospital

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Introduction
ERCP treats benign and malignant pancreaticobiliary obstruction, as well as infection related to biliary pathology. The European Society of Gastrointestinal Endoscopy (ESGE) guidelines recommend that acute cholangitis is treated within 72 hours. Beaumont Hospital provides ERCP services for the RCSI hospital group with approximately 500 performed per annum.

Aims/Background
This audit assesses the time from receipt of referral to ERCP. It further aims to assess the wait times dependent on indication for ERCP.

Method
All new inpatient referrals for ERCP over a three-month period (June-August 2023) were reviewed. Referrals for elective repeat ERCP were excluded.

Results
109 referrals were assessed; 13 were excluded due to lack of clear date of referral receipt or outpatient status. 96 ERCPs were included for analysis. 18/96(19%) were due to known or suspected malignant biliary obstruction and 78/96(81%) were for choledocholithiasis. 21/96(22%) patients had a clinical suspicion for cholangitis. The average wait time from referral was 7.4 days[1-48]. Time to ERCP for suspected malignancy, stone pathology, and cholangitis was 5.8[1-23], 7.8[1-48], and 6.4 days[1-23] respectively. 60/96(63%) patients had ERCP within 7 days of referral. 9/21(43%) of cholangitis presentations had ERCP performed within 3 days of referral.

Conclusions
For the treatment of cholangitis in our cohort, only 43% had the procedure performed within 3 days, falling well below the target recommended by ESGE. This audit highlights the challenges to meet service demand for ERCP in the RCSI hospital group. This delay in patient care may negatively impact patient outcomes and contribute to delayed discharge.

ABSTRACT 44 (23W126)

Sláintecare in action: Transitioning IBS care to the community, a pilot study of a new IBS pathway.

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Introduction
Patients with Irritable Bowel Syndrome (IBS) remain a high burden in terms of endoscopy and outpatient Gastroenterology clinic load. IBS can be diagnosed using ROME IV criteria without the need for endoscopy. Dietitian care has been shown to be effective.

Aims/Background
To develop a new IBS pathway to transition IBS care to the community.

Method
The PDSA cycle was used. Plan: A collaborative plan was set in action between Gastroenterology, CUH and community dietitians. Referral pathways and patient selection were agreed and ethical approval for the study was obtained from Cork Research Ethics Board Do: At the point of initial referral triage, patients meeting ROME criteria for IBS are sent for initial investigations with follow-up in a registrar-led clinic. If suitable, patients are discharged for community dietitian intervention thereafter.

Results
Study: A total of 16 patients have been assessed for the pathway and 6 referred to the community in the 3 months since clinic initiation. An interim analysis revealed 18% of clinic reviews met criteria for community referral. Act: More rigorous selection criteria were introduced at the point of triage which has improved the referral rate to the community to 80% of attenders.

Conclusions
A community dietitian IBS pathway has the potential to transition care from tertiary referral centres to the community settings. Robust selection criteria, rigorous triaging and appropriate initial investigations are the key to selection of suitable patients with IBS to transition to the community.

ABSTRACT 45 (23W128)

A retrospective study to assess if polypectomy technique and type of cut impacts recurrence rate after large colonic polypectomy.

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Introduction
Large polyps (>1 cm in size) are very common even in asymptomatic patients. Current guidelines recommend repeat colonoscopy based on numbers, size and histology.

Aims/Background
This is a retrospective study to look at the recurrence rate post polypectomy of large polyps (defined as above 1 cm in size) and factors influencing including polypectomy technique (EMR or Cold snare) and type of cut (single or piecemeal), over a period of 3 years from January 2017 to December 2019 performed in Louth county hospital, Dundalk.

Method
We obtained endoscopy data from 2017 to 2019 from Endoraad and histology data from lab system and pathology report review. This cohort included all referral methods including direct access and NCSS patients.

Results
We had total 123 patients in the study group ,38 females and 85 males. Out of them, 10 were excluded due to incomplete data. Out of the 113 patients ,100 had EMR,9 had cold snare and 3 had hot snare polypectomy. Among the 100 patients whom we had available data on the type of cut, 92 had single en-bloc resection and 8 had it in piecemeal. 92/113patients who had confirmed repeat scopes,10 had recurrence of polyps, 3/9 (33.3%)in the cold snare group, 2/3(66.6%) in the hot snare group and 5/100(5%) in the EMR group. 2/8(25%) piecemeal resection and 8/92(8.7%) en-bloc resections had recurrence

Conclusions
There is significant correlation between the recurrence rate and the technique and type of cut of polypectomy. However, documentation of type of cut is not available in the current Endoraad system. We recommend a drop down record of type of cut (single or piecemeal) in the endoscopy report and that repeat colonoscopy interval guidelines should include not only size , but also the type and cut of polypectomies .

ABSTRACT 46 (23W131)

Bismuth Quadruple Therapy as first line eradication regimen; experience in an EU border county Hospital.

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Introduction
Helicobacter Pylori (HP) has been identified as a Class 1 Carcinogen. HP antibiotic-resistance is an increasing problem worldwide with recent Irish data showing Clarithromycin resistance at 25%. Bismuth-Quadruple Therapy (BQT) has been recommended as an alternate first line therapy by HSE but national use has been limited due to prohibitive factors.

Aims/Background
To assess HP eradication rate with 14-day BQT and identify prohibitive factors associated with its use in a peripheral border-county Hospital over an 18 month period.

Method
Data of HP positive patients' treated with BQT was collected from gastroenterology OPD and endoscopy records including demographic data, method of checking eradication and symptoms. Prohibitive factors of using BQT were identified. All patients were contacted to assess symptoms and compliance with returning stool samples.

Results
Demographics; 52% male, mean age 49 (range 17-82). 86% (n=53) had positive CLO, 12% (n=7) had positive histology, 2% (n=1) had positive stool antigen. 98% (n=59) had eradication confirmed with stool antigen, 2% (n=1) had histology confirmation. HP eradication with first-line BQT was 90% (n=56%). Second-line eradication was 100% (n=6); 1 received Levofloxacin-based-Triple-Therapy, 5 Levofloxacin-Quadruple-Therapy. All patients had dyspepsia as initial symptom with resolution seen in 90% (n=56) post-eradication. Early prohibitive factors were; availability of Bismuth which was overcome with local pharmacy engagement and cost which was overcome when changing from Tetracycline to Doxycycline.

Conclusions
Our data confirms excellent HP eradication rates (90%) with first-line BQT with 100% eradication achieved with second line therapy. Prohibitive factors identified were easily rectified with ongoing engagement.

ABSTRACT 47 (23W132)

Report On The Indications And Outcomes Of Urgent (P1) Gastroscopy In An Irish Affiliated Hospital.

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Introduction
OGD is the gold standard test for the investigation of upper gastrointestinal (UGI) symptoms. Demand has been consistently increasing, with 101.622 OGDs performed in 2019 in Ireland. Endoscopy services in Ireland provide a triage process that offers endoscopic procedures within an appropriate time frame based on risk assessments and individual clinical evaluation.

Aims/Background
To look at the indications and outcomes for patients referred for Urgent (P1) OGDs as per the national endoscopy triage programme.

Method
Data was collected retrospectively by identifying referrals made by general practitioners to endoscopy unit through the Open Access system between 1st January 2023 to 30th August 2023. Indications, outcome of endoscopy and histology were collected.

Results
35 patients included in this study, 17 female and 18 male. Median age was 55. The most common indications was reflux symptoms (43%) followed by dysphagia (29%). The most common endoscopic finding was hiatus hernia (40%) followed by Oesophagitis (31%). One patient who had OGD for anaemia was found to have a possible submucosal mass. Subsequently, colonoscopy and CT imaging identified an extrinsic colorectal malignancy. Barrett's Oesophagus was evident in 2 male patients only. Histology showed no dysplasia. 33% of OGDs performed were normal.H. Pylori associated-gastritis was in 4 patients.

Conclusions
This report gives insight into the common endoscopic and histology findings. It is notable that the diagnostic yield for sinister pathology is low. Further study with an expanded patient cohort are planned to further investigate the actual diagnostic yield. This may inform amendment of the criteria for P1 upper GI endoscopy.

ABSTRACT 48 (23W138)

Review of Percutaneous Endoscopic Gastrostomy (PEG) insertion – indications, efficacy and safety.

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Introduction
Percutaneous endoscopic gastrostomy (PEG) in MMUH has reduced year on year. Whilst PEG guidelines exist, they are vague regarding numbers needed to attain or maintain competence at PEG placement.

Aims/Background
We examined referrals for PEG placement in MMUH over a 3 year period, including success of PEG placement, progression to radiologic gastrostomy (RIG), reasons for failure of PEG placement, short-term complications and mortality, and impact of the preprocedural consultation.

Method
We included MMUH patients, referred for PEG from 2020 to 2022. We analysed endoscopic referral data, GI consult data and the paper based PEG log book

Results
78, with average age of 64.4 years. 50% referrals from came from Neurology. 59/78 made it into the endoscopy room with the intention to place PEG (75%). 48/78 had successful placement (61% of original cohort). 8 of the 11 unsuccessful PEGs proceeded to successful RIG placement. Periprocedural complications occurred in 11/59 patients (19%) - 3 sedation related, 5 technical issues, 3 post placement complications. 70% of the original cohort (n=78) were alive at 30 days, and 66% alive at 60 days. 19 of the original 78 patients were seen on consult only and did not progress to PEG placement. (5/19 direct to RIG. 14/19 no gastrostomy). Only 4/11 failed PEGs had a pre procedure consultation.

Conclusions
Only 61% of patients referred for PEG had a successful PEG placement, 20% of patients assessed underwent RIG placement either de novo, or after PEG failure. The preprocedure consultation may help to better stratify patients. Dwindling PEG numbers and the 'rise of the RIG' has significant implications for training and maintenance of an important skillset.

ABSTRACT 49 (23W140)

A Snap Shot Of Waiting Times For Admitted GI Patients In The Era Of Speciality Redistribution Should We Be Doing More?

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Introduction
Specialty redistribution in the Mater Hospital was a positive development for patients. GI patients experience significant delays between ED triage and review by the GI team.

Aims/Background
We sought to establish when and where delays are occurring.

Method
We conducted a retrospective review of triage times for patients redistributed to the GI service during December 2022 and June 2023 using written and electronic patient records. Day of admission, ED triage time, time seen by GIM SHO and GI team were recorded.

Results
81 admissions were reviewed. Mean age 62 years, 59%(n=48) male. 74%(n=60) were admitted on a weekday, 37%(n=30) outside normal working hours. 11%(n=9) presented on a Friday. Median time from ED triage until seen by the GIM SHO/Reg on a weekday was 7hrs 19 minutes and 6 hours 39 minutes at the weekend. This compares to 21 hrs 13 minutes until seen by the GI team during weekday admissions. For Friday admissions, median time until seen by the GI team was 50 hours 22 minutes, reducing to 43 hours 17 minutes for weekend admissions. 60%(n=49) of admissions were accounted for by decompensated liver disease, GI bleeding and anaemia.

Conclusions
There is an unsatisfactory wait for specialist input into what are often quite sick patients. We could tackle this in various ways: A. GI ANP for rapid assessment of GI patients on Fridays B. More rapid triage of specialist patients on Fridays before the weekend C. GI teams move out of GIM to provide daily assessment and takeover of GI patients with a full team

ABSTRACT 50 (23W141)

How well are we treating PBC? A service review

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Introduction
PBC (Primary Biliary Cholangitis) is a chronic, autoimmune, cholestatic liver disease. Early detection, symptom management and appropriate therapy are key to prevent significant morbidity and mortality

Aims/Background
Recently, BASL (British Association for the Study of the Liver), PBC-UK and the PBC foundation produced the first national audit of PBC in the UK. We looked to examine some of these standards in our own PBC cohort.

Method
PBC patients were identified from our Fibroscan database. Public patients only were included. Data on demographics, serology, treatment prescribed and disease stage were collected. The data were anonymised. The audit was registered with the Hospital Clinical Audit Department.

Results
102 patients were identified, 6 were excluded as they had passed away, 3 were attending other hospitals and 1 was found not to have PBC based on a liver biopsy. The median age was 67 years, 54 years at diagnosis. 8 patients were male. 77 (83.7%) had ALP >ULN. 91.3% were on UDCA and 25% on a fibrate. No patients were taking obeticholic acid. 15 (16%) of patients have advanced fibrosis or cirrhosis. All of these patients have undergone screening for HCC.

ISG MEETING, Winter 2023

Conclusions
This audit has identified that there is a sizeable cohort of PBC patients, 1 in 6 of whom have advanced liver disease; the vast majority of patients with PBC in our service do not have normal ALP levels, and weight-based UDCA prescribing may suboptimal. A structured approach to the care of patients with PBC is warranted, adhering to the UK standards.

ABSTRACT 51 (23W142)

Design, Delivery and Evaluation of Specialist Inflammatory Bowel Disease Educational Programme: An Irish Perspective

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Introduction
The higher education sector plays an integral role in ensuring that healthcare professionals (HCPs) have the relevant knowledge, skills and competence to deliver high quality evidence-based care to patients. However, there is a lack of academically accredited programmes available to educate HCPs on the principles of inflammatory bowel disease care.

Aims/Background
To design, deliver and evaluate an academically accredited educational programme in the area of IBD.

Method
The design and development was undertaken in collaboration with subject matter experts in IBD via stakeholder consultations to seek a strategic view on programme design and content. The Certificate in Inflammatory Bowel Disease Care was validated by Munster Technological University in Ireland in 2021 and the first cohort was enrolled in January 2022. This online, 10 credits (ECTS) postgraduate programme runs over 12 weeks each academic year. Student profiles are collected at the start of the programme, and a final evaluation is completed in week 12 of the programme.

Results
To date, 37 healthcare professionals have graduated from the programme. Content analysis of the feedback data revealed that the graduates find the programme to be practice focused and increases their understanding of providing evidence-based IBD care. Modifications are applied to each new cohort based on the students' feedback and following consultation with subject matter experts, to ensure the programme is relevant and up-to-date.

Conclusions
As there is a global need for more healthcare professionals with specialised training in IBD, our experiences can offer useful insights into co-designing, delivering and evaluating academically accredited educational programmes in IBD.

ABSTRACT 52 (23W145)

Early inpatient management of Inflammatory Bowel Disease Flare in Galway University Hospital

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Introduction
Appropriate management of inpatient inflammatory bowel disease (IBD) flares improves patient outcomes. Best practice can be achieved by adherence to well established international guidelines.

Aims/Background
To audit our practice of early inpatient management of IBD flares against international standards

Method
A retrospective audit of suspected IBD flares admitted over a 12-month period. We included patients admitted with suspected and later confirmed IBD flares. We excluded infectious and ischaemic colitis presentations. Data was collected from electronic medical records.

Results
In total, 54 patients were included. 56% were male (n=28) and the median age was 38. 39% (n=21) had ulcerative colitis, 57% (n=31) Crohn's disease, and 4%(n=2) yet to be determined IBD. 80% (n=43) required IV steroids on admission. The majority, 94% (n=51) were prescribed VTE prophylaxis on admission, and the subsequent 6% were charted within the first 24-hours of admission. 57% (n=31) had stool samples sent for C difficile and culture & sensitivity (C&S). During their admission, only 15 patients (28%) were referred to dieticians. 74% (n=40) had a PFA upon admission. 36% (n=3) of patients with ulcerative colitis underwent endoscopic assessment within first 24 hours of admission.

Conclusions
This audit revealed good levels of VTE prophylaxis prescribed on admission. It highlighted the need for increased testing of stool C&S and C. difficile. It also suggested low levels of dietician referrals and early endoscopic assessment. From the results highlighted in this audit, we have increased NCHD education and introduced an Acute Severe Colitis (ASC) pathway. We will then re-audit our practice.

ABSTRACT 53 (23W146)

What Makes a Difference in Capsule Endoscopy Training? – Experience From a Newly Established Capsule Endoscopy Unit

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Introduction
Barriers to implementation of Capsule Endoscopy(CE) include prolonged reading time(RT) and perceived difficulty in achieving confidence. Although curriculums suggest a prerequisite case number to achieve competence, correlations between RT and confidence are poorly studied.

Aims/Background
To assess RT, confidence, capsule transit times(CTT), and their correlation between 2 novice capsule-endoscopists in a newly-established CE centre.

Method
Reader 1 (R1): endoscopist in training, and Reader 2 (R2): CE Nurse with endoscopy nursing experience. RT calculated using a stopwatch recorded prospectively over 12 months. Likert scale used to measure confidence (1-5). Pearson coefficient used to calculate correlation between variables.

Results
Demographics: 39% male(n=43), 61% female(n=67). Mean age 55years (range 21-89). Total 110 CE (47 small bowel CE (SBCE), 63 colon CE (CCE)). Average CTT: SBCE 268.3minutes (range 20-868), CCE 348.9minutes (33-962). R1:21 SBCE, mean RT 33minutes (range 19-48). 26 CCE, mean RT 55.7minutes (range 20-129). Mean confidence 3.4 range (1-5). Moderate positive correlation between confidence and number of procedures (R-value 0.64, p<0.00001). R2:26 SBCE, mean RT 45.7minutes (range 22-84). 37 CCE, average RT 45.8minutes (range 8-74). Mean confidence 2.8 (range 2-4). Weak positive correlation between confidence and number of procedures (R-value 0.47, p-value 0.0001). RT had a moderate inverse correlation with reader confidence(R-value -0.5, p-value <0.00001). RT correlated poorly with CTT(R-value 0.27, p-value 0.004). Differences in confidence between readers were statistically significant (3.4 vs 2.8, p-value 0.00008).

Conclusions
In concordance with curriculums, confidence is achieved with number of readings. RT does not correlate with confidence. Other factors may impact RT which are areas for further studies.

ABSTRACT 54 (23W147)

Inflammatory Bowel Disease (IBD) nurses knowledge practice and attitudes to Microscopic colitis (MC)

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Introduction
Microscopic colitis is increasingly getting recognition as Inflammatory Bowel Disease for the past two decades. However it is not under the classical umbrella of inflammatory bowel disease which incorporates Crohn's Disease and Ulcerative Colitis. There is currently no education programs developed for IBD nurses and it is not formally incorporated into IBD nurse referral pathway.

Aims/Background
To assess knowledge, practice and attitudes of IBD nurses in relation to Microscopic colitis

Method
A quantitative cross sectional survey was conducted using a 17 point questionnaire. 29 IBD nurses (n=29) from the IBD National association of Ireland (IBDNAI) responded from a total of 52 (55.7%). Inclusion criteria 1. registered practicing nurse, 2. on IBDNAI registry and 3. willing to participate. Data was collected and analyzed on SPSS. Descriptive statistics implemented.

Results
The majority are female (90%) and (41%) had over 11 years of experience. Clinical Nurse specialist was (65.5%) and the majority had Post Grad (28%) or Masters (34.5%). Mean and standard deviation scores for knowledge indicated similar variations. Knowledge scores are high for symptoms are high (65.5%- 90%) but average for investigations and treatments. Correlations for years of experience, qualifications and knowledge were implemented using Chi Square and Spearman's correlation. The majority of nurses (71%) do not receive referrals and do not review patients diagnosed with MC at the out-patients department. A mixed response (57%)was for MC as part of the IBD nurse case-load and 67.8% agreed MC should be incorporated in the N-ECCO guidelines.

Conclusions
Microscopic Colitis is a recognized form of IBD. Gaps in knowledge for MC exist among IBD nurses. There are currently no education programs for IBD nurses on MC and as such it is slow to integrate into busy IBD nurse case-load. Education on MC is required to boost awareness for IBD nurses and improve practice.

ABSTRACT 55 (23W149)

Impact Of The Adoption Of Novel Oral Anticoagulants On Endoscopy Pre-Assessment

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Introduction
Since their first approval in 2008, Direct Oral Anticoagulants (DOACs) have been vital in treating and preventing thrombotic and embolic events. From 2014-2018, DOAC prescribing has increased 68% nationally and warfarin use has decreased by over 50%. A well recognised adverse effect of DOACs is Gastrointestinal (GI) bleeding and endoscopy is the primary diagnostic investigation of choice when suspected.

Aims/Background
To identify trends in patients on anticoagulation attending endoscopy pre-assessment from 2013 to 2023.

Method
A database of all outpatients on anticoagulation attending endoscopy pre-assessment in TUH from 2013 to August 2023 was utilised. Unisoft endoscopy reporting tool was used to generate the total number of endoscopic procedures performed and their indications and outcomes since 2013. The two databases were analysed and cross referenced.

Results
Anticoagulated patients attending endoscopy pre-assessment have doubled in the last ten years (14. 5 patients per month in 2013 vs 35 thus far in 2023). Those taking warfarin have decreased by 57% (1.4 patients per month in 2013 vs 0.6 thus far in 2023), while DOAC use has exponentially increased (1 in 2013 vs 5.6 per month thus far in 2023).

Conclusions
While the introduction of DOACs has led to increased rates of anticoagulant prescribing, there has also been an increase in patients attending endoscopy pre-assessment. This begs the question - do DOACs directly contribute to increasing endoscopic evaluation in the outpatient setting. This requires further investigation to assess whether a significant correlation exists.

ISG MEETING, Winter 2023

ABSTRACT 56 (23W150)

Gut vs Guidelines – Evaluating Post-Polypectomy Surveillance In Endoscopy In Accordance With National Guidelines

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Introduction
Endoscopic surveillance of patients following detection of pre-malignant polyps is an important process in the early detection and prevention of colorectal cancers. In an era of unprecedented demand being placed on our endoscopy services nationally, identification of unnecessary procedures and use of alternative pathways reduces the burden on our endoscopy departments.

Aims/Background
To investigate the proportion of requested post-polypectomy colonoscopies that were adherent to The British Society of Gastroenterology/European Society of Gastrointestinal Endoscopy (BSG/ESGE) surveillance guidelines.

Method
A retrospective analysis of endoscopy reports and the corresponding histology was conducted. Data was collected for a 5-month period and cases with confirmed polypectomy were included. The plan to proceed with surveillance colonoscopy was determined from the endoscopist's report or subsequent clinic letters.

Results
There were 103 colonoscopies with polypectomy included in the study. 71 patients (68.9%) had subsequent surveillance procedures booked. Of the 71 patients, 47 (66%) of the surveillance colonoscopies were not in accordance with BSG/ESGE guidelines. 12 (26%) of these were performed by Gastroenterology endoscopists with the remaining 35 (74%) surveillance studies arranged by other endoscopists. Where guidelines were not strictly followed, the performing endoscopist often noted factors influencing their decision to proceed with further surveillance. 19 patients (45%) who had surveillance colonoscopy arranged who did not fulfill high risk features as per guidelines would have been appropriate for the national bowel screening programme.

Conclusions
A significant number of colonoscopies for post-polypectomy surveillance are not in accordance with up-to-date recommendations. A large percentage of patients with planned surveillance endoscopy were suitable for National Bowel Screening. The most recent BSG/ESGE guidelines have recently been adopted by BowelScreen and extended into the symptomatic service since December 2022. All Endoscopists should familiarise themselves with the latest guidelines, which will reduce the number of colonoscopy referrals and improve waiting times for Endoscopy.

ABSTRACT 57 (23W151)

Rising Rates Of Iron Deficiency Anaemia – Are Anticoagulants To Blame?

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Introduction
Since their first approval in 2008, Direct Oral Anticoagulants (DOACs) have been vital in treating and preventing thrombo-embolic events. However, an important adverse effect of DOACs is Gastrointestinal (GI) bleeding. Iron deficiency anaemia (IDA) of unknown aetiology or where a GI source is suspected is usually investigated with endoscopy.

Aims/Background
To identify trends in patients on anticoagulation attending endoscopy pre-assessment from 2013 to 2023.

Method
A database of all anticoagulated patients attending endoscopy pre-assessment in TUH was utilised. Unisoft endoscopy reporting tool was used to generate the total number of endoscopic procedures performed and their indications since 2013. The two databases were analysed and cross referenced.

Results
Anticoagulated patients attending endoscopy pre-assessment have doubled in the last ten years (14. 5 patients per month in 2013 vs 35 thus far in 2023). The total number of procedures performed for IDA has increased (53 procedures per month in 2013 vs 85 per month thus far in 2023). The total number of anticoagulated patients attending endoscopy pre-assessment investigated for IDA have increased four-fold (1.5 patients per month in 2013 vs 6.5 in 2023). Oesophageal ulcer findings have tripled (2.83 per month in 2013 and 8.88 per month thus far in 2023) with no corresponding change in the number of anticoagulated patients.

Conclusions
With increasing rates of DOAC prescribing, there has been a disproportionate rise in the number of patients on anticoagulation attending endoscopy pre-assessment for evaluation of IDA. This trend requires further investigation to assess whether a significant correlation exists.

ABSTRACT 58 (23W161)

Pathology identified at colonoscopy in a cohort of patients with cystic fibrosis

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Introduction
Patients with cystic fibrosis are at an increased risk of developing cancers throughout the GI tract. At age 40, up to 50% will have colorectal adenomas, and 25% advanced adenomas.The CF foundation recommends that colorectal cancer screening begin at age 40, or 30 for those who have received a solid organ transplant. At our centre, we have commenced enrolling these patients into a surveillance programme.

Aims/Background
To review the endoscopy and pathology results for patients in this cohort who have undergone colonoscopy.

Method
A review of EndoRAAD data including basic patient demographics, sedation used, comfort scores and pathology identified, and a review of histology where available.

Results
43 patients in total have been screened thus far, 28.44 (64%) male and a median age of 45.3 years. Endoscopy results were available for 39. Despite these being surveillance procedures, half of the patients reported lower GI symptoms at the time of their procedure. 23% had poor prep. 13 (33%) had at least one adenoma identified.

Conclusions
In this small retrospective study, 33% of patients had adenomas identified in their colon - a signficantly larger proportion than in the general, age-matched population. Further study is required as enrolment in screening continues. A broader GI surveillance programme for patients with CF must be considered, but due to service constraints will likely remain colorectal cancer focused for now.

ABSTRACT 59 (23W162)

A Single-Centre Review of Repeat Upper Endoscopy After Diagnosis of Gastric Ulcer

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Introduction
Following diagnosis of a gastric ulcer, repeat endoscopy is recommended to ensure adequate healing after appropriate treatment and to exclude malignancy.

Aims/Background
Assess compliance with current standards for repeat upper endoscopy within 12 weeks of diagnosis of a gastric ulcer.

Method
2140 OGDs were performed at St Vincent's University Hospital (SVUH) between 01/01/2023 and 30/06/2023. In total, 70 patients were diagnosed with gastric ulcers. 1 patient was excluded (RIP <12 weeks.) Data was reviewed and compared with JAG standards.

Results
69 patients were included. 60% (n=40) occurred as an outpatient and 40% (n=29) as an inpatient. 50% (n=34) of patients had a repeat OGD within 12 weeks of diagnosis with a gastric ulcer. 30% (n=23) had a repeat OGD >12 weeks after diagnosis with gastric ulcer. A significant number of patients did not have a follow-up OGD at SVUH (20%, n=12). 90% (n=11) of these patients had an inpatient OGD. However, 2 patients were referred for follow- up locally and 1 patient was diagnosed with malignant ulcer at initial OGD. Follow-up was clearly listed in 50% (n=6) of reports in this cohort.

Conclusions
In contrast with JAG recommendations to repeat endoscopy within 12 weeks for all gastric ulcers, 50% of repeat procedures occurred within this timeframe at SVUH. Many inpatients did not have a repeat OGD as follow-up was not arranged by primary team on discharge. Rates of repeat endoscopy could be improved by educating referring teams or reviewing rebooking pathway to encompass both inpatient and outpatient procedures.

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