Autumn Meeting

Park Avenue Hotel, Belfast
Friday October 7th, 2016

usg Ulster Society of Gastroenterology

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Welcome Message from the President of USG Mr Eamon Mackle.

Dear Colleagues and Friends

Welcome to the Park Avenue Hotel and the Autumn Meeting of the Ulster Society of Gastroenterology. This will be the third full day meeting of the Society and I think there is enough in the programme to both educate us and to stimulate positive change in our Gastroenterological practice. The day should also allow us to renew friendships with colleagues and to discuss gastroenterological problems.

The Autumn meeting is an opportunity for trainees to present their work both as free papers as well as posters and for us to keep abreast of what is happening in Gastroenterology. The executive committee have put together an excellent programme which I am sure contains something of interest for all of us.

Usually Pathologists have the last word however we have Dr Maurice Loughrey as the first speaker and he is going to tell us what is important in the pathology of colorectal polyps. The rest of the session is on IBD and includes talks on better use of drugs by Dr Charles Lees of Edinburgh and a talk on the IBD registry by Mr Richard Driscoll. After the Coffee break we tackle the subject of Medical Informatics and how it can improve healthcare. Dr Roy Harper leads the session talking about the Northern Ireland Electronic Care Record:- which along with PACS are the two most useful informatics advances I have seen in my career. Dr Bu Hayee from Kings College London looks at the improvement in outcomes in IBD from a fully commissioned care pathway. For all of you lovers of apps on your iPhones Dr Gareth Parkes looks at a new app which assists in IBD care.

After lunch we have a session the theme of which is hepatology. The burden to society and the health service of alcohol is immense thus we have Professor John O'Grady of King's College, London talking about Transplantation in alcohol related disease. Dr Johnny Cash follows with a talk on the modernisation of Hepatology Services. The session finishes with Professor Catherine Williamson of King's College, London, an expert on liver disease of pregnancy, and she will talk about when to call a hepatologist.

A meeting like this doesn't just happen and I am as usual indebted to a relatively small cadre of people. Dr Patrick Allen and Dr Jenny Addley have put in an immense amount of time in planning this meeting and I thank them. Michael Dineen and Cora Gannon yet again have proven invaluable in providing advice to us in producing the programme and organizing the venue and the meeting.

A meeting like this is not cheap to organise and we are all indebted to our friends and supporters from the Pharmaceutical and Instrument Industries for their continued financial support.

As I mentioned in the Spring Brochure the next meeting will be a joint British Irish and Ulster Gastroenterology. We will be holding the meeting in the Europa Hotel on the 27th and 28th of April 2017 and I ask you to keep these dates free in your diaries.

Lastly I would like to thank all the speakers and also most importantly thank you all for attending this meeting and helping to make it a success.

Eamon Mackle
President Ulster Society of Gastroenterology

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It is generally recommended that half the adult dose may be given to children up to a body weight of 40kg; and the normal adult dose to those above 40kg. **Method of administration:** The granules should be taken on the tongue and swallowed, without chewing, with plenty of liquid. **Contra-indications:** Known hypersensitivity to salicylates or any of the excipients. Severe impairment of renal or hepatic function. **Warnings/ precautions:** Blood tests (differential blood count; liver function parameters such as ALT or AST; serum creatinine) and urinary status (dip sticks) should be determined prior to and during treatment at the discretion of the treating physician. Caution is recommended in patients with impaired hepatic function. Should not be used in patients with impaired renal function. Mesalazine-induced renal toxicity should be considered if renal function deteriorates during treatment. Patients with pulmonary disease, in particular asthma, should be very carefully monitored. 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Salofalk 1000mg granules, pack size 50 sachets - £28.74; €38.28. Salofalk 1.5g granules, pack size 60 sachets - £48.85. Salofalk 3g granules, pack size 60 sachets - £97.70; €129.07 (UK - NHS price; IE - PHV). Product licence number: Salofalk 500mg granules - PL08637/0007; PA573/3/1. Salofalk 1000mg granules - PL08637/0008; PA573/3/2. Salofalk 1.5g granules PL08637/0016. Salofalk 3g granules PL08637/0025; PA573/3/6. **Product licence holder:** Dr Falk Pharma GmbH, Leinenweberstr.5, D-79108 Freiburg, Germany. **Date of preparation:** December 2012. Further information is available on request.

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Date of preparation: August 2013

DrF13/138

PROGRAMME

Park Avenue Hotel, Belfast
October 7th 2016

09.00	**Registration**
09.30	**Colorectal and IBD session**
09.30	**Abstract presentations (2)**
09.50	***Pathology of colorectal polyps, benign and malignant: what's important and what's not?*** **Dr Maurice Loughrey,** Consultant Pathologist, Belfast Trust.
10.10	***Better use of existing drugs and new drugs for the IBD clinic.*** **Dr Charlie Lees,** Consultant Gastroenterologist, Edinburgh Royal Infirmary
10.30	***The UK IBD registry- where will it lead us?*** **Mr Richard Driscoll,** Chief Executive, The UK IBD Registry
11.00	**Coffee, Poster Viewing & Meet the Industry**
11.30	**Medical informatics-How will this improve healthcare?**
	Better interactive patient management in NI with the Electronic care record – what is the future? **Prof Roy Harper,** Consultant Physician and Endocrinologist, Ulster Hospital Dundonald
11.50	***Improving outcomes in IBD: results from a fully commissioned care pathway.*** **Dr Bu Hayee,** Clinical Lead, Kings College London
12.10	***Smart phone applications to assist with IBD care including the new IBD app.*** **Dr Gareth Parkes,** Consultant Gastroenterologist, Barts Hospital London
12.30	**Abstract presentations (2)**
13.00	**Lunch, Poster Viewing & Meet the Industry**
14.00	**Hepatology**
14.00	***Transplantation in alcohol related liver disease.*** **Professor John O'Grady,** Professor of Hepatology, Kings College London
14.20	***Modernising hepatology services in the 21st century*** **Dr Johnny Cash,** Consultant Hepatologist, Belfast Trust.
14.40	***Obstetric hepatology- when to call a hepatologist?*** **Prof Catherine Williamson,** Professor of Women's Health, King's College London
15.20	**Abstract presentation (2)**
15.45	**Presentation of prizes and close of meeting**

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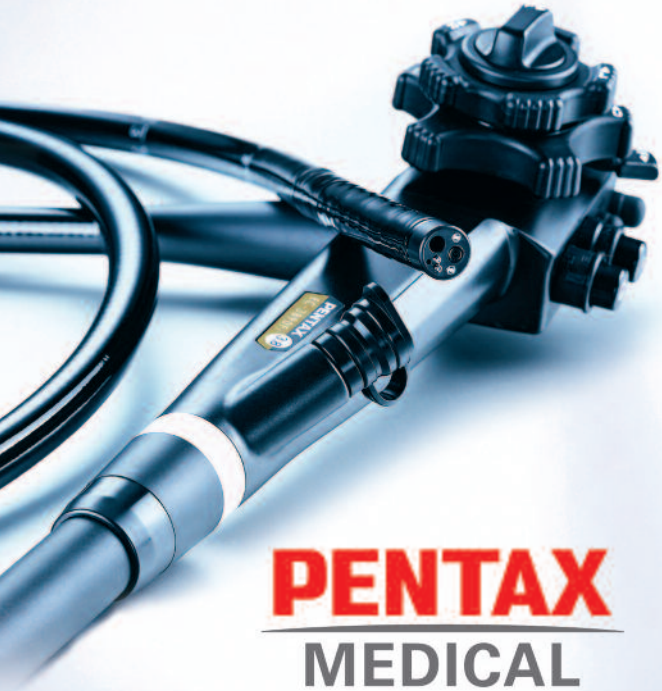

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Biographies

Mr Eamon Mackle

Consultant Surgeon Southern Trust
President USG

Eamon Mackle admits to being a Surgeon, albeit with interests in GI Surgery and the pelvic floor. He has been a Consultant in Craigavon Area Hospital since 1992. He is President of the Ulster Society of Gastroenterology and is a Past President of the Ulster Medical Society. He is a past member of council of AUGIS.
He is an Undergraduate examiner for QUB, RCSI and the Medical University of Bahrain. He is a member of the Intercollegiate Committee for Basic Surgical Examinations as well as a member of the OSCE Subgroup and ViceChair of the IMRCS Paper Panel.

Dr Patrick Allen

Consultant Gastroenterologist
Secretary USG

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 since 2012 and was on the organising committee for the BIG Meeting held in the Waterfront Hall in 2013. His main interests are IBD and Endoscopy.

Dr Jenny Addley

Consultant Gastroenterologist
Treasurer USG

Dr Jenny Addley Graduated from Trinity College Dublin in 2002 and completed her Gastroenterology Training in Northern Ireland Deanery. She is currently employed as a Consultant Gastroenterologist in the Ulster Hospital,Dundonald. Within Gastroenterology, Jenny has an interest in Hepatology and Quality Improvement, is a member of the Faculty of Medical Leadership and Management and has recently been appointed Alcohol Care Team Lead for the South Eastern Trust. Jenny is also involved with the BSG SWiG group (Supporting Women in Gastroenterology) and currently participates in their Mentorship Programme for new consultants.

Dr Maurice Loughrey

Consultant Pathologist, Belfast Trust.

Dr. Maurice Loughrey is a consultant gastrointestinal pathologist in the Royal Victoria Hospital, Belfast, and an Honorary Senior Lecturer with Queen's University Belfast. His main research interest is in colorectal cancer and bowel cancer screening pathology, for which he is the quality assurance lead for Northern Ireland and a member of the UK steering committee. He is the lead author of the Royal College of Pathologists dataset for reporting colorectal cancer and has recently led a revision of national reporting guidelines for bowel cancer screening pathology."

Dr Charlie Lees

Consultant Gastroenterologist,
Edinburgh Royal Infirmary

Dr Charles Lees trained in medicine at University College London with subsequent specialist training in Edinburgh, with doctoral studies in the Satsangi lab. Dr Lees has a large NHS clinical practice covering all aspects of luminal gastroenterology and endoscopy. His particular clinical expertise is in diagnostics, as well as the management of the Crohn's disease and ulcerative colitis.
In recognition of his clinical and research expertise he was awarded the prestigious European Rising Star in Gastroenterology Award in 2009.Dr Lees is a long-serving member of the European Crohn's and Colitis Organisation (ECCO) Education Committee and run several major international clinical courses for consultants and trainees in gastroenterology.

Mr Richard Driscoll

Chief Executive, The UK IBD Registry

Richard was Vice-Chair of the IBD Registry Board until December 2012 and is now working with the BSG as Development Lead for the IBD Registry. For many years until his recent retirement he was Chief Executive of Crohn's and Colitis UK, the primary UK patient organisation for patients who have Inflammatory Bowel Disease. Richard has been committed to improving healthcare services for IBD, chairing the group which developed national standards for IBD and playing a leading role in the UK IBD Audit, IBD Quality Improvement Project and the IBD Registry. Richard is Chair of the Board of HQIP, the body that administers government funding for national audits.

Prof Roy Harper

Consultant Physician and Endocrinologist, Ulster Hospital Dundonald

Dr Roy Harper has worked for the South Eastern Trust in Northern Ireland, (formerly the Ulster Community & Hospitals Trust) as a Consultant Physician and Endocrinologist from 1999. He has an honours degree in biochemistry (1984), an honours degree in medicine (1987) and obtained a Doctor of Medicine (MD) by thesis (1994) from Queen's University Belfast. He was elected as a Fellow of the Royal College of Physicians in 2000.

He is an experienced clinician and researcher and has a particular interest and considerable expertise in harnessing information and communication technologies to successfully enhance clinical care services for patients with diabetes and other chronic diseases. He has helped develop award-winning innovative remote monitoring technologies to support patients at home, multimedia educational materials to support patient education and has developed strong collaborative and productive links with the University of Ulster and was awarded a Visiting Professorship within the Faculty of Engineering (School of Mathematics and Computing) in 2006.

He is a clinical advisor to the Centre for Connected Health and sits on the Northern Ireland HSC ICT Programme Board. He is the Chairman of BCS Health Northern Ireland. He is also a key driver for the Northern Ireland Electronic Care Record pilot project which is now up and running. He has helped develop innovative patient monitoring systems to enhance the care of hospital inpatients and to improve patient safety. He is a champion for effective ICT developments within healthcare being involved in major system deployments and in testing hardware and software solutions. He is currently working towards an MSc in Healthcare Informatics.

Dr Bu Hayee

Clinical Lead, Kings College London

Dr Hayee qualified in the first ever batch of graduates from GKT Medical Schools in 1999. His specialist training was in and around London and Kent. After completing a PhD at University College London in 2010, he joined King's as a locum consultant in 2011, taking up a substantive post in 2012.

He is currently training lead for Endoscopy, also setting the PEG assessment service and introducing novel procedures like nasobridle, Endoclot and double balloon enteroscopy. With his other colleagues in the department of Gastroenterology, Dr Hayee leads development of the specialist Inflammatory Bowel Disease (IBD) clinic and wider service, emphasising closer links with the Department of Colorectal Surgery and creating a more patient-centred service.

After the trail blazed by Mr Amyn Haji, he undertook a visiting fellowship to Yokohama, Japan to study advanced therapeutic endoscopy techniques with Professor Haruhiro Inoue and Shin-ei Kudo. This will help provide a state-of-the-art service to local and regional patients.

He combines his two main interests (IBD and Endoscopy) in clinical service and research. He has projects investigating graft versus host disease of the gut, the influence of obesity on Crohn's disease, chromoendoscopy for colitis surveillance, and has an active interest in novel treatments for IBD.

Dr Gareth Parkes

Consultant Gastroenterologist, Barts Hospital London

Education

Queens' College Cambridge BA, MA

Bart's and the London Medical School - MBBS with distinction

King's College London - PhD - The role of the gastrointestinal bacteria in the development of irritable bowel syndrome

Current Roles

Consultant Gastroenterologist - Royal London Hospital, Bart's Health NHS Trust

Consultant Endoscopist and Gastroenterologist - London Independent Hospital

Consultant Gastroenterologist - LycaHealth - No 1 Westferry Circus

Interests

I have a specialist interest in luminal gastroenterology, in particular inflammatory bowel disease and irritable bowel syndrome. Within my NHS role I work in a team treating complex Crohn's and Ulcerative colitis that I am an experienced endoscopist competent in gastroscopy, flexible sigmoidoscopy, colonoscopy and polyp removal.

Inflammatory Bowel Disease

I have had experience in three major centres in inflammatory bowel disease and now am part of a team of IBD specialists at the Royal London. I have published in this area and I am actively involved with clinical trials of novel biological therapies. I have experience in specialist IBD endoscopy, novel biologic agents and complex IBD patients.

Irritable Bowel Syndrome

I have an active interest in irritable bowel syndrome or IBS, in particular in the role that diet and the gut microbiota play in the causes and treatment for this condition. I have published widely in this field in particular in the role that probiotic preparations can have in the treatment of IBS.

Endoscopy

I have broad range of endoscopic experience and I am competent in a wide range of diagnostic and therapeutic procedures including in the diagnosis of cancer, ulcers, Barrett's oesophagus, colitis, Crohn's disease, diverticular disease and polyps. In particular I specialise in difficult colonoscopy and polypectomy as well as working as a trainer within the NHS .

Professor John O'Grady

Professor of Hepatology, Kings College London

Professor John O'Grady graduated from the National University of Ireland (Galway) in 1978. After undertaking his general medical training in Ireland, he joined the Liver Unit at King's College Hospital, London, in 1984. His dual interests initially were acute liver failure and liver transplantation. He was appointed Consultant Hepatologist at St.James' Hospital in Leeds in 1992 but in 1996 returned to King's College Hospital where he currently works as Professor of Hepatology.

He has a long-standing interest in outcomes after liver transplantation. This is reflected in involvement in clinical trials directed at defining optimal immunosuppresssion (notably the TMC trial). The impact of recurrent disease on long-term outcome has also been of considerable interest to him.

He was President of the British Association for the Study of the Liver (BASL) from 2007-9. Currently he is Chairman of UK Transplant Liver Advisory Group. He is also Deputy Editor of the American Journal of Transplantation. He co-edited the textbook Comprehensive Clinical Hepatology (2 editions) and has numerous publications relating to clinical aspects of liver transplantation and acute liver failure.

Dr Johnny Cash

Consultant Hepatologist, Belfast Trust

Dr Johnny Cash is a consultant Gastroenterologist and Hepatologist in the Royal Victoria Hospital, Belfast. His main clinical interests are liver transplantation and the complications of cirrhosis, particularly portal hypertension. He also has an interest in healthcare modernisation and has recently been appointed assistant medical director for continuous improvement in the Belfast Health and Social Care Trust. He has been the co-lead for medicine and clinical lead of the programmed treatment unit in the Royal Victoria hospital since 2011. He has been on the board of the Irish society of Gastroenterology since election in 2011 and is chair of the DHSSPS Drug Treatment & support advisory committee. In his spare time he is a keen fell runner.

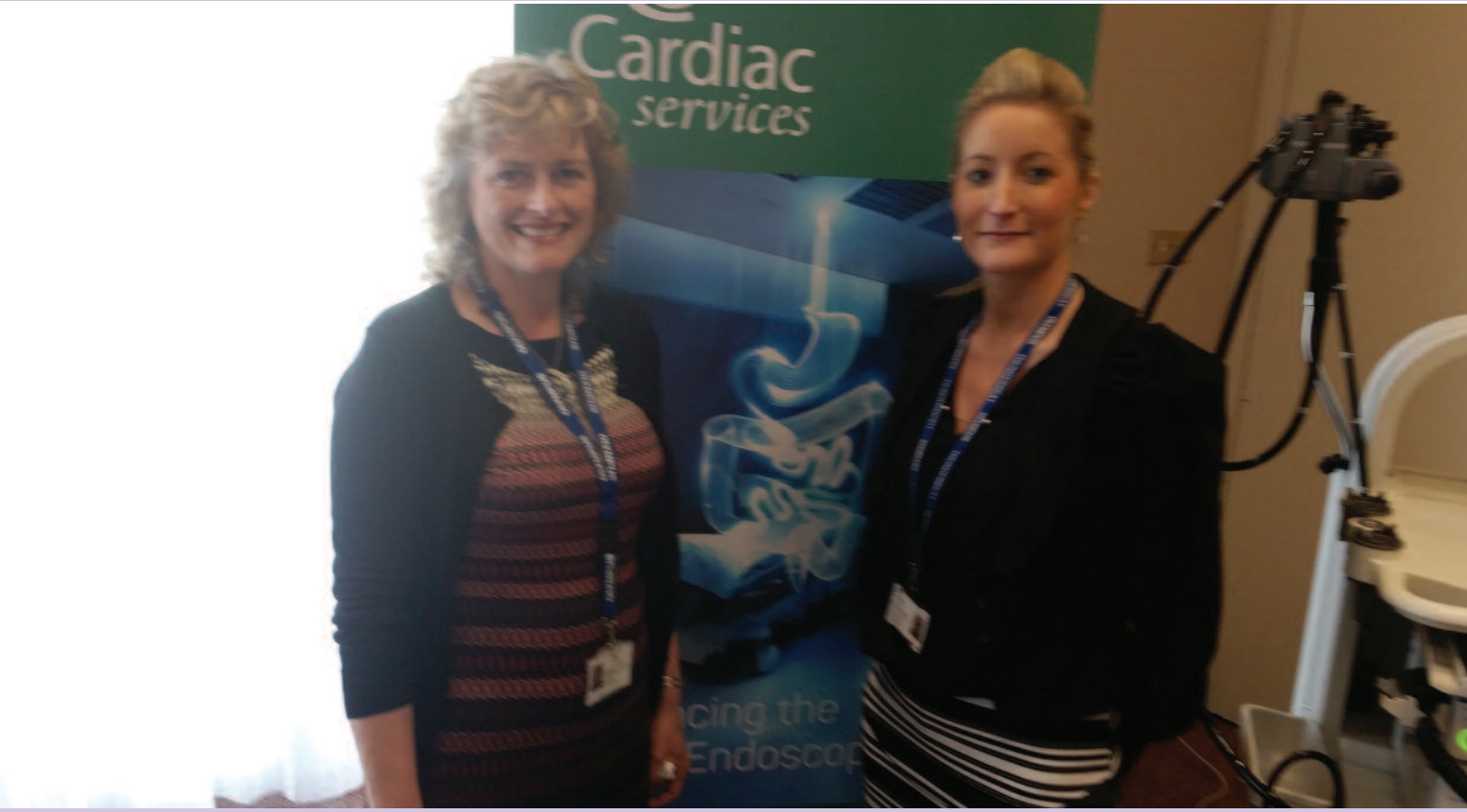
Prof Catherine Williamson

Professor of Women's Health, King's College London

Catherine Williamson took up the role of Professor of Women's Health at King's College London in 2013. Between 2007 and 2013, she was Professor of Obstetric Medicine at Imperial College. She is a leading clinical researcher in maternal medicine in the UK and internationally. Her principal research focus is on the maternal and fetal aetiology and outcomes of a common liver disease of pregnant women, intrahepatic cholestasis of pregnancy (ICP). She is part of the UK team running a clinical trial to find the best treatments. She also runs a research programme investigating gestational signals that influence alterations in lipids, glucose and bile acids in pregnancy. The group also focusses on the influence of intrauterine environment on the subsequent health of the offspring. Catherine uses a large database to study the outcome of tumours of endocrine glands in pregnant women in the UK, with the aim of improving treatment for affected mothers and their unborn babies. She also works on prediction of diseases in pregnant women. Catherine is an assessor of maternal deaths in the UK. Professor Williamson receives referrals to the specialist obstetric medicine clinic at St Thomas' Hospital from colleagues in the UK and internationally and regularly speaks about medical disorders of pregnancy at international courses and conferences.

USG Spring Meeting Belfast 2016

Dr Patrick Allen, supervising Q&A



Fiona Ross & Sarah-Jane Russell, Cardiac Services

Oral Presentations – USG Autumn Meeting 2016

Abstract no.	Author(s)	Abstract Title	Time
1	Helen Coleman	'Missed' oesophageal adenocarcinoma and high Grade dysplasia in Barrett's oesophagus patients: A large population-based study	9.30
2	Evelyn Ervine	Percutaneous Endoscopic Caecostomy - An endoscopic ACE procedure	9.40
3	Blain Murphy	Do premalignant conditions impact health and wellbeing? A mixed methods systematic review.	12.30
4	L Beth Getty	Dietary Inflammatory Index and the risk of colorectal Polyps within the Tennessee Colorectal Polyp Study	12.40
5	Emma Gardiner	Outcomes for home parenteral nutrition patients in Northern Ireland - a ten year review (2006-2016)	15.20

Poster Presentations – USG Autumn Meeting 2016

Abstract no.	Author(s)	Abstract Title
6	Mais Khasawneh	Recognition of Alcohol related brain damage on a Gastroenterology Unit.
7	John McGoran	Social Media in Gastroenterology: USG in the Twittersphere
8	Ronan T Gray	Statin use and survival in colorectal cancer: results from a Population-based cohort study and an updated systematic review and meta-analysis.
9	Andrew Spence	Risk of Adenocarcinoma in Gastric Atrophy and Intestinal Metaplasia: A systematic review and meta-analysis
10	Rebecca Little	Transforming Transition for Paediatric IBD patients in Northern Ireland
11	John McGoran	USG in the Twittersphere
12	Odhran Doherty	Gastric outlet obstruction in neurofibromatosis type 1: An uncommon manifestation and even rarer presentation

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Adverse events should also be reported to Vifor Pharma UK Ltd. Tel: +44 1276 853633

References:
1. Ferinject Summary of Product Characteristics
2. Vifor Pharma UK, Data on File 85
3. Evstatiev R *et al.* Gastroenterology. 2011; 141(3): 846–53
4. Kulnigg S *et al.* Am J Gastroenterol. 2008; 103(5): 1182–92
5. Ponikowski *et al.* Eur Heart J. 2015; 36(11): 657–68

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Date of Preparation: September 2016
Code: UK/FER/16/0258

Abstract 1 ORAL PRESENTATION 1

'Missed' oesophageal adenocarcinoma and high grade dysplasia in Barrett's oesophagus patients: a large population-based study

Author(s): van Putten M, Johnston BT, Murray LJ, Gavin AT, McManus DT, Bhat S, Turkington RC, Coleman HG.

Department(s)/Institutions: a Department of Research, Netherlands Comprehensive Cancer Organisation (IKNL), Eindhoven, the Netherlands.
b Department of Gastroenterology, Royal Victoria Hospital, Belfast Health and Social Care Trust, Belfast, Northern Ireland.
c Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland
d Northern Ireland Cancer Registry, Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland
e Department of Pathology, Belfast City Hospital, Belfast Health and Social Care Trust, Belfast, Northern Ireland.
f Department of Gastroenterology, Craigavon Area Hospital, Southern Health and Social Care Trust, Belfast, Northern Ireland.
g Centre for Cancer Research and Cell Biology, Queen's University Belfast, Belfast, Northern Ireland

Aims/Background: A recent systematic review suggests that 25% of oesophageal adenocarcinomas (OAC) developing in Barrett's oesophagus (BO) patients are 'missed' at index endoscopy, however more population-based data are needed.

Method: Patients from the Northern Ireland BO register diagnosed between 1993-2010 were selected (n=13,159). Linkage to the Northern Ireland Cancer Registry identified patients who developed OAC or high-grade dysplasia (HGD) by end 2013. The main outcome was the proportion of HGD/OAC diagnosed within 3-12 months following BO diagnosis (potential 'missed' cases). Logistic regression analysis compared characteristics of 'missed' versus 'incident' HGD/OAC occurring after one year after incident BO.

Results: There were 267 patients diagnosed with HGD/OAC at least three months after BO diagnosis, of which 34 patients (12.7%) were potential 'missed' cases. The proportion of 'missed' HGD/OAC increased to 25% within patients with low-grade dysplasia (LGD) compared to 9% of non-dysplastic BO patients. Older age carried a higher risk of 'missed' compared with incident HGD/OAC. Non-dysplastic BO patients were more likely to be detected with a 'missed' OAC (rather than HGD), compared with BO-LGD patients (89 v. 40% of 'missed' progression detected as OAC, respectively).

Interpretation: HGD/OAC may be 'missed' at index BO endoscopy in up to 13% of BO patients and 9% of non-dysplastic BO patients who progressed to HGD/OAC, which is significant but substantially lower than previously reported estimates. Higher rates of 'missed' HGD/OAC in LGD-BO likely reflect appropriate surveillance. Increased awareness, adequate biopsy sampling and identifying biomarkers may reduce the number of 'missed' cases.

Abstract 2 ORAL PRESENTATION 2

Percutaneous Endoscopic Caecostomy – An endoscopic ACE procedure.

Author(s): Ervine E, Carlile A, Kelly E, McCallion W

Department(s)/Institutions: Royal Belfast Hospital for Sick Children, Belfast

Background: Percutaneous endoscopic caecostomy (PEC) is an endoscopic modification of the antegrade continence enema (ACE) technique originally described by Malone in 1990. An ACE has become a popular way to treat refractory incontinence & constipation. Malone created an appendicostomy into the caecum via an open surgical procedure to give access to the colon for washout without using the rectum. The PEC is created using the same principles as a Percutaneous Endoscopic Gastrostomy(PEG) insertion to place a device into the caecum that will allow colonic washout and achieve continence.

Aims: We present our experience with PEC procedure to show it is a safe technique that could be carried out by endoscopists.

Method: We undertook a retrospective review of PEC procedures carried out in RBHSC between 1999-2015. All procedures done by the same operator.

Results: Sixteen cases were identified (12 boys & 4 girls), age range 3 -14 years at placement. Underlying diagnosis was idiopathic constipation in 12, Anorectal malformation in 2, Intestinal neuronal dysplasia in 1 & Hirschsprungs in 1.
Complications included one granuloma around caecostomy site and one failed colonoscopy converted to an open procedure.
Eleven of the sixteen children went on to achieve improved bowel management. Four failed treatment for constipation with the PEC & went on to have stoma formation. One child died before use of the PEC.

Conclusions: PEC is a safe procedure with no significant endoscopy related complications. It negates having a formal open operation that can therefore is another skill for an endoscopist.

Abstract 3 ORAL PRESENTATION 3

Do premalignant conditions impact health and wellbeing? A mixed methods systematic review.

Author(s): Murphy B[1]*, McShane CM[1], Santin O[2], Treanor CT[1], and Anderson LA[1]

Department(s)/Institutions: 1. Cancer Epidemiology and Health Services Research Group, Centre for Public Health, Queen's University Belfast. 2. School of Nursing and Midwifery, Queen's University Belfast

Aims/Background: Background and Aims
Premalignant conditions, such as colorectal polyps and Barrett's oesophagus (BO) may impact on the health and wellbeing of patients however, no comprehensive assessment has been undertaken. We sought to systematically review the literature on the effects of precancerous conditions, including gastrointestinal disorders, on health and wellbeing.

Method: Databases PubMed, PsycInfo, Web of Science, EMBASE and Medline were searched from inception through to September 2016 to identify studies measuring quality of life

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(QoL) and/or the psychosocial impact of premalignant conditions. Studies were included if they included both patients with a confirmed premalignant condition, and a patient-/self-reported measure or qualitative assessment of QoL/psychosocial health. Meta-analytic procedures were undertaken to combine findings from quantitative questionnaires.

Results: In total, 93 articles, comprising of 14,465 patients (BO n=16 articles; Polyps n=8 articles; n=4782 patients) met the inclusion criteria. Preliminary analysis of generic and disease specific questionnaires suggests having a premalignant diagnosis may negatively impact a patients' QoL and psychological wellbeing. The qualitative data indicates that information seeking and uncertainty are key QoL/psychosocial concerns for patients. For BO and Polyps, the role of surveillance and changing of behaviours were key issues.

Discussion: Clinicians should be aware of the potential psychosocial impact of premalignant conditions. This is especially relevant in gastroenterology, as many patients with BO or polyps are on long-term care pathways, requiring continued support from their healthcare team.

Key word: Systematic Review, Barrett's oesophagus, Premalignant conditions, Colorectal polyps.

Abstract 4 ORAL PRESENTATION 4

Dietary Inflammatory Index and the risk of colorectal polyps within the Tennessee Colorectal Polyp Study

Author(s): L. Beth Getty1, Helen G Coleman1, Nitin Shivappa2,3, James R Hebert2,3, Reid M Ness,4,5 Walter E. Smalley,4,5 Wei Zheng,4,5 and Martha J Shrubsole4,5.

Department(s)/Institutions: 1 Centre for Public Health, Queen's University Belfast, Northern Ireland.
2 Cancer Prevention and Control Program, Department of Epidemiology and Biostatistics, Arnold School of Public Health, University of South Carolina, Columbia, SC, USA.
3Connecting Health Innovations LLC (CHI), Columbia, SC 29201, USA
4 Veterans Affairs Tennessee Valley Geriatric Research, Education and Clinical Center, Nashville, TN, USA
4 Division of Epidemiology, Department of Medicine, Vanderbilt Epidemiology Center, Vanderbilt-Ingram Cancer Center, Vanderbilt University School of Medicine, Nashville, TN, USA

Keywords: diet; inflammation; colorectal cancer; colorectal polyps.

Aims/Background: To understand the association between intake of dietary factors linked to the inflammatory response and risk of colorectal polyps using the dietary inflammatory index (DII), a previously developed measure of anti- and pro-inflammatory diet with higher scores referring to more pro-inflammatory diet.

Method: The DII was utilised to calculate the risk of developing polyps in a large colonoscopy-based case-control study that recruited 3246 controls, 1354 adenoma patients, 472 hyperplastic polyps (HP) and 363 patients with synchronous HP and adenoma. DII and lifestyle information were obtained through a food frequency questionnaire and telephone interview, respectively. Statistical methods included; unconditional logistic regression models and relevant confounders were tested to calculate odds ratios (OR) and 95% confidence intervals (CI) for polyp risk according to categories of the DII.

Results: Quartiles of the DII were compared, and the highest DII was associated with statistically significant increased risks of HP (OR 1.46, 95% CI 1.06, 2.01 p for trend 0.04), adenomas (OR 1.38, 95% CI 1.12, 1.70, p for trend 0.04), and sessile serrated adenomas (OR 2.43, 95% CI 1.52, 3.89, p for trend <0.001) in comparison to the lowest DII quartile . Similar statistically significant associations were observed between the DII and risks of single or multiple polyps, and polyps located in either the left or right side of the colorectum. The positive association between the DII and polyp risk was consistent across strata of body mass index, smoking status and NSAID use categories. Conclusion: A high DII is associated with the risk of colorectal polyps, therefore promoting the importance of an anti-inflammatory diet may aid the prevention of colorectal polyps, the precursor to colorectal cancer.

Abstract 5 ORAL PRESENTATION 5

Outcomes for home parenteral nutrition patients in Northern Ireland – a ten year review (2006-2016).

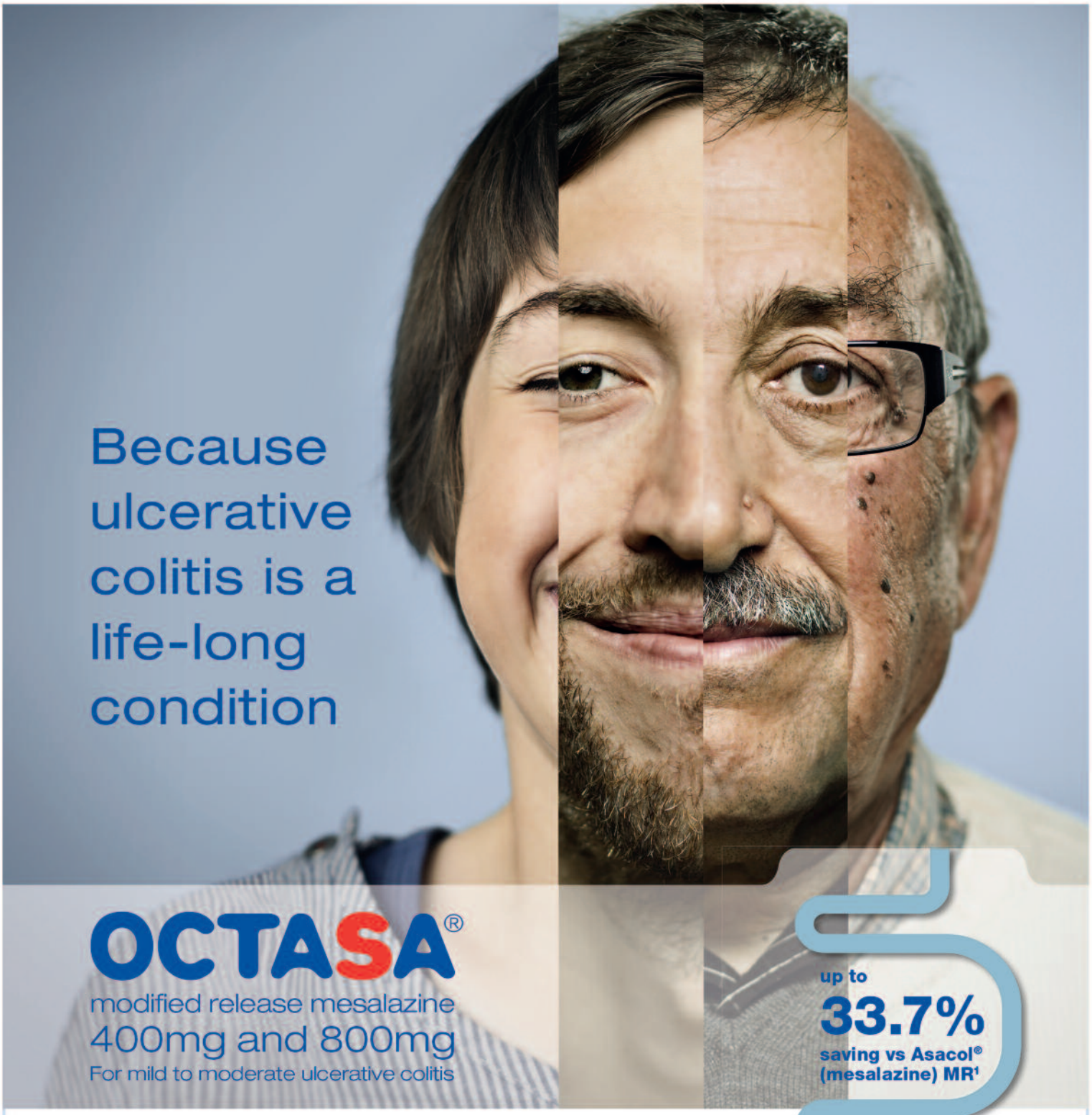
Author(s): E. Gardiner, E. Murray, G. Rafferty and G.B. Turner.

Introduction: Intestinal failure (IF) patients in Northern Ireland requiring home parenteral nutrition (hPN) are managed in the Belfast Trust. The aims of this review were to analyse the aetiology of IF; admission rates (particularly those due to catheter related blood stream infections (CRBSI)) and patient outcomes.

Method: Electronic records including radiology and microbiology results for all patients on hPN in Northern Ireland from 2006-2016 were reviewed.

Results: 86 patients used hPN between 2006-2016. One patient was excluded due to incomplete data. The average age at presentation was 51 (range 19-78). The mean number of days hPN was administered was 1072 (range 23-3834). The most common causes of IF were Crohn's disease (29%), surgical complications (22%) and mesenteric ischaemia (18%).
There were 414 admissions in the timescale - 137 admissions were due to CRBSI. The CRBSI rate was 1.5 per 1000 catheter days (previously 1.81 (1994-2014)). 43 patients had no infections (51%) and 10 had >5 infections, accounting for 55% of all CRSBI admissions.
The most common organisms identified were Gram negative organisms (38%) Coagulase Negative Staphylococci (34%); and Yeasts (11%).
28% of patients remain on home parenteral nutrition; 21 patients have had restoration of intestinal continuity.

Conclusions: Parenteral nutrition remains a safe treatment in the management of intestinal failure. Our CRBSI rate has reduced in the past 10 years, likely due to ongoing patient education and training.



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Abstract 6 POSTER PRESENTATION 1

Recognition of Alcohol related brain damage on a Gastroenterology Unit

Author(s): Khasawneh M, Watson J, Allen P , Addley J

Department(s)/Institutions: Departments of Gastroenterology and Addiction Psychiatry, South Eastern Trust.

Introduction: Alcohol Related Brain Damage (ARBD) is characterised by prolonged cognitive impairment with link to excessive alcohol ingestion and thiamine deficiency.

There is a current drive in Northern Ireland and elsewhere in the UK, to address the service needs for patients with ARBD.

Method: A questionnaire was distributed among health care professionals in a regional Gastroenterology unit to assess the overall awareness of ARBD, recognition and subsequent treatment with view to service development.

Results: 22 responses were collected (consultants, junior doctors and nurses) Each had variable exposure to ARBD patients on daily, weekly and monthly basis (n=2,11 & 9).
50% described problems with the detection and diagnosis of ARBD with delayed diagnosis in 32% and lack of special training 60%.
Regular challenges included managing behavioural difficulties, aggression and concerns regarding patient and staff safety in non specialised wards.
50% felt facilities for current management of ARBD required improvement. (No official Protocol (50%) ,lack of specialised unit (40%), lack of support on discharge (27%)
Suggestions for service development included a specialised unit,regional protocol for management, training to healthcare providers in dealing with ARBD patients,Increase psychiatric input and supportive rehabilitation facilities.

Conclusions: The study highlights the lack of services for ARBD patients in Northern Ireland leading to delayed diagnosis and initiation of appropriate treatment.

Early intervention into acute wards will significantly improve the outcome for these patients, and improve patient and staff safety on the wards. Investment is required to provide education, develop ARBD care pathways and a specific rehabilitation Unit in Northern Ireland.

Abstract 7 POSTER PRESENTATION 2

Social Media in Gastroenterology: USG in the Twittersphere

Author(s): McGoran J, Agnew P, Turner GB, Allen P

Department(s)/Institutions: Belfast City Hospital, Ulster Hospital

Social media has established itself in recent years as a valuable tool in medical professional development. In gastroenterology social media accounts have allowed for greater accessibility to educational resources and broadened professional debate. Lack of peer review, loss of privacy and interpersonal animosity are some commonly cited concerns.
Twitter is designed as a platform to share ideas rather than personal encounters, giving it an advantage over other social media in professional use. Posts of up to 140 characters encourage succinct communication and 'hashtags' can optimise connectivity by attaching reference labels.

An attitudes survey towards social media in gastroenterology and hepatology was conducted among NI trainees and all Belfast Trust consultants and specialty doctors. Responses from survey participants indicated that a minority use social media in their professional lives but over half would entertain this idea if the right opportunity was presented. A majority of responders strongly disagreed that a professional account should be used for 'social matters'.
A USG Twitter account has been established to give fellow members and delegates the opportunity to communicate in this way. By linking up with accounts for other societies and journals in gastroenterology and hepatology we hope to enhance exposure to the latest research, guidelines and opinions in our specialty.

Abstract 8 POSTER PRESENTATION 3

Statin use and survival in colorectal cancer: results from a population-based cohort study and an updated systematic review and meta-analysis.

Author(s): Gray RT, Coleman HG, Hughes C, Murray LJ, Cardwell CR.

Department(s)/Institutions: Cancer Epidemiology and Health Services Research Group, Centre for Public Health, Queen's University Belfast, Royal Victoria Hospital, Belfast BT12 6BA, Northern Ireland.

Introduction: Statins may have anti-cancer properties and possibly improve survival in colorectal cancer (CRC). In this study the association between statin use and survival in a population-based CRC cohort was assessed and an updated meta-analysis was performed.

Method: A cohort of 8,391 patients with newly diagnosed Dukes' A-C CRC (2009-2012) was identified from the Scottish Cancer Registry. This cohort was linked to the Prescribing Information System and the National Records of Scotland Death Records (until January 2015) to identify 1,064 colorectal cancer-specific deaths. Adjusted hazard ratios (HRs) and 95% confidence intervals (CIs) for cancer-specific mortality by statin use were calculated using time dependent Cox regression models. The systematic review included relevant studies published before January 2016. Meta-analysis techniques were used to derive combined HRs for associations between statin use and cancer-specific and overall mortality.

Results: In the Scottish cohort, statin use before diagnosis (HR=0.84, 95%CI 0.75-0.94), but not after (HR=0.90, 95% CI 0.77-1.05), was associated with significantly improved cancer-specific mortality. The systematic review identified 15 relevant studies. In the meta-analysis, there was consistent (I2=0%) evidence of a reduction in cancer-specific mortality with statin use before diagnosis (n=86,622, pooled HR=0.82, 95% CI 0.79-0.86) but this association was less apparent and more heterogeneous (I2=67%) with statin use after diagnosis (n=19,152, pooled HR=0.84, 95% CI 0.68-1.04).

Conclusions: In a Scottish CRC cohort and updated meta-analysis there was some evidence that statin use was associated with improved survival. However, these associations were weak in magnitude and, particularly for post-diagnosis use, varied markedly between studies.

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1. Available from: http://www.nice.org.uk/guidance/ta337 [Accessed January 2016].

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Abstract 9 POSTER PRESENTATION 4

Risk of Adenocarcinoma in Gastric Atrophy and Intestinal Metaplasia: a Systematic Review and Meta-analysis

Author(s): Spence AD[1], Cardwell CR[1], McMenamin UC[1], Hicks BM[1], Johnston BT[2], Murray LJ[1], Coleman HG[1]

Department(s)/Institutions: 1Cancer Epidemiology and Health Services Research Group, Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland, United Kingdom
2Belfast Health and Social Care Trust, Belfast, Northern Ireland, United Kingdom

Background: Gastric adenocarcinoma (GC) is the third leading cause of death from cancer worldwide. The mucosal changes of gastric atrophy (GA) and intestinal metaplasia (IM) are recognised pre-cancerous lesions. Accurate quantification of progression risk from GA / IM to GC is necessary to determine the feasibility of surveillance programmes.

Aims: This systematic review and meta-analysis examines the risk of GC in patients with GA or IM.

Method: Four databases were searched for relevant articles (EMBASE, MEDLINE, Web of Science, Cochrane Library) published up to 10th June 2016 that investigated the risk of developing GC in individuals with GA or IM. Independent data extractors assessed articles according to inclusion/exclusion criteria. Random effects meta-analyses were conducted to generate pooled estimates of cancer incidence.

Results: Fifteen relevant articles were identified, of which there were eight studies of GC incidence in GA and nine of GC incidence in IM patient populations (two articles investigated both GA and IM). The pooled estimate of GC in patients with GA and IM was 2.94 (Figure 1) and 2.63 (Figure 2) per 1,000 person-years, respectively, but there was marked heterogeneity for both (I2=94%, heterogeneity P<0.001; and I2=93%, heterogeneity P<0.001, respectively).

Conclusions: The overall annual incidence rate of GC in patients with GA or IM is 0.29% and 0.26%, respectively. The substantial heterogeneity supports the need for more robust studies.

Figure 1

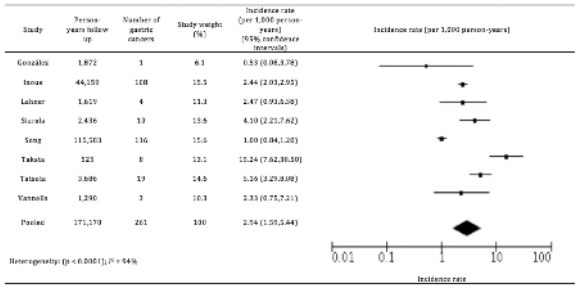
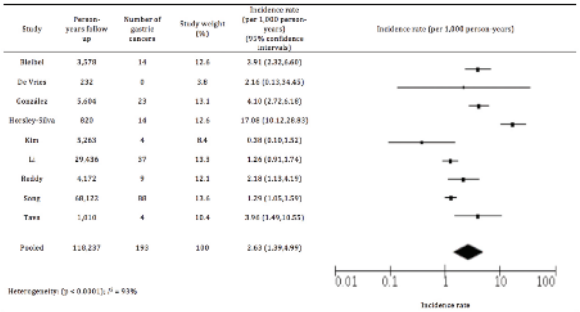


Figure 2



Abstract 10 POSTER PRESENTATION 5

Transforming Transition for Paediatric IBD patients in Northern Ireland

Author(s): Little R, McLoughlin L, Szabo A

Department(s)/Institutions: Paediatric Gastroenterology, Royal Belfast Hospital for Sick Children, Belfast Health and Social Care Trust

The Paediatric Gastroenterology team in Belfast has been continuously developing their service to facilitate efficient transfer of adolescent care to Adult Gastroenterology. Initially this process was by referral letter only however, in view of the increasing prevalence of Inflammatory Bowel Disease (IBD), establishing a well-structured transition clinic was essential. We sought to elucidate the level of preparedness for, and experience at, transition clinic from our adolescent attendees.

We devised a questionnaire which was distributed to all adolescent patients attending transition clinic over a six month period, which they completed anonymously. Data was then collated.

Of the twenty two patients surveyed 100% rated the quality of care at transition clinic as excellent or good. 100% agreed they were well supported by the medical and nursing staff present, 82% of which agreed the clinic adequately prepared them for moving to Adult Gastroenterology care. However, only 50% of patients knew their medication names and doses. 32% wanted more advice regarding symptom management and investigations. 75% of patients had ongoing dietetic and psychology input. Concern regarding continuity of these valuable services and the loss of a supportive relationship with the paediatric nurse specialist were the main perceived stressors and anxieties for our patient cohort.

Over the last eight years the Paediatric Gastroenterology team has successfully established transition clinics with all five trusts across the province. Collaboration between the Paediatric and Adult Gastroenterology teams in Northern Ireland has transformed the continuity, safety and patient experience for young people with IBD transitioning between our expert services.

Abstract 11 POSTER PRESENTATION 6

USG in the Twittersphere

Author(s): McGoran J, Agnew P, Turner GB, Allen P

Department(s)/Institutions: Belfast City Hospital, Ulster Hospital

Social media has established itself in recent years as a valuable tool in medical professional development. In gastroenterology social media accounts have allowed for greater accessibility to educational resources and broadened professional debate. Lack of peer review, loss of privacy and interpersonal animosity are some commonly cited concerns.
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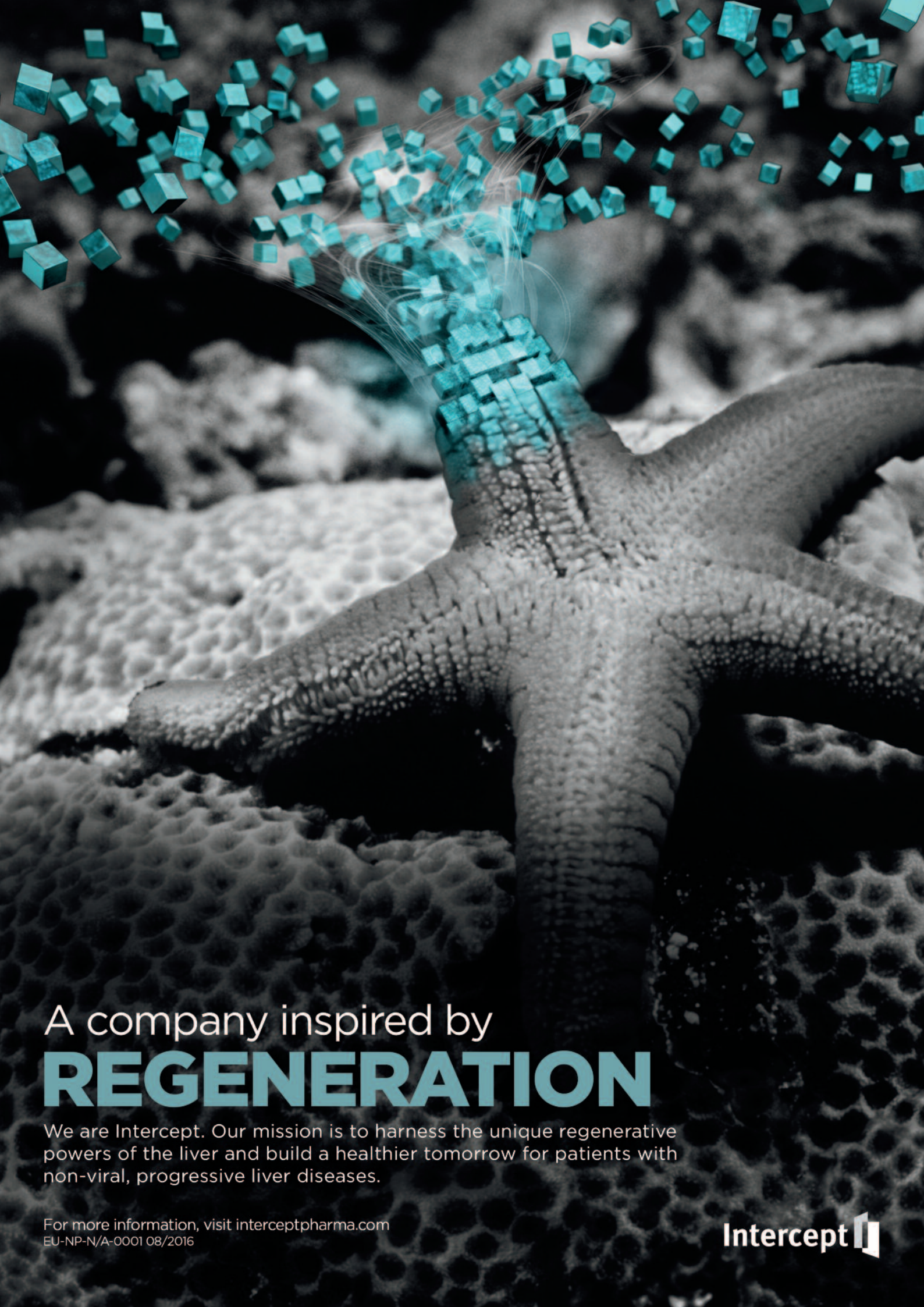
An attitudes survey towards social media in gastroenterology and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hepatology was conducted among NI trainees and all Belfast Trust consultants and specialty doctors. Responses from survey participants indicated that a minority use social media in their professional lives but over half would entertain this idea if the right opportunity was presented. A majority of responders strongly disagreed that a professional account should be used for 'social matters'.
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Abstract 12 **POSTER PRESENTATION 7**

Gastric outlet obstruction in neurofibromatosis type 1: an uncommon manifestation and even rarer presentation

Author(s): Doherty O, McGoran J, Scott R

Department(s)/Institutions: Department of Gastroenterology, Belfast City Hospital

A 70 year old gentleman presented to the Emergency Department with vomiting and significant weight loss over a four week period. Views on initial gastroscopy were limited due to a large residual gastric volume so a repeat procedure after prolonged fasting was arranged, where biopsies taken from the pyloric region proved insufficient for diagnosis. CT revealed a thickened gastric pylorus as well as a 5.5cm soft tissue mass arising from the fundus, consistent with gastrointestinal stromal tumour (GIST).
On examination it was evident that he had numerous limb lesions, axillary freckling and short stature consistent with neurofibromatosis type 1 (NF-1). This diagnosis generated considerable interest among the multidisciplinary team and after careful discussion he underwent total gastrectomy for the obstructing lesion of uncertain underlying pathology. Our patient may have been at significant risk of further gastroduodenal tumours had he undergone only a partial gastrectomy.
NF-1 is a rare autosomal dominant condition, with a 25% risk of developing GISTs. Diagnosis in older age is unusual and this presentation whereby it is diagnosed in patients presenting with gastrointestinal neoplasms is even more so. The condition not only has implications for patients but also for family members as they are prone to the same condition and associated neuroendocrine/gastrointestinal tumours. In everyday practice a high index of suspicion is required to allow early diagnosis and onward management.

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Date of Preparation: April 2016 PN/HCARE/004.16

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  - Anti-integrin with no identified systemic immunosuppressive side effects
- Recommended by NICE as an option:
  - For the treatment of adults with moderately to severely active UC when conventional therapy or a tumour necrosis factor alpha inhibitor (anti-TNF) are ineffective, no longer effective, or cannot be tolerated[2]
  - For the treatment of adults with moderately to severely active CD if an anti-TNF has failed (disease has responded inadequately or has lost response to treatment) or cannot be tolerated or is contra-indicated[3]

As part of the Entyvio risk management plan, patients should be monitored for any new onset or worsening of neurological signs and symptoms

Entyvio® (vedolizumab) PRESCRIBING INFORMATION

Refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: 300 mg powder for concentrate for solution for infusion. **Indication:** Adult patients with moderately to severely active ulcerative colitis(UC)/Crohn's disease (CD) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a tumour necrosis factor-alpha (TNFα) antagonist. **Dosage & Administration:** Treatment should be initiated and supervised by a specialist healthcare professional experienced in diagnosis and treatment of ulcerative colitis or Crohn's disease. Patients should be monitored during and after infusion in a setting equipped to manage anaphylaxis. Ulcerative colitis: Recommended dose regimen 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Reconsider treatment if no evidence of therapeutic benefit at week 10. If patients experience a decrease in response, they may benefit from increased dosage frequency to 300mg every 4 weeks. Corticosteroids may be reduced/discontinued in patients who respond to treatment with Entyvio. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Crohn's disease: Recommended dose regimen is 300mg administered by intravenous infusion over approximately 30 minutes at 0, 2, 6 weeks and 8 weeks thereafter. Patients who have not shown evidence of therapeutic benefit may benefit from a dose at week 10. Continue therapy every 8 weeks from week 14 in responding patients. Therapy should be discontinued if no evidence of therapeutic benefit is observed at week 14. If therapy is interrupted and needs to be restarted, Entyvio dosing every 4 weeks may be considered. Paediatric populations: No data available in children aged 0-17 years. Not recommended. Elderly patients: No dosage adjustment required. Renal or hepatic impairment: Entyvio has not been studied in these populations. No dose recommendation can be given. **Contraindications:** Hypersensitivity to Entyvio or any of the excipients. Active infections such as tuberculosis (TB), sepsis, cytomegalovirus, listeriosis and opportunistic infections such as Progressive Multifocal Leukoencephalopathy (PML). **Warnings and Precautions:** Patients should be observed continuously during infusions for signs/symptoms of hypersensitivity reactions. Patients should continue to be observed for two hours following infusion completion for the first two infusions and one hour for subsequent infusions. Infusion-related reactions (IRR): Hypersensitivity reactions have been reported, the majority were of mild to moderate severity. Discontinue treatment if anaphylaxis or other serious allergic reactions occur and institute appropriate treatment. In mild to moderate IRR, slow or interrupt infusion. Consideration for pre-treatment with antihistamine, hydrocortisone and/or paracetamol should be given prior to next infusion, for patients with history of mild/moderate IRR to Entyvio. Infections: Not recommended in patients with active, severe infections until infections are controlled. Consider withholding in patients who develop severe infection while on treatment with Entyvio. Before initiating treatment, patients must be screened for TB. If latent TB is diagnosed, anti-tuberculosis appropriate treatment must be initiated prior to Entyvio treatment. Progressive Multifocal Leukoencephalopathy (PML): No cases were observed in Entyvio clinical trials, but John Cunningham (JC) virus infection resulting in PML and death has occurred in patients treated with other integrin receptor antagonists and systemic immunosuppressive agents. A risk of PML cannot be ruled out. Monitor patients for any new or worsening neurological signs/symptoms. Malignancy: Underlying increased risk of malignancy in UC and CD. Immunomodulatory products may increase risk. Prior and concurrent use of biological products: No clinical data available for Entyvio use in patients previously treated with natalizumab or rituximab. Patients previously exposed to natalizumab should wait at least 12 weeks prior to initiating Entyvio therapy. Entyvio not recommended for concomitant use with biologic immunosuppressants as no clinical data available. Live and oral vaccines: Patients may continue to receive non-live vaccines. Patients recommended to be up-to-date with all appropriate immunisations prior to initiating Entyvio. Live vaccines may be administered concurrently only if benefit clearly outweighs risk. **Interactions:** No interaction studies performed. Concomitant administration of corticosteroids, immunomodulators (azathioprine, 6-mercaptopurine, and methotrexate) and aminosalicylates did not have a clinically meaningful effect on Entyvio pharmacokinetics. **Fertility, pregnancy and lactation:** Women of child-bearing potential should use adequate contraception and continue for at least 18 weeks after last Entyvio treatment. Since maternal antibodies are excreted in breast milk, decision whether to discontinue breast-feeding or discontinue/abstain from Entyvio should be made according to relative benefit to child of breast-feeding or to mother of Entyvio. **Undesirable Effects:** Very Common (≥1/10): nasopharyngitis, headache, arthralgia. Common (≥1/100, <1/10): bronchitis, gastroenteritis, URTI, influenza, sinusitis, pharyngitis, paraesthesia, hypertension, oropharyngeal pain, nasal congestion, cough, anal abscess, anal fissure, nausea, dyspepsia, constipation, abdominal distension, flatulence, haemorrhoids, rash, pruritus, eczema, erythema, night sweats, acne, muscle spasm, back pain, muscular weakness, fatigue, pain in extremities, pyrexia. Other serious undesirable effects (≥1/1000 to <1/100): respiratory tract infection, infusion site reaction, infusion-related reaction. **Refer to the SmPC for details on full side effect profile and interactions. Basic NHS Price:** £2,050. **Legal Classification:** POM. Marketing Authorisation: EU/1/14/923/001 300mg powder for concentrate for solution for infusion. Takeda UK Ltd is responsible for sale and supply of Entyvio in the UK. Further information is available from Takeda UK Ltd. Building 3, Glory Park, Glory Park Avenue, Wooburn Green, Buckinghamshire, HP10 0DF. Tel: 01628 537900 Fax: 01628 526617.
PI Approval Code: UK/EYV/1511/0240
Date of revision: November 2015.

Please refer to the summary of product characteristics for details on the full side-effect profile and drug interactions of Entyvio. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.
Adverse events should also be reported to Takeda UK Ltd. Tel- 01628-537900

Reference 1. Entyvio® Summary of Product Characteristics. http://www.medicines.org.uk/emc/medicine/28980. Last accessed April 2016 **2.** National Institute for Health and Care Excellence final appraisal determination - Vedolizumab for treating moderately to severely active ulcerative colitis. March 2015 **3.** National Institute for Health and Care Excellence final appraisal determination - Vedolizumab for treating moderately to severely active Crohn's disease after prior therapy. July 2015

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