Autumn Meeting

Park Avenue Hotel, Belfast
Friday October 12th, 2018

usg Ulster Society of Gastroenterology

DEC™ Video Duodenoscope
ED34-i10T2

New Elevator Every Time.

PENTAX MEDICAL

Disposable Elevator Cap (DEC™) allows simplified reprocessing and increased cleaning capability.

Setting the new standard in ERCP

The PENTAX Medical Solution

The innovative design of the PENTAX Medical DEC Duodenoscope introduces a unique solution in the market and simplifies the overall reprocessing process.

Distal end with open access incorporating Single Use Elevator

The DEC™ Duodenoscope distal end, a crucial element for the prevention of patient infection, has been designed to offer easier access for brushing.

35%

reduction in steps for distal end reprocessing*

In comparison to the standard duodenoscopes of major manufacturers. Source: PENTAX Medical internal benchmarking.

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Welcome to Autumn USG 2018

Dear Colleagues and Friends,

It is a great pleasure to welcome you to the Autumn USG. It is a real extravaganza with a number of highly relevant and important topics being considered: missed early lesions at endoscopy by the BSG leaders in this field (Nigel Trudgill and John Anderson); a debate on the roles of Medicine and Surgery in IBD by Jill Somerville and Aidan Armstrong, and a headline talk by Dr John Morris on what to do when things go wrong at endoscopy. Last but not least Mark Taylor is going to challenge us with his talk "Time for change". This meeting also incorporates abstracts on local research and a research-based talk on the evaluation of Barrett's dysplasia by Dr Myrtle van der Wel from Amsterdam, who is working on the international BOLERO study along with participants from Northern Ireland, including Helen Coleman. There is also a very interesting parallel programme for nurses during the morning.

The committee hopes that you will find the day informative and relevant to your work in gastroenterology. It is also a great chance to meet your colleagues and representatives from the pharma industry who so generously support our meetings. Please make a point of interacting with them.

If there are any topic(s) or format that you would particularly like to see at future USG's please discuss with one of the committee and maybe you would like to consider coming on the committee yourself-we are always happy to welcome new talent.
Enjoy the day.

Peter Watson
President USG

Intercept

APPROACHING PBC DIFFERENTLY AFTER 20 YEARS[1,2]

Introducing OCALIVA

OCALIVA offers an option for patients with inadequately controlled PBC on UDCA or as monotherapy for those who are unable to tolerate UDCA[1]

Engage with the pathway

OCALIVA is a first-in-class selective and potent FXR agonist. FXR is thought to play a crucial role in bile acid homeostasis and pathways controlling inflammation and fibrosis[1,3]

Proven efficacy

When OCALIVA was given in combination with UDCA,* almost 5 times as many patients achieved reductions in ALP and stabilisation of bilirubin levels at 12 months compared with UDCA alone.† The effects of OCALIVA were sustained over an additional 12 months of therapy in the open-label extension study[4]

OCALIVA is indicated for the treatment of primary biliary cholangitis (also known as primary biliary cirrhosis) in combination with UDCA in adults with an inadequate response to UDCA or as monotherapy in adults unable to tolerate UDCA.[1] OCALIVA has a conditional licence.

*UDCA was withheld from patients intolerant to UDCA.[4]
†35 patients receiving OCALIVA 10 mg + UDCA (48%) and 46 patients receiving OCALIVA titration + UDCA (46%) achieved the primary composite endpoint of ALP <1.67 x ULN with a ≥15% reduction from baseline and total bilirubin ≤ULN compared with 7 patients on placebo + UDCA (10%).[4]

OCALIVA▼
obeticholic acid

Abbreviated Prescribing Information
OCALIVA ▼ (obeticholic acid)
Please refer to the Full Summary of Product Characteristics (SmPC) before prescribing

Presentation: OCALIVA supplied as film-coated tablets containing 5 mg and 10 mg obeticholic acid.
Indication: For the treatment of primary biliary cholangitis (also known as primary biliary cirrhosis) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA or as monotherapy in adults unable to tolerate UDCA.
Dosage and administration: Oral administration. Hepatic status must be known before initiating treatment. In patients with normal or mildly impaired (Child Pugh Class A) hepatic function, the starting dose is 5 mg once daily. Based on an assessment of tolerability after 6 months, the dose should be increased to 10 mg once daily if adequate reduction of alkaline phosphatase (ALP) and/or total bilirubin have not been achieved. No dose adjustment of concomitant UDCA is required in patients receiving obeticholic acid. For cases of severe pruritus, dose management includes reduction, temporal interruption or discontinuation for persistent intolerable pruritus; use of bile acid binding agents or antihistamines (see SmPC).
Moderate to Severe Hepatic Impairment: In patients with Child-Pugh B or C hepatic impairment, a reduced starting dose of 5mg once weekly is required. After 3 months, depending on response and tolerability, the starting dose may be titrated to 5 mg twice weekly and subsequently to 10 mg twice weekly (at least 3 days between doses) if adequate reductions in ALP and/or total bilirubin have not been achieved. No dose adjustment required in Child Pugh Class A function. **Mild or moderate renal impairment:** No dose adjustments are required. **Paediatric population:** No data. **Elderly:** No dose adjustment required; limited data exists.
Contraindications: Hypersensitivity to the active substance or any excipients. Complete biliary obstruction.
Special warnings and precautions for use: After initiation, patients should be monitored for progression of PBC with frequent clinical and laboratory assessment of those at increased risk of hepatic decompensation. Dose frequency should be reduced in patients who progress from Child Pugh A to Child Pugh B or C Class disease. Serious liver injury and death have been reported in patients with moderate/severe impairment who did not receive appropriate dose reduction. Liver-related adverse events have been observed within the first month of treatment and have included elevations in alanine amino transferase (ALT), aspartate aminotransferase (AST) and hepatic decompensation.
Interactions: Following co-administration of warfarin and obeticholic acid, International Normalised Ratio (INR) should be monitored and the dose of warfarin adjusted, if needed, to maintain the target INR range. Therapeutic monitoring of CYP1A2 substrates with narrow therapeutic index (e.g. theophylline and tizanidine) is recommended. Obeticholic acid should be taken at least 4-6 hours before or after taking a bile acid binding resin, or at as great an interval as possible.
Fertility, pregnancy and lactation: Avoid use in pregnancy. Either discontinue breast-feeding or discontinue/abstain from obeticholic acid therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. No clinical data on fertility effects.
Undesirable effects: Very common (≥1/10) adverse reactions were pruritus, fatigue, and abdominal pain and discomfort. The most common adverse reaction leading to discontinuation was pruritus. The majority of pruritus occurred within the first month of treatment and tended to resolve over time with continued dosing. Other commonly (≥ 1/100 to < 1/10) reported adverse reactions are, thyroid function abnormality, dizziness, palpitations, oropharyngeal pain, constipation, eczema, rash, arthralgia, peripheral oedema, and pyrexia. Please refer to the SmPC for a full list of undesirable effects.
Overdose: Liver-related adverse reactions were reported with higher than recommended doses of obeticholic acid. Patients should be carefully observed, and supportive care administered, as appropriate.
Legal category: POM
Marketing authorisation numbers: EU/1/16/1139/001 & 002
Marketing authorisation holder: Intercept Pharma Ltd, 2 Pancras Square, London, N1C 4AG, United Kingdom
Package Quantities and Basic NHS cost: OCALIVA 5 mg and 10 mg £2,384.04 per bottle of 30 tablets.
Date of revision: 11th April 2018

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 Intercept Pharma Ltd on +44 (0)330 100 3694 or email: drugsafety@interceptpharma.com

Abbreviations: ALP, alkaline phosphatase; FXR, farnesoid X receptor; PBC, primary biliary cholangitis; UDCA, ursodeoxycholic acid.

References: 1. OCALIVA (obeticholic acid). Summary of Product Characteristics, 2018. 2. FDA Drug Approval Package: Urso (ursodiol) NDA# 020675. http://www.accessdata.fda.gov/drugsatfda_docs/nda/97/020675s015TOC.cfm (Last accessed March 2018). 3. Ding L, *et al*. Bile acid nuclear receptor FXR and digestive system diseases. *Acta Pharm Sin B* 2015;5:135–44. 4. Nevens F, *et al*. A Placebo-controlled trial of obeticholic acid in primary biliary cholangitis. *N Engl J Med* 2016;375:631–43.

UK-PP-PB-0286 August 2018

Ulster Society of Gastroenterology Autumn Meeting
Quality Improvement in Gastroenterology
12th October 2018

Programme

08.30 Registration

SESSION 1
Early diagnosis of GI cancers

Chairs: **Dr Peter Watson and Mr Eamon Mackle**

09.30 ***Post OGD Upper GI Cancer***
Dr Nigel Trudgill,
Consultant Gastroenterologist,
Sandwell and West Birmingham Hospitals

10.00 ***Post colonoscopy colorectal cancer***
Dr John Anderson,
Consultant Gastroenterologist,
Cheltenham General Hospital.

10.30 ***3 Free papers (8min+2min questions)***

11.00 **COFFEE - MEET-THE-INDUSTRY & POSTER VIEWING**

SESSION 2
Research and innovation

Chairs: **Dr Helen Coleman and Dr Philip Hall**

11.30 ***3 free papers (8min+2min questions)***

12.00 ***What makes an expert? The Global BOLERO Study in Barrett's dysplasia***
Dr Myrtle van der Wel,
Academic Medical Centre,
Amsterdam, The Netherlands

12.20 ***USG Bursary 2018 recipients: outline of planned work***
Dr Andy Spence,
Gastroenterology SpR
Mr Stephen McCain,
Surgical SpR

12.30 **LUNCH - MEET-THE-INDUSTRY & POSTER VIEWING**

SESSION 3
It's all about quality

Chairs: **Mr Tim McAdam and Dr Shivaram Bhat**

13.30 ***IBD Treatment Debate: Endoscopist v. Surgeon***
Dr Jill Somerville,
Northern HSCT
Mr Aidan Armstrong,
Consultant Surgeon,
Belfast City Hospital.

14.00 ***Endoscopy: What to do when things go wrong?***
Dr John Morris,
Consultant Gastroenterologist,
Glasgow Royal Infirmary.

14.45 ***Time for change***
Mr Mark Taylor,
Consultant Surgeon,
Mater Hospital, Belfast HSCT

15.15 **DEBATE AND PANEL DISCUSSION**

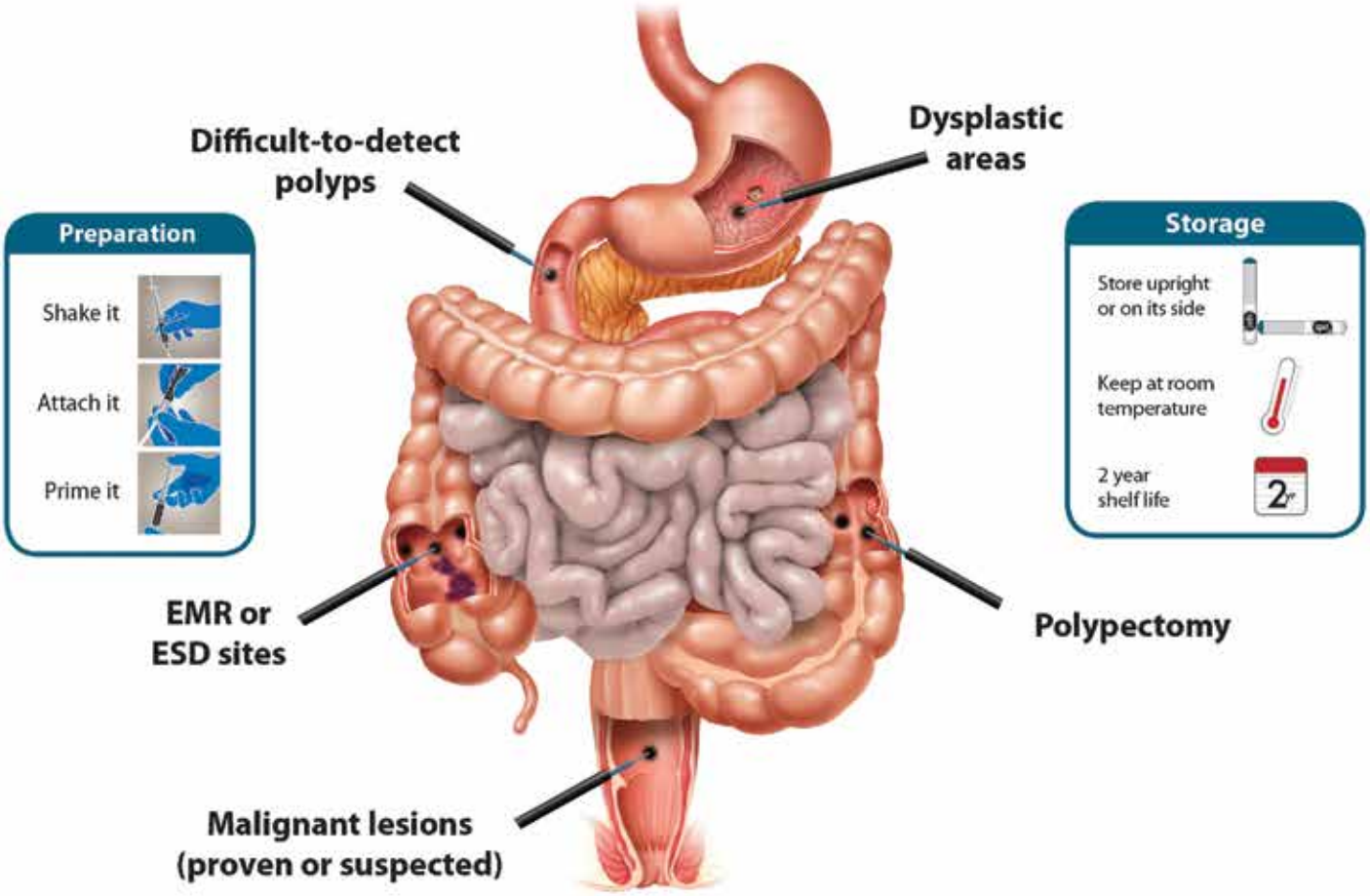
CLOSE OF MEETING

FEEDBACK

GI Supply
Specialty Endoscopic Products

Spot® Ex Endoscopic Tattoo

Take The NExt Step In The Fight Against Colon Cancer



Preparation

Shake it

Attach it

Prime it

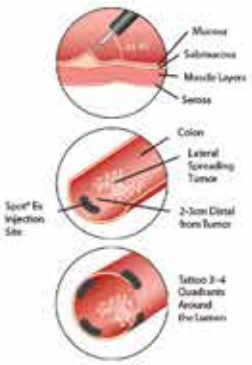
Storage

Store upright or on its side

Keep at room temperature

2 year shelf life

Submucosal Injection[1]



1. Place injection 2-3cm distal (downstream) of the area of interest.
2. Inject tangentially, at a 30-45° angle to the mucosa.[1]
3. Create a saline bleb to find the submucosal plane prior to injecting Spot Ex to reduce risk of transmural injection.[1]
4. Place Spot Ex tattoos in 3-4 quadrants around the lumen to increase likelihood of seeing it at follow-up.[1]
5. Use 0.5-0.75 mL per injection site, and no more than 8 mL per patient.[1]

Expanded indications support adoption of guidelines[1,2]

Expedite localisation at follow-up procedures[3]

Extra efficiency from new features

FLEETWOOD HEALTHCARE EXCELLENCE THROUGH INNOVATION

Contact Fleetwood Healthcare
Tel: (01)201-4620 | Email: sales@fleetwoodhealthcare.ie

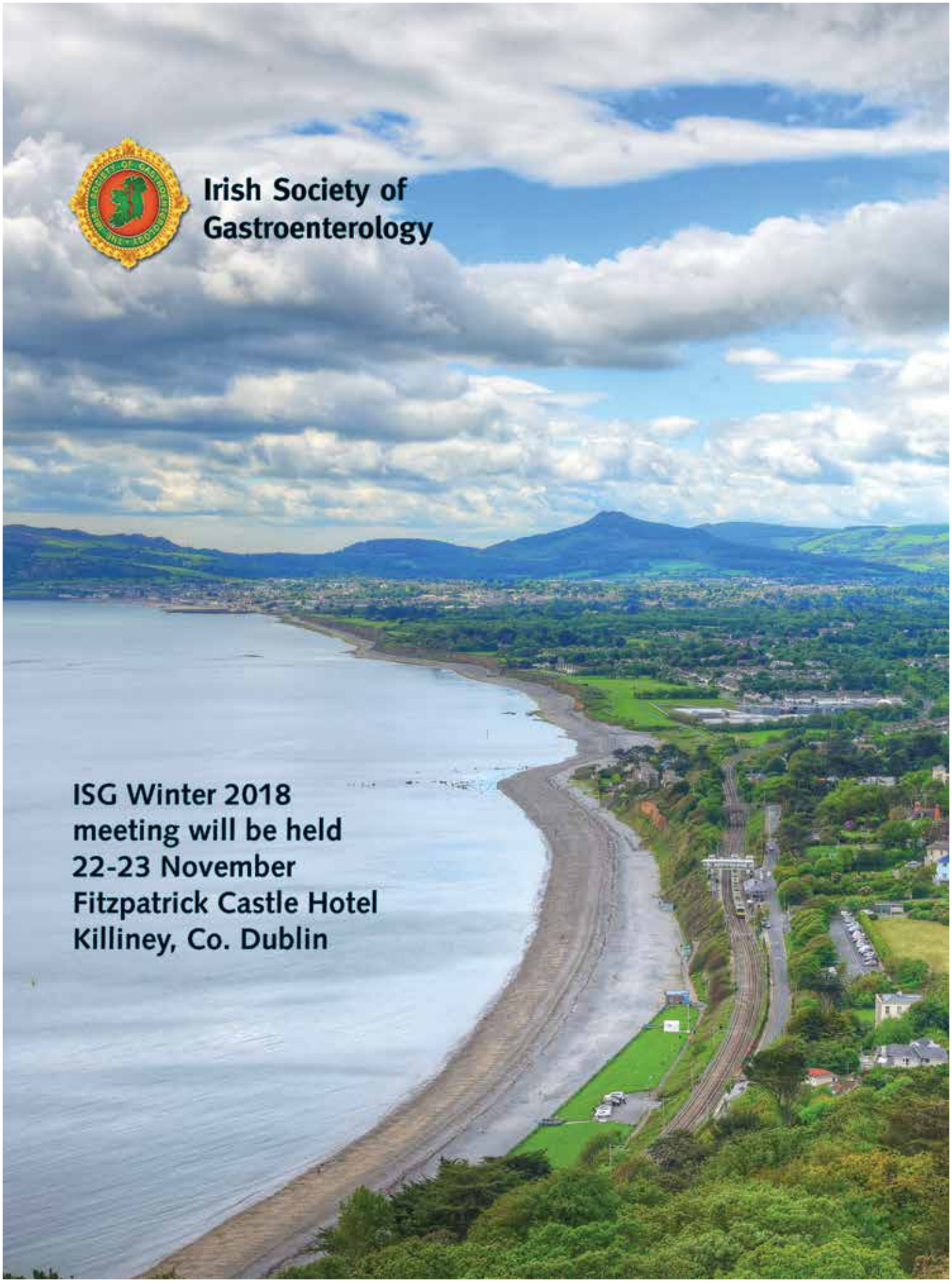
[1] Spot Ex Instructions For Use. G45-006 Rev 03. May 2018.
[2] Ferlitsch M, Moss A, Hassan C, et al. Colorectal polypectomy and endoscopic mucosal resection (EMR): ESGE Clinical Guideline. 2017.
[3] Easier identification at follow-up procedures as compared to no tattoo

Nurses Programme

USG 12 October 2018
at Park Ave Hotel, Belfast

9.30 - 10.10	**Alan Wilson** Gastroenterology Pharmacist Belfast Trust ***"Overview of biologic therapy in IBD- Challenges & Opportunities"***
10.10 - 10.50	**Dr Tracey Owen** Consultant in public health medicine at the PHA ***"Making bowel cancer screening bigger and better'"***
10.50 - 11.10	Tea/Coffee Break
11.10 - 11.50	**Dr Conor Braniff** Consultant Hepatologist, Belfast Trust. ***"TIPSS"***
11.50 - 12.30	**Prof. John O'Leary** Chair of Pathology, TCD & Lead in Cancer Research ***"Evolution and Revolution in Gastrointestinal Diagnostics"***
12.45	Lunch

The Northern Ireland Practice and Education Council for Nursing and midwifery (NIPEC) was established by the Northern Ireland Assembly in 2002 under the Health and Personal Social Services Act as an NDPB (Non Departmental Public Body) to support the development of nurses and midwives by promoting high standards of practice, education and professional development. NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.


Irish Society of
Gastroenterology
ISG Winter 2018
meeting will be held
22-23 November
Fitzpatrick Castle Hotel
Killiney, Co. Dublin

USG Executive Committee

President:
Dr Peter Watson,
Consultant Gastroenterologist
Royal Victoria Hospital, Belfast.

Hon Sec:
Dr Shivaram Bhat,
Consultant Gastroenterologist
Craigavon Area Hospital

Hon Treas:
Dr Philip Hall,
Consultant Gastroenterologist
Belfast Trust

Member:
Mr Eamon Mackle,
Consultant Surgeon
Craigavon Area Hospital.

Member:
Dr Patrick Allen
Consultant Gastroenterologist
South Eastern Trust

Member:
Dr Jenny Addley
Consultant Gastroenterologist
Ulster Hospital, Dundonald, Belfast

Member:
Dr Helen Coleman
Senior Lecturer in Cancer Epidemiology
Centre for Public Health
Queens' University Belfast

Member:
Mr Tim McAdam
Consultant Colorectal Surgeon
Belfast Trust

Organising Team

Michael Dineen
Chief Exec ISG /
Event Organiser USG

Cora Gannon
Administrator ISG/USG

oral once-daily

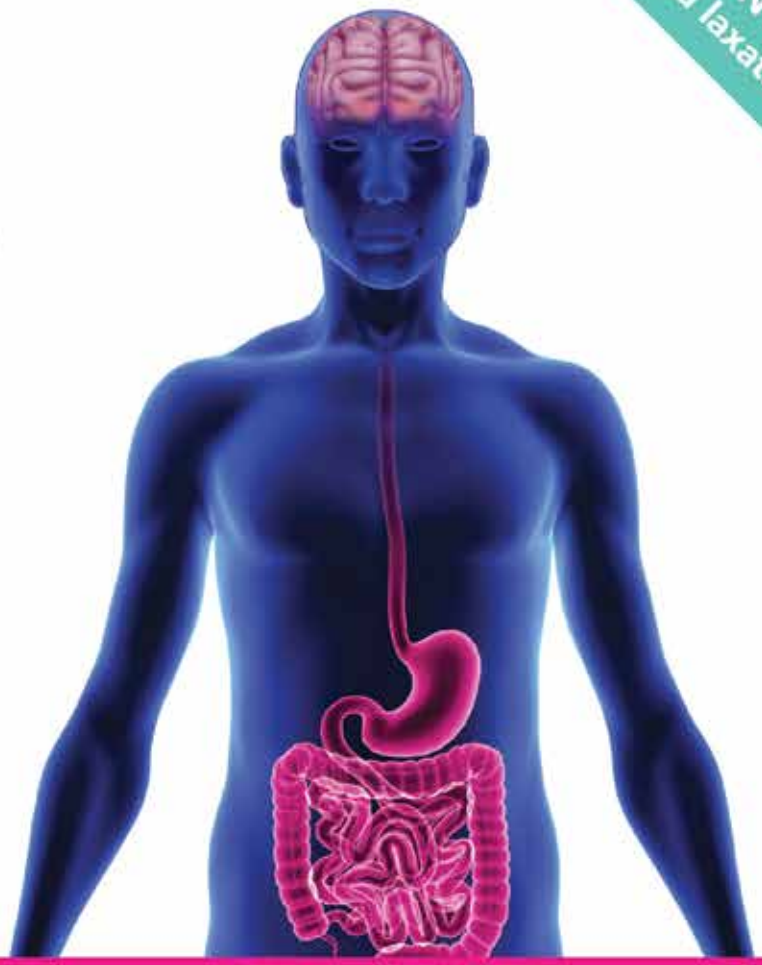
moventig®▼

naloxegol

MOVENTIG is not a laxative

TREATMENT OF OPIOID-INDUCED CONSTIPATION (OIC) SHOULD BE A NO-BRAINER

Indicated for the treatment of opioid-induced constipation in adult patients who have had an inadequate response to laxative(s)* **MOVENTIG 25mg once-daily** is a PAMORA† that treats OIC at its source in the bowel with minimal impact on opioid-mediated analgesic effects on the central nervous system (CNS).[1]



WHEN LAXATIVES FAIL TO RELIEVE OPIOID-INDUCED CONSTIPATION

MOVE TO MOVENTIG 25mg

* Definition of laxative inadequate responder (LIR): In the two weeks prior to first study visit patients had to have reported concurrent OIC symptoms of at least moderate severity while taking at least one laxative class for a minimum of four days during the pre-study period.[1]

† PAMORA: Peripherally-Acting Mu-Opioid Receptor Antagonist.

REFERENCES: 1. MOVENTIG Summary of Product Characteristics.

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

PRESCRIBING INFORMATION (prepared January 2018) Moventig 12.5mg and 25mg film-coated tablets*▼ (naloxegol oxalate). Consult Summary of Product Characteristics (SmPC) before prescribing

Indication: Opioid-induced constipation (OIC) in adult patients who have had an inadequate response to laxative(s) (concurrent OIC symptoms of at least moderate severity while taking at least one laxative class for a minimum of four days during the previous 2 weeks). **Dosage and administration:** Recommended 25 mg once daily. Take on empty stomach at least 30 minutes prior to first meal of day or 2 hours after first meal of day. Crushed tablets can be mixed with water (120ml) and drunk immediately or administered via a nasogastric tube (CH8 or greater). *Renal impairment:* Moderate to severe renal impairment starting dose 12.5mg. Discontinue if side effects impact tolerability. Increase to 25mg if well tolerated. *Hepatic impairment:* Use in severe hepatic impairment not recommended. *Moderate CYP3A4 inhibitors:* Starting dose 12.5mg, can be increased to 25mg if well tolerated. *Paediatric population (<18 years):* Safety and efficacy not yet established. **Adverse effects:** Consult SmPC for full list of side effects. *Very Common:* Abdominal pain, diarrhoea. *Common:* Nasopharyngitis, headache, flatulence, nausea, vomiting, hyperhidrosis. *Uncommon:* Opioid withdrawal syndrome. Not known: Hypersensitivity. **Contraindications:** Hypersensitivity to active substance or any of the excipients or any other opioid antagonist. Patients with known or suspected gastrointestinal (GI) obstruction or patients at increased risk of recurrent obstruction. Patients with underlying cancer who are at heightened risk of GI perforation, such as those with underlying malignancies of gastrointestinal tract or peritoneum, recurrent or advanced ovarian cancer or vascular endothelial growth factor (VEGF) inhibitor treatment. Concomitant use with strong CYP3A4 inhibitors. **Warnings and precautions:** Use with caution in patients with any condition which might result in impaired integrity of the gastrointestinal tract wall. Advise patients to discontinue therapy and promptly report if unusually severe or persistent abdominal pain develops. Use with caution in patients with clinically important disruptions to the blood brain barrier and observe for potential CNS effects. Discontinue if interference with opioid-mediated analgesia or opioid withdrawal syndrome occurs. Use with caution in patients taking methadone. If opioid withdrawal syndrome is suspected the patient should discontinue Moventig and contact their physician. Use with caution in patients with a recent history of myocardial infarction, symptomatic congestive heart failure, overt cardiovascular (CV) disease or with a QT interval of ≥500msec. Use with caution in OIC patients with cancer-related pain. **Use in pregnancy and lactation:** Not recommended. **Legal category:** POM. **Marketing Authorisation numbers:** Moventig 12.5mg x 30 tablets EU/1/14/962/001; Moventig 12.5mg x 30 x 1 film-coated tablets EU/1/14/962/008; Moventig 25mg x 30 tablets EU/1/14/962/005; Moventig 25mg x 30 x 1 film-coated tablets EU/1/14/962/010. **Further information available on request from the Marketing Authorisation holder:** Kyowa Kirin Ltd. Galabank Business Park, Galashiels, Scotland TD1 1QH, UK.

For the United Kingdom:
NHS cost: Moventig 12.5mg, 30 tablets, £55.20; Moventig 25mg, 30 tablets, £55.20.

ADVERSE EVENT REPORTING: 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 Kyowa Kirin Ltd. on +44 (0)1896 664000, email medinfo@kyowakirin.com

For the Republic of Ireland:

ADVERSE EVENT REPORTING: Adverse Events should be reported. Information about adverse event reporting can be found at www.hpra.ie. Adverse Events should also be reported to Kyowa Kirin Ltd. on +44 (0)1896 664000, email medinfo@kyowakirin.com

KYOWA KIRIN

Date of preparation: August 2018 **Code:** UKIRE/MOV/0170

Biographical Sketches

Dr Nigel Trudgill
Consultant Gastroenterologist,
Sandwell and West Birmingham Hospitals

Consultant Gastroenterologist, Deputy Medical Director and Responsible Officer at Sandwell and West Birmingham Hospitals NHS Trust, West Midlands, UK. Graduated Sheffield University in 1988. Chair of BSG oesophageal section committee and member BSG endoscopy committee.. Leads regional oesophageal manometry and reflux monitoring service. Screening Centre Director Sandwell and West Birmingham Bowel Cancer Screening Centre. Director of Royal College of Physicians Medical Workforce Unit. Current President of Midlands Gastroenterological Society. Current research interests in health informatics in gastroenterology and endoscopy quality.

Dr John Anderson
Consultant Gastroenterologist,
Cheltenham General Hospital

Dr John Anderson is a Consultant Gastroenterologist in Cheltenham, Gloucestershire and has a clinical practice mainly related to advanced therapeutic endoscopy, training and education. Dr Anderson provides a specialist tertiary therapeutic colonoscopy service for both symptomatic and screening patients in the Regional Bowel Cancer Screening Programme (BCSP). As National Endoscopy Training Lead, he was part of the National Endoscopy Team, formed to enhance UK endoscopy service provision and develop of training and educational programmes for nurses, doctors and trainees. He recently stepped down as Chairman of the BCSP accreditation committee. His current roles include Director of the Gloucestershire Endoscopy Training Centre, BCSP and BSG Endoscopy committee members, JAG and BCSP assessor. In 2017 he was appointed as Lead for National Quality Improvement in Colonoscopy (EQIP) in the UK.

Dr Myrtle van der Wel
Academic Medical Centre,
Amsterdam, The Netherlands

Dr. Myrtle van der Wel became interested in 'all things small' when, as a child, she joined her mother (a medical microbiologist) in the laboratory during weekend shifts. She finished medical school in 2012. After working as an Internal Medicine resident for one year, she started her PhD in September 2013 at Gastroenterology and Pathology departments of the Academic Medical Center in Amsterdam (the Netherlands). The focus of her research project was 'Observer agreement in Barrett's oesophagus', in 2015 leading to the set-up of the national digital review panel for dysplastic Barrett's oesophagus. This review panel now employs 15 gastro-intestinal pathologists. As from January 2018, she started her residency in Pathology. She hopes to keep combining her clinical work with research.

Dr John Morris
Consultant Gastroenterologist,
Glasgow Royal Infirmary

Dr John Morris is a Consultant Gastroenterologist and Honorary Senior Lecturer at Glasgow Royal Infirmary. He is President of the Scottish Society of Gastroenterology, Director of the West of Scotland Regional Endoscopy Training Centre and Gastroenterology Specialty Advisor to Greater Glasgow and Clyde Health Board. Dr Morris was previously Clinical Director for Digestive Diseases at Glasgow Royal Infirmary and visiting Associate Professor of Medicine at the Medical University of South Carolina, USA.
Dr Morris has a strong clinical commitment in luminal Gastroenterology,and in particular, therapeutic endoscopy .He has been responsible for the introduction of several innovative techniques and procedures such as NOTES, Hemospray for nonvariceal upper GI bleeding and duodenal mucosal resurfacing for Diabetes Mellitus.
Dr Morris has demonstrated a strong commitment to Endoscopy Education and has been a member of the British Society of Gastroenterology and European Society of Gastrointestinal Endoscopy Committees. He has delivered several National and International Live Endoscopy Workshops on behalf of these organisations.
Dr Morris has published and has ongoing research interests in the field of Capsule Endoscopy and Small Bowel Enteroscopy, Barrett's Endotherapy ,NOTES and metabolic endoscopy.
Currently he is leading a Multi-Society Acute Upper GI Bleeding Endoscopy Quality Improvement Project in the UK.

Mr Mark Taylor
Consultant Surgeon,
Mater Hospital, Belfast HSCT

Mr Mark A Taylor PhD FRCSI FRCS(Eng) FRCS(Gen Surg) is a Consultant HPB Surgeon at the Mater Hospital, Belfast Health and Social Care Trust. He is a Visiting Professor of Ulster University. He trained in Belfast and at the Regional HPB and Transplant Unit in Edinburgh. His Doctorate of Philosophy was in the pathophysiology of obstructive jaundice. He is the President Elect of GBI Hepato-pancreato-biliary Association (GBIHPBA), Director of Education and Training in AUGIS and board member of the Medical Advisory

Board of Bowel Cancer UK. In 2016, he was appointed by the Health Minister to an independent Expert panel tasked with Reconfiguration of Health and Social care in Northern Ireland. He is a member of the Transformation Implementation Group (TIG)in the Department of Health. In his spare time he is the District Surgeon and Trustee of St John Ambulance and a keen cyclist. He has published extensively in the field of Hepatobiliary Surgery.

Dr Jill Somerville
Consultant Gastroenterologist

I enjoyed training in gastroenterology in Northern Ireland and have been a consultant gastroenterologist for 4 years in Antrim hospital, including transitional IBD clinics and bowel cancer screening.

Alan Wilson
Gastroenterology Pharmacist Belfast trust, Clinical Pharmacist of the Year 2014.

As an experienced clinical pharmacist Alan provides expert pharmaceutical advice, supports new drug applications and the development of guidelines and protocols. He is also a pharmacist independent prescriber. Alan is well known for going that extra mile for his patients.

Dr Conor Braniff
Consultant Hepatologist
Royal Victoria Hospital, Belfast.

Professor John O'Leary
Chair of Pathology, TCD & Lead in Cancer Research

Professor John O'Leary holds the positions of Professor/Chair of Pathology, Trinity College Dublin, Director of Pathology, The Coombe Women and Infants University Hospital, Dublin, and Consultant Histopathologist, St. James' Hospital, Dublin, Ireland. His consultant diagnostic experience includes Gynaecological pathology, Breast pathology, Gastrointestinal pathology, Molecular diagnostic pathology and Cytopathology. Prof. John O'Leary heads a multi-investigator group of 40 scientists at TCD focused on the molecular characterisation of several cancer systems including: Ovary, cervix, prostate, thyroid and head and neck cancer and cancer stem cell biology and the diagnosis of paediatric infections. In addition, the laboratory has a significant international reputation in the area of pregnancy proteomics and transcriptomics.

USG Committee Members

Dr Peter Watson,
President USG

Since 1991 Dr Watson has been consultant gastroenterologist at the Royal Victoria Hospital and senior lecturer in the Centre of Medical Education at Queen's University Belfast, where he is Academic Clinical Lead for Undergraduate Medicine. He was elected President of the Ulster Society of Gastroenterology in October 2016 .
His research interests have been in coeliac disease and more latterly Barrett's oesophagus and oesophageal cancer. He is on the Trials Management Group of AspECT (Aspirin and Esomeprazole Chemoprevention Trial of Oesophageal Cancer in Barrett's Oesophagus) and is co-lead of the recently formed Northern Ireland GI Research Network, which aims to promote research in gastroenterology in the clinical community.
He is serving a second term on the Oesophageal Committee of the British Society of Gastroeterology and has been an author on the BSG guidelines for Barrett's oesophagus and the forthcoming guidelines on oesophageal strictures.
He is an enthusiastic advocate of promoting excellence in medicine by means of shared experience and ideas with experts and peers at educational meetings such as BIG**Dr**

Shivaram Bhat
Consultant Gastroenterologist
Hon Secretary USG

Dr Shivaram Bhat is a consultant Gastroenterologist at Craigavon Area Hospital in Northern Ireland. He graduated from Queens University Belfast medical school (2002) with subsequent postgraduate training in Northern Ireland and a clinical fellowship at the John Radcliffe Hospital in Oxford. During his postgraduate training he completed a PhD researching cancer progression in Barrett's oesophagus. His clinical and research interests include inflammatory bowel disease and early detection of GI cancer. He is a bowel cancer screening endoscopist and is the IBD lead for the Southern Health and Social Care Trust.

Dr Philip Hall
Consultant Gastroenterologist
Belfast Trust
Hon Treasurer USG

Dr Philip Hall has recently been appointed consultant gastroenterologist within the Belfast Trust. He graduated from Queens University Belfast in 2008 and completed gastroenterology training in Northern Ireland. He has a Masters degree in Clinical Education.
He completed an advanced therapeutic endoscopy fellowship in St Michael's Hospital, Toronto in 2017 and has interests in upper GI therapeutics, ERCP and quality improvement.

Dr Patrick Allen
Consultant Gastroenterologist

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 is a past Secretary for the Ulster Society of Gastroenterology 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

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.

Mr Eamon Mackle
Consultant Surgeon Southern Trust

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 a past president of the Ulster Society of Gastroenterology and also 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 Helen Coleman
Senior Lecturer Queen's University Belfast

Dr Helen Coleman is a Senior Lecturer in Cancer Epidemiology at the Centre for Public Health at Queen's University Belfast, and previously studied there during her PhD and postdoctoral research projects. She has also spent time conducting research at Vanderbilt University, Nashville, TN, USA, Ulster University, and at the MRC-Human Nutrition Research centre in Cambridge, England. Dr Coleman's general research interests are in cancer epidemiology, particularly modifiable risk factors for progression from pre-cancerous conditions to cancer and factors associated with recurrence or survival after a cancer diagnosis. She is also involved in health services research projects that aim to optimise how individuals are treated and followed-up after a diagnosis of a pre-malignant condition or cancer, including analysis of Northern Ireland Bowel Cancer Screening data. Her strong interests are in cancers of the digestive tract, especially colorectal polyp/cancer, and oesophageal adenocarcinoma/ Barrett's oesophagus epidemiology.

Mr Tim McAdam
Consultant Colorectal Surgeon
Belfast Trust

I am a Consultant Colorectal Surgeon and clinical Lead in Belfast Trust having worked as a Consultant in Aberdeen for 6 years.
I was a medical student in QUB and trained in North of Scotland and England. My main interests are management of colorectal cancer, member of specialist endometriosis team and pelvic floor disorders. I am a faculty member for RCSEd surgical skills, NOTSS, RCSEng strategies in emergency surgery. I am a recognised national trainer for laparoscopic colorectal surgery.

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Maintenance treatment: 2g once daily. *Sachets and 500mg tablet:* Children over 6 years old: Active disease: individual dosing, starting with 30-50 mg/kg/day in divided doses (total dose should not exceed 4g/day). Maintenance treatment: individual dosing, starting with 15-30 mg/kg/day in divided doses (total dose should not exceed 2g/day). *Enema:* Adults: one enema at bedtime. *Suppositories:* Adults: 1 suppository daily. ***Contraindications:*** patients with known hypersensitivity to salicylates or any of the excipients and patients with severe liver and/or renal impairment. ***Special Warnings and Precautions:*** Blood tests (differential blood count; liver function parameters such as ALT or AST; serum creatinine) and urinary status should be determined prior to and during treatment, at the discretion of the treating physician. Caution is recommended in patients with impaired hepatic function. PENTASA should not be used in patients with impaired renal function. 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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 Ferring Pharmaceuticals Ltd. Tel: 0844 931 0850. Email: medical@ferring.com

References: 1. Pentasa Slow Release Tablets 500 mg. SmPC. 2. Salofalk 250 mg/5ml Oral Suspension. SmPC. 3. Octasa 400 mg MR Tablets. SmPC. 4. Asacol 400 mg MR Tablets. SmPC. 5. Mesavant XL 1200 mg Gastro-resistant, Prolonged Release Tablets. SmPC. 6. Salofalk 500 mg Gastro-resistant Prolonged Release Granules. SmPC. 7. Colazide 750 mg Capsules. SmPC. 8. Olsalazine Sodium 250 mg Capsules. SmPC. 9. Salazopyrin En-Tabs. SmPC. 10. Salazopyrin Tablets. SmPC. 11. Probert C.S.J. et al. J Crohn's Colitis 2014;8:208–7 12. Mathew, P. et al. Gut 2005;54(7):980–5 13. Dignass A.U. et al. Clin Gastroenterol Hepatol 2010;7(7):782–9 14. Bokemeyer B. et al. J Crohn's Colitis 2012;6:415–82. 15. Fiorino G. et al. Aliment Pharmacol Ther 2013;37(8):787–75. 16. Pentasa Slow Release Tablets 1 g. SmPC. 17. Pentasa Sachet 1 g. SmPC. 18. Pentasa Sachet 2 g. SmPC. 19. Pentasa Sachet 4 g. SmPC. 20. Pentasa Enema 1 g. SmPC. 21. Pentasa Suppositories 1 g. SmPC.

Date of preparation: March 2018. Job code: PA/439/2018/UKa

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Oral Presentations - USG Meeting 2018

Ref. No.	Title of Paper:	Name	Time
101	Sex Hormone Receptor Expression In Oesophageal Adenocarcinoma And Recurrence And Survival: A Retrospective Cohort Study	Una McMenamin	10.30am
103	The Association Between Drinking Water Quality and Oesophageal Cancer Risk and Mortality: A Systematic Review	Ellen Creegan	10.40am
104	New strategies for offering hepatitis C treatment to 'difficult to reach' patient cohorts in Northern Ireland.	Rebecca O'Kane	10.50am
107	Vitamin D Receptor As A Marker of Prognosis In Oesophageal Adenocarcinoma: A Prospective Cohort Study	Stephen McCain	11.30am
109	A multicentre, retrospective cohort study into risk factors and outcomes for Clostridium Difficile in the Belfast Trust.	Gary Morrison	11.40am
110	The Association Between Smoking, Alcohol and Colon Cancer Survival By KRAS, BRAF, P53 and MSI status: A Molecular Pathology Epidemiology Cohort Study.	Nick Yeo	11.50am

Poster Presentations - USG Meeting 2018

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18A100	Laparoscopic Cholecystectomy is Safe and Feasible in Isolated Day-Case Units	Marian Seceleanu
18A102	Vedolizumab for Inflammatory Bowel Disease – Success or Failure?	Gary Dobson
18A105	Audit of Pre-assessment Care of Patients Undergoing Chemotherapy And Surgery for Early Stage Oesophageal and Gastro-Oesophageal Junction Adenocarcinoma	Rosalie Douglas
18A106	The Role of Nutritional Status in Oesophageal and Gastro-Oesophageal Junction Adenocarcinoma	Rosalie Douglas
18A108	Alcohol, Smoking, Related Biomarkers And Oesophageal Adenocarcinoma Survival: A Molecular Pathology Epidemiology Cohort Study In Northern Ireland	Stephen McCain

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ORAL PRESENTATIONS

Abstract No. USG A'2018 101
Sex Hormone Receptor Expression In Oesophageal Adenocarcinoma And Recurrence And Survival: A Retrospective Cohort Study

Authors:
ÚC McMenamin1, J Trainor2, HG Coleman1,4, DT McManus2, BT Johnston3, RC Turkington4
Institution:
1 Cancer Epidemiology Research Group, Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland.
2 Department of Pathology, Belfast Health and Social Care Trust, Belfast, Northern Ireland.
3Department of Gastroenterology, Royal Victoria Hospital, Belfast Health & Social Care Trust, Belfast, Northern Ireland.
4Centre for Cancer Research and Cell Biology, Queen's University Belfast, Belfast, Northern Ireland.

Introduction:
A striking epidemiological feature of oesophageal adenocarcinoma (OAC) is its unexplained male predominance, suggesting a protective effect for oestrogens, but few studies have investigated expression of sex hormone receptors in OAC.

Aim:
To evaluate Estrogen Receptor (ER) α and β and Androgen Receptor (AR) tumour expression in OAC and investigate associations with recurrence and survival.

Methods:
We identified 148 OAC patients who underwent neo-adjuvant chemotherapy prior to surgical resection between 2004-2012 at the Northern Ireland Cancer Centre. Immunohistochemical expression of ERα, ERβ and AR was determined and Cox proportional hazards regression was used to calculate hazard ratios (HR) and 95% confidence intervals (CI) for associations between sex hormone receptor expression and overall survival, cancer-specific survival and recurrence-free survival. Sensitivity analysis was conducted restricting analysis to patients with gastro-oesophageal junctional (GOJ) cancer.

Results:
A low proportion of OAC tumours stained positive for ERα (4%) and AR (3%) while one third stained positive for ERβ (31%). After a mean follow-up of 3 years (max 9 years), no significant associations were seen for ERα, ERβ or AR expression and OAC recurrence or survival. A borderline significant reduction in mortality was observed for positive ERβ tumour expression, when restricting to patients with GOJ cancer (adjusted HR 0.58, 95% CI 0.33, 1.03, p=0.06).

Conclusion:
In the largest study to date, we found little evidence of ERα or AR expression in OAC. We observed moderate expression of ERβ and there was suggestive evidence that its expression was associated with improved survival in GOJ cancer patients.

Abstract No. USG A'2018 103
The Association Between Drinking Water Quality and Oesophageal Cancer Risk and Mortality: A Systematic Review

Authors:
Creegan E, Kunzmann AT, van den Brandt P, Coleman HG
Institution:
Centre for Public Health, Queen's University, Belfast, County Antrim, N. Ireland; School for Public Health and Primary Care, Maastricht University, The Netherlands

Introduction: Current knowledge of risk factors for oesophageal cancer do not fully account for disparate oesophageal cancer incidence worldwide. Numerous studies have reported conflicting results regarding the association between drinking water quality and oesophageal cancer development, or related mortality, but this evidence has yet to be summarised.

Aim: To conduct a systematic review of evidence investigating the association between the quality of drinking water and oesophageal cancer incidence/mortality risk.

Methods: A search strategy was applied to four databases from inception to June 2018. Observational studies evaluating drinking water quality and oesophageal cancer risk or mortality in adults were included. Studies were categorised according to the measure of drinking water quality investigated (source, nitrogenous compounds, Ca/Mg, heavy metals and other). A random effects meta-analysis was conducted for studies evaluating drinking water source.

Results: Thirty-four studies were included, consisting of 14 case-control, four cohort and 16 ecological studies, that examined a variety of exposures relating to drinking water quality. The pooled risk estimate from six case-control studies (five from China and one from Iran) showed a significant increased risk of oesophageal cancer in individuals drinking non-tap water, compared with tap or piped water (relative risk 2.41, 95% confidence interval 1.42-4.08). Too much heterogeneity existed among other studies to enable meta-analyses.

Conclusions: Consuming water from non-piped sources was associated with a 2.4-fold increased risk of oesophageal cancer, comparing with tap water consumption. Further studies are needed to examine the specific contaminants in drinking water that may be involved in oesophageal cancer aetiology.

Abstract no. USG A'2018 104
New strategies for offering hepatitis C treatment to 'difficult to reach' patient cohorts in Northern Ireland.

Authors:
R O'Kane, O McCormick, K Patterson, G Wasson, A McCurley, N McDougall
Institution:
Regional Liver Unit, Royal Victoria Hospital, Belfast

Introduction:
Chronic hepatitis C virus (HCV) infection can lead to cirrhosis and associated complications. The advent of highly effective all-oral HCV treatments has revolutionised the management of HCV and led to discussions regarding the possibility of HCV eradication. In light of treatment advances, the focus of HCV treatment is moving towards identifying and treating 'difficult to reach' cohorts.

Method:
The Regional Liver Unit, RVH has modified its traditional outpatient service to target difficult to reach cohorts, namely prisoners and homeless patients.
For the prison cohort, outreach clinics were offered at a single prison site when the prison service identified sufficient patients for review.
For the homeless cohort, the Liver Unit liaised with the social services Outreach team and offered rapid access to a "One Stop Shop" (Consultant, nurse specialist, pharmacist, blood tests and Fibroscan all at single visit) within 4 weeks of referral. This initiative began in 2017 due to public health concerns regarding a cluster of new HCV cases in a homeless cohort.
These two interventions were reviewed to determine whether or not they led to a successful outcome (commencing treatment) for 'difficult to reach' patients.

Results:
Since Autumn 2016, 20 prisoners have been booked in to a hepatology clinic in Maghaberry prison. Three refused to leave their cells, 3 were not able to stay in NI for treatment, and 14 (70%) agreed to treatment (8 already started). An additional 27 prisoners have been referred for treatment of HCV but were released from prison before a clinic appointment could be offered. Seventeen (63%) of the 27 were lost to follow-up, 6 commenced treatment and 4 remain on the waiting list.
For the homeless cohort, 20 patients were referred since the 'one-stop-shop' began in Sept 2017. Only 6 (30%) engaged with the rapid assessment program and commenced treatment. The remaining 14 (70%) either failed to attend first appointment (8) or became too unstable to start treatment after being assessed (6).

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Conclusions:
70% of prisoners who are offered assessment while still in prison proceed to receive HCV treatment. However, if the offer of assessment/treatment waits until after release from prison, nearly two thirds are lost to follow-up. Therefore, efforts should be made to offer all HCV positive prisoners treatment before they leave prison.
Similarly, 70% of the homeless cohort fail to engage with a hospital based assessment despite support from Outreach teams and being prioritised for urgent appointments. New strategies delivering assessment in the community will be required to reach this cohort.

Abstract No. USG A'2018 107
Vitamin D Receptor As A Marker of Prognosis In Oesophageal Adenocarcinoma: A Prospective Cohort Study

Authors:
S McCain, J Trainor, DT McManus, ÚC McMenamin, S McQuaid, V Bingham, JA James, M Salto-Tellez, RC Turkington, HG Coleman
Institution
Centre for public health ICS-B Building, RVH Site, Grosvenor Road, Belfast, BT12 6BJ,

Background
Oesophageal cancer causes 400,000 deaths worldwide each year and ranks as the sixth most common cause of cancer mortality. 5-year survival rates range between 10% and 18%. In addition to early detection initiatives, there is a need to identify actionable, prognostic biomarkers to help predict patient outcome and also to identify novel therapeutic targets.
Aim
Vitamin D receptor (VDR) expression has been associated with survival in several cancer sites. This study aims to evaluate the association between VDR expression and prognosis in oesophageal adenocarcinoma patients.
Method
Oesophageal adenocarcinoma specimens and clinical data were collected from 130 patients treated with neo-adjuvant chemotherapy prior to surgical resection at the Northern Ireland Cancer Centre between 2004 and 2012. Tissue microarrays were created and immunohistochemical staining for VDR was performed on triplicate tumour cores from each resection specimen. Cox proportional hazards models were applied to evaluate associations between VDR, according to tertiles of expression, and survival outcomes.
Results
During a median of 2.5 (maximum 9) years of follow-up, 75 patients died. In analysis adjusted for confounders, higher VDR expression was associated with an improved overall survival (HR 0.49 95% CI 0.25-0.96) and disease-specific survival (HR 0.50 95% CI 0.26-0.99), when comparing the highest with the lowest tertile of expression. These associations were strongest in sensitivity analysis restricted to junctional tumours
Conclusions
This study is the first to demonstrate that patients with higher VDR expression in oesophageal adenocarcinoma have a more favourable prognosis. Further work is needed to validate these findings, and to define the role of VDR in the aetiology, progression and management of oesophageal adenocarcinoma.

Abstract No. USG A'2018 109
A multicentre, retrospective cohort study into risk factors and outcomes for Clostridium Difficile in the Belfast Trust.

Authors:
Morrison G, Brown A
Institution:
Belfast Trust

Background/Aim
Studies show that the incidence of Clostridium Difficile Infection (CDI) is rising in our hospitals. This study was compiled to analyse risk factors and outcomes of CDI positive patients in the Belfast Trust over a period of 12 months (Nov 2016-Nov 2017).
Method
Data was collected from 5 centres within the Belfast Trust totaling 85 patients. Age greater than 65 was included as a risk factor. Previous hospital admission (within 90 days of positive culture), antibiotic usage, regular Proton Pump Inhibitor use and Inflammatory Bowel Disease were recorded risk factors.
Results
Age and recent anti-microbial use were identified as major risk factors, 71.8% and 87.1% respectively. 70.6% had a recent hospital admission. PPI usage was also found to have a positive correlation to testing positive for CDI, with 48.2% of patients having used a PPI at some point preceding or during admission.
One patient in this study required surgical intervention (1.8% of cases) despite 4.7% developing Toxic Megacolon. 23.5% of the patients included in the study died during the admission, assumed at least in part, to be due to CDI.

Conclusions
The analysis verifies the previously known risk factors: age, antibiotic use and hospital admissions. Interestingly PPI usage ranked higher than IBD and previous infection as a risk factor. This leads us to question the appropriateness of PPI use in patients with pre-existing risk factors. This would be of particular concern as the data suggests that there is nearly a 1in 4 chance of death in the event of developing CDI in hospital.

Abstract No. USG A'2018 110
The Association Between Smoking, Alcohol and Colon Cancer Survival By KRAS, BRAF, P53 and MSI status: A Molecular Pathology Epidemiology Cohort Study.

Authors:
J Yeo,1 MB Loughrey,2,3 RT Gray,1 S McQuaid,2,4 JA James,2,3,4 M Salto-Tellez,2,3 DB Longley,2 HG Coleman.1,2
Institutions
1Cancer Epidemiology Research Group, Centre for Public Health, Queen's University Belfast, 2Centre for Cancer Research and Cell Biology, Queen's University Belfast 3 Department of Pathology, Belfast Health and Social Care Trust, 4 Northern Ireland Biobank.

Introduction
Previous studies have highlighted lifestyle factors in colon cancer survival. Smoking and alcohol may interact with features of tumour biology to influence patient outcomes.
Aim
To investigate the association between smoking status, alcohol intake and colon cancer survival by MSI, P53, KRAS and BRAF status, in a large population-based study.
Methods
Information from 661 patients who underwent surgery for their Stage II or III colon cancer between 2004 and 2008 in Northern Ireland were included. Follow-up and death information was retrieved via linkage to the Northern Ireland Registrar General's Office up to end 2013. Tissue blocks were retrieved via the Northern Ireland Biobank, and DNA extracted to determine mutations in BRAF, KRAS, P53 and MSI status. The association between lifestyle factors and survival was tested using Cox Proportional Hazard models, adjusting for key confounders.
Results
Smoking was associated with poorer outcomes in colon cancer patients, when investigating both all-cause mortality (HR 1.55, 95% CI 1.17-2.05) and colorectal cancer-specific mortality (HR 1.48, 95%CI 1.05–2.06). Stratified analyses by molecular features found this increased risk of colorectal cancer-specific death to be strongest in patients with MSI-high or P53 mutant tumours (HR 7.21 [95% CI 2.19 – 23.78]) and 1.69 [95% CI 1.10 - 2.56]), respectively. No associations were observed between alcohol intake and survival in colon cancer patients, which did not alter in analyses stratified by molecular subtypes.
Conclusion
Smoking was associated with poorer survival in Stage II and III colon cancer patients, particularly in those with MSI-high or P53 mutant tumours.

POSTER PRESENTATIONS

Abstract No. USG A'2018 100
Laparoscopic Cholecystectomy is Safe and Feasible in Isolated Day-Case Units

Authors:
M.J. Mullan, M.V.Seceleanu
Department of Surgery, South West Acute Hospital, Enniskillen, UK

Introduction:
Laparoscopic cholecystectomy is the treatment of choice for symptomatic cholelithiasis. To achieve NHS target plan to perform 60% of all elective cholecystectomies as day cases, laparoscopic cholecystectomy was introduced into most day surgery units.
Aims:
The aim of this study was to assess the safety and acceptability of day-case laparoscopic cholecystectomy in an isolated day-case unit.
Methods:
This is a prospective study of the first twenty-one laparoscopic cholecystectomies performed in the unit between October 2017 and June 2018. Causes of failed discharges, postoperative complications and readmission rates were recorded. Patient recovery was monitored by telephone questionnaire and satisfaction was assessed at outpatient follow up.
Results:
Twenty-one patients underwent laparoscopic cholecystectomy as a day case procedure. Nineteen patients were discharged on the day of surgery. Two patients were unplanned admissions and transferred to the nearby district hospital: one patient required further analgesia and one patient was transferred in view of surgery- no progression policy applied. Mean operation time was 65 min. Two patients were readmitted with wound infection and postoperative choledocholithiasis. There was no conversion to open cholecystectomy or return to theatre for emergency laparotomy. Twenty patients were satisfied with the service when reviewed in the clinic.
Conclusions:
Day-case laparoscopic cholecystectomy in an isolated day surgery unit is safe and feasible with an acceptable discharge rate and level of patient satisfaction. Success depends on patient selection and education, consultant led and delivered surgery, appropriate transfer protocols in place and a policy of non-progression when encountering unexpected difficult cases.

Abstract No. USG A'2018 102
Vedolizumab for Inflammatory Bowel Disease – Success or Failure?

Authors:
Dobson G, McGuigan A, McIlmunn C, Tan CJ
Institution:
Belfast Health and Social Care Trust

Background:
Infliximab & Adalimumab have long been indicated for induction of remission of Crohn's Disease (CD) and Ulcerative Colitis (UC). More recently Vedolizumab has been considered as a "rescue" therapy for unresponsive disease. However, there are no data to demonstrate if the use of Vedolizumab helps to prevent surgical intervention.
Aim:
To assess how successful Vedolizumab is in preventing progression to surgery
Method:
We performed a retrospective review of CD & UC patients who were commenced on treatment with Vedolizumab. Success was determined by induction of remission. Failure was determined are either cessation of the treatment or progression to surgical procedure.
Results:
48 patients had CD. Age at induction ranged 15-66 years. 33 (69%) patients failed to achieve remission on Vedolizumab – 9 had surgery, 24 were switched to a further Biologic agent – 8 of which subsequently had a surgical procedure.
25 patients had UC. Age at induction ranged 16-69 years. 13 (52%) patients failed to achieve remission on Vedolizumab. 10 have underwent a surgical procedure, and 1 further has been recommended to have surgery but refused.
Significant differences in success of treatment was identified when patients were analysed by age at induction ($p>0.01$).
Conclusions:
Despite the success of Biologic therapies there remains some doubt as to their longer-term outcomes in regards to preventing surgical intervention. In particular this early data appears to show a low rate of success in patients treated with Vedolizumab. The rate of

surgery in this small group is higher than expected, and questions its purported benefits.

Abstract No. USG A'2018 105
Audit of Pre-assessment Care of Patients Undergoing Chemotherapy And Surgery for Early Stage Oesophageal and Gastro-Oesophageal Junction Adenocarcinoma

Authors:
Douglas R, Singh U, Sutton E, Williams A, McGaughey S, Kennedy R, Turkington R.C
Institution:
Centre for Cancer Research and Cell Biology, Queens University Belfast, Northern Ireland.
Department of Surgery, Belfast City Hospital, Northern Ireland.

Background
Patients with early stage oesophageal (OAC) and gastro-oesophageal junction (GOJ) adenocarcinoma are offered platinum-based chemotherapy prior to radical surgery. Comprehensive physical and nutritional assessment is required to enable accurate patient selection
Aim
An audit of pre-assessment care of patients with early stage OAC and GOJ in the Northern Ireland Cancer Centre was undertaken to ensure that the care given to these patients is following current Association of Upper Gastrointestinal Surgeons (AUGIS) guidelines.
Method
Clinical notes were reviewed for patients diagnosed from the opening of the Upper GI Surgery unit in June 2015 until December 2017. Demographic, haematological, radiological, physiotherapy and dietetic factors were collected.
Results
94 patients were diagnosed between June 2015 and 2017 of whom 74 (79%) were male and the median age was 63.5 (31-82). All patients received staging CT and CT PET scans. Fifty eight patients (62%) had endoscopic ultrasound performed. All patients were seen by a physiotherapist and dietitian at pre-assessment. Physiotherapy assessments were available for 67 (71%) patients and all patients had shuttle walk test, BORG score, heart rate and oxygen saturations recorded. Dietetics assessments were available for 64 (68%) patients and all had dysphagia scores, hand grip strength, height and weight recorded. Fifty five (86%) of patients had weight change over time period recorded.
Conclusions
Appropriate pre-assessment care was given as per current guidelines for patients with early stage oesophageal cancer.

Abstract No. USG A'2018 106
The Role of Nutritional Status in Oesophageal and Gastro-Oesophageal Junction Adenocarcinoma

Authors:
Douglas R, Singh U, Sutton E, Williams A, McGaughey S, Kennedy R, Turkington R.C
Institution:
Centre for Cancer Research and Cell Biology, Queens University Belfast, Northern Ireland.
Department of Surgery, Belfast City Hospital, Northern Ireland.

Background
The incidence of oesophageal cancer is rising. Despite improvement in treatment, the five year survival rate is 12%. Patients present with dysphagia and weight loss which affects their nutritional status and their ability to tolerate treatment.
Aim
We aim to assess how patients' nutritional status can affect their survival.
Method
Retrospective review of clinical notes of patients diagnosed with early stage oesophageal (OAC) and gastro-oesophageal adenocarcinoma (GOJ) in the Northern Ireland Cancer Centre between 2013 and 2017. Patients' demographics and survival data were collected. The body mass index (BMI), Lorentz ideal body weight and the nutritional risk index (NRI) were calculated. Being underweight is defined as having a BMI of less than 18.5. Normal NRI is defined as a score of more than 100.
Results
164 patients were diagnosed with early stage OAC/GOJ between 2013 and 2017 of whom 134 (81.7%) were male and the median age was 63.9 (31-82). Seven patients (4.4%) were underweight and their recurrence free (RFS) and overall survival (OS) were significantly worse [HR 0.36 (CI 0.13-1); p=0.04 and HR 0.33 (CI 0.12-0.94); p=0.028) respectively). Twelve (7.6%) have NRI of less than 100. NRI<100 strongly predicted for poorer RFS [HR 2.6 (CI 1.1-6.2); p= 0.023] and OS [HR 3.4 (CI 1.5-7.7); p=0.002].
Conclusions
Poor nutritional status is a poor prognostic factor in patients undergoing neo-adjuvant chemotherapy and surgery for oesophageal adenocarcinoma.

Abstract No. USG A'2018 108
Alcohol, Smoking, Related Biomarkers And Oesophageal Adenocarcinoma Survival: A Molecular Pathology Epidemiology Cohort Study In Northern Ireland

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Background
Cigarette smoking and alcohol consumption are associated with the development of multiple cancers, but evidence is lacking regarding their impact on cancer survival and in particular oesophageal adenocarcinoma survival.
Aim
To assess the impact of smoking and alcohol consumption on survival in oesophageal adenocarcinoma in a population-based study and assess the impact of these lifestyle factors on survival within biomarker groupings
Method
Oesophageal adenocarcinoma specimens and clinical data were collected from 130 patients treated with neo-adjuvant chemotherapy prior to surgical resection at the Northern Ireland Cancer Centre between 2004 and 2012. Tissue microarrays were created and immunohistochemical staining for p53, HER2, GLUT-1 and CD8 was performed on triplicate tumour cores from each resection specimen. Survival analysis was calculated using Cox proportional hazards regression models.
Results
During a median of 2.5 (maximum 9) years of follow-up, 75 patients died. In adjusted analysis comparing ever with never alcohol consumption there was a non-significant increased risk of mortality in overall (HR 1.70 95% CI 0.95-3.04) and disease specific survival (HR 1.70 95% CI 0.93-3.11). There was no difference in survival in current or former smokers compared to never smokers. In biomarker analysis, there was a statistically significant worsened survival in patients who were ever drinkers and had GLUT1 positive (HR 2.5 95% CI 1.37-4.57) and CD8 positive tumours (HR 2.78 95% CI 1.31-5.89).
Conclusions
Ever alcohol consumption may have an impact on survival in patients with oesophageal adenocarcinoma and in particular those patients with CD8 and GLUT1 positive tumours. More studies with larger numbers need to be performed to investigate these findings further.

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[1]**Health Services Management Centre** at the University of Birmingham and the Strategy Unit at NHS Midlands and Lancashire Commissioning Support Unit. Sept 2015. Scoping the Future.

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

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References: 1. Dulai P, Meserve J, Hartke J, *et al.* Poster presented at European Crohn's and Colitis Organisation (ECCO); 15–18 February 2017; Barcelona, Spain. Abstract DOP023. **2.** Dulai PS, Singh S, Jiang X, *et al.* Am J Gastroenterol. 2016;111(8):1147-1155. **3.** Loftus EV, Colombel JF, Feagan B, *et al.* Poster presented at the European Crohn's and Colitis Organisation (ECCO); 15–18 February 2017; Barcelona, Spain. Poster P209. **4.** Vermeire S, Loftus EV, Colombel JF, *et al.* Poster presented at Digestive Disease Week (DDW); 6–9 May 2017; Chicago, IL, USA. Poster Su1931. **5.** Takeda UK Data on File UK/DF/1804/0008(1).

UK/EYV/1908/0089.
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