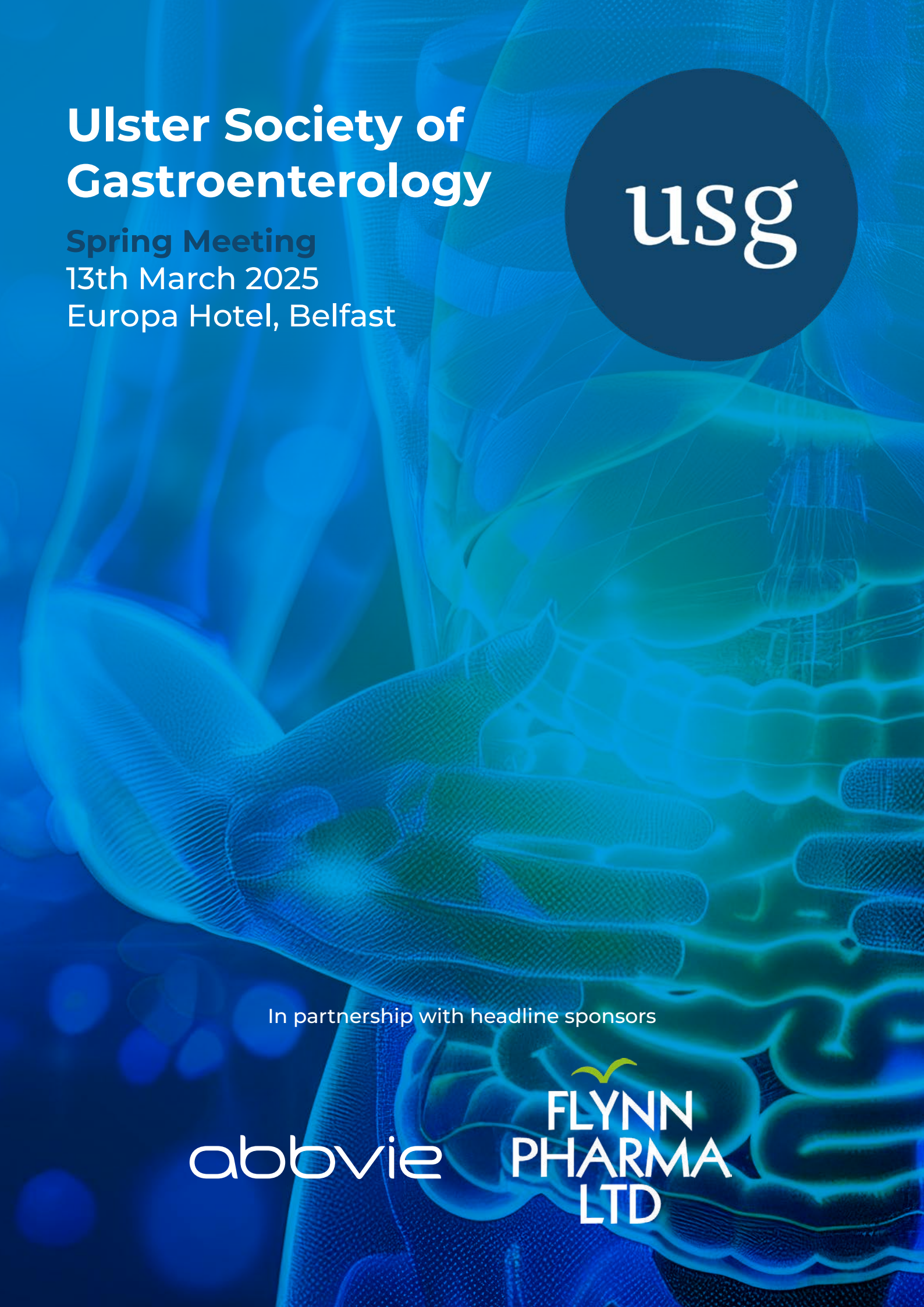
Ulster Society of Gastroenterology

usg

Spring Meeting

13th March 2025

Europa Hotel, Belfast



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Welcome to
USG Spring 2025 Meeting

Welcome to the Ulster Society of Gastroenterology Spring 2025 Conference!

We are delighted to have you join us for what promises to be an engaging and informative event. Our program has been designed to include a diverse range of topics with breakout sessions to cater to everyone's interests. We hope that you find today clinically useful and that you all leave with some pearls of wisdom that enhance your practice.

We have a line-up of excellent speakers in hepatology, imaging, addiction, psychology, pelvic floor dysfunction and its management, capsule endoscopy and complex polyp management in older patients. In addition to this we have a breakout nursing session covering service development, dietary management and genetic counselling.

As always, our conference serves not only as a platform for learning but also as an opportunity for networking and reconnecting with friends and colleagues. To foster this spirit of collaboration, we invite you to join us for a reception following the meeting.

I would like to extend huge thanks to our industry partners for their continued support, as well as to the USG committee members, particularly Lisa McNeill and Darragh McCullagh, for their invaluable contributions in shaping this program. A special acknowledgment goes to Maeve Maguire, our Executive Manager, whose tireless efforts behind the scenes have made this event possible.

We are pleased to offer Continuing Professional Development (CPD) credits for this meeting. Your feedback is invaluable to us, as it helps enhance our future conferences and better meet your needs. Please take a moment to fill in the feedback forms using the QR codes provided.

I would also like to express sincere gratitude to the outgoing USG Committee members who have developed and strengthened the Society and our meetings with their enthusiasm and commitment over the last 3 years. Drs Tony Tham, Leah Gilroy and Catriona McKenna deserve special mention along with our colleagues in nursing and surgery Brendan Byrne and Raymond Kennedy.

The Committee look forward to enjoying today's meeting with you and we hope that you can engage with questions and discussions as we know you will.

Warm regards,

Graham Turner
President, Ulster Society of Gastroenterology

USG Executive Committee

Dr Graham Turner	USG President
Dr Darragh McCullagh	Secretary
Dr Lisa McNeill	Treasurer
Dr Andrew Spence	Scientific Adviser
Ms Rachael McBride	Surgical Representative
Leanne McWha	Nursing Representative
Dr Rebekah Toner	Trainee Representative
Maeve Maguire	Executive Manager

Programme

08:30	Registration & Breakfast	**Exchange Entrance**
Morning Symposium		
09:00	Tomorrow starts today: SKYRIZI® (risankizumab) in Crohn's and UC management	**Chair: Dr Graham Turner** **Speaker: Dr Kamal Patel**
09:30	Opening Remarks	**Dr. Graham Turner**
Session 1: Liver Disease | Panel Chairs: Dr Jamie McKnight & Dr Rebecca O'Kane		
09:40	Nurse-led fatty liver service	**Dr Leanne Stratton & Jess Brown**
10.05	Liver imaging (lumps and bumps)	**Dr. Justin Smyth**
COFFEE BREAK: 10.30 - 10.45		
Session 2: GI Disorders | Panel Chairs: Dr Catherine Larkin & Dr Stuart McIlwaine		
10:50	Constipation and lower GI disorders vs NSAID	**Dr. Carolyn Adgey**
11:20	Cinical psychology talk	**Andrew Sutherland**
11:50	Abstracts 1 & 2	**Andrew Teeney & Kathryn Small**
12:10	Panel Q&A / Discussion	
LUNCH: 12.30 - 13.30		
Afternoon Symposium		
	Flynn Pharma Ltd Symposium: Current Usage and Update on Helicobacter Pylori treatments..	**Chair: Dr Graham Turner** **Speaker: Dr Inder Mainie**
Session 3: Parallel Sessions 14.05 - 14.50		
Nursing Session: Topics include gut-brain axis, genetic counselling | **Panel Chair: Leanne McWha**		
Endoscopy Session - 'When not to investigate' | **Panel Chairs: Dr Darragh McCullagh & Dr Christy Reid**		
14.05	Small bowel endoscopy	**Dr. Grant Caddy**
14.20	Complex colorectal polyps	**Kevin McCallion**
14.50	Abstracts 3 & 4	**Alex Craig & James Doyle**
COFFEE BREAK: 15.10 - 15.25		
Session 4: : Pelvic Floor Dysfunction | **Panel Chairs: Dr Richard Howard & Dr Hannah McCaughan**		
15:30	Surgical Perspective, Pelvic Floor Clinic	**Rachael McBride**
15:55	Physiotherapy perspective	**Alison Robinson**
16.25	Panel Q&A / Discussion	
16:40	Abstract Winner Announcement & Closing Remarks	**Dr Graham Turner**
CONFERENCE CLOSE		

CLICK here for SKYRIZI (risankizumab) 180mg, 360mg and 600mg Prescribing Information.
See below for adverse event reporting information. This advertisement is intended for UK healthcare professionals only.

For your patients 16 years and older with moderately to severely active Crohn's Disease or adult patients with moderately to severely active ulcerative colitis, SKYRIZI provides the opportunity for endoscopic and symptomatic control.[1-3]

Skyrizi® (risankizumab)

TAKE BACK CONTROL

The first and only Anti-IL23 p19 inhibitor licensed in both Crohn's and ulcerative colitis[4]

SEQUENCE; An open label head-to-head trial in Crohn's Disease between SKYRIZI and ustekinumab[5]

SEQUENCE is a Phase IIIb, open-label (efficacy assessor-blinded), multicentre, randomised study that compared the efficacy and safety of SKYRIZI vs ustekinumab over 48 weeks for the treatment of adult subjects with moderate-to-severe Crohn's who have failed anti-TNF therapy. SKYRIZI met both primary endpoints of non-inferiority for clinical remission (CDAI) at Week 24 and superiority of endoscopic remission at Week 48 ($p<0.0001$) versus ustekinumab

SKYRIZI is indicated for the treatment of patients 16 years and older with moderately to severely active Crohn's disease who have had an inadequate response, lost response, or were intolerant to either conventional therapy, or a biological therapy or if such therapies are not advisable.[4]

SKYRIZI is also now approved in ulcerative colitis

SKYRIZI is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biological therapy.[4]

Some patients may not be suitable for Skyrizi. You are strongly advised to read the prescribing information (PI) which can be accessed by clicking the links above and the Summary of Product Characteristics, which is available online in the Electronic Medicines Compendium.

SKYRIZI is contraindicated in patients with hypersensitivity to the active substance or excipients and in those with clinically important active infections (e.g. active tuberculosis).

It is preferable to avoid the use of SKYRIZI during pregnancy. Women of childbearing potential should use an effective method of contraception during treatment and for at least 21 weeks after treatment. It is unknown whether risankizumab is excreted in human milk. A decision should be made whether to discontinue/abstain from risankizumab therapy, taking into account the benefit of breast-feeding to the child and the benefit of risankizumab therapy to the woman.

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or via the MHRA Yellow Card app, available in the Google Play or Apple App Stores.
Adverse events should also be reported to AbbVie on GBPV@abbvie.com

Reference: 1. D'Haens G, Pannacione R, Baert F, et al. Risankizumab as induction therapy for Crohn's disease: results from the phase 3 ADVANCE and MOTIVATE induction trials. The Lancet. 2022;399:2015-30. 2. Ferrante M, Panaccione R, Baert F, et al. Risankizumab as maintenance therapy for moderately to severely active Crohn's disease: results from the multicentre, randomised, double-blind, placebo-controlled, withdrawal phase 3 FORTIFY maintenance trial. The Lancet. 2022;339:2031-46. 3. Louis, E et al. Risankizumab for Ulcerative Colitis: Two Randomized Clinical Trials. JAMA, e2412414. 22 Jul. 2024, doi:10.1001/jama.2024.12414 4. SKYRIZI Summary of Product Characteristics. 5. Peyrin-Biroulet L, et al. Presented at the United European Gastroenterology Week, 14–17 October 2023, Copenhagen, Denmark: LB01.

UK-SKZG-250060 March 2025

Morning Symposium
Biographical Sketches

Dr Kamal Patel

Dr Patel graduated from Guy's, King's and St Thomas' Medical School in 2003, having undertaken an intercalated degree in Physiology in 2000. He undertook specialist training in gastroenterology and hepatology in the South East London deanery, and an advanced inflammatory bowel disease (IBD) / endoscopy fellowship at Guy's and St Thomas' Hospital, prior to taking up a consultant post at St George's Hospital in 2016. He has also completed a Diploma in Medical Education in 2016.

He is involved in all aspects of gastroenterological care, running weekly gastroenterology clinics at St George's and Nelson Health Centre along with specialist inflammatory bowel disease clinics at St George's. He carries out regular upper and lower gastrointestinal endoscopy lists at St George's, with a special interest in more complex endoscopic procedures relating to IBD strictures, IBD dysplasia and Intestinal Failure.

Dr Patel has been the Co-IBD Lead for the Trust since 2017, and continues to maintain a major research interest in IBD. His work has been presented at the American Gastroenterology Association, United European Gastroenterology Association and the British Society of Gastroenterology. He is involved with the clinical research facility at St George's, and is currently principal investigator for numerous NHS adopted IBD clinical trials.

Dr Graham Turner, USG President, Belfast, UK

Dr Graham Turner works as a Consultant Gastroenterologist in Belfast at both the Royal Victoria and Belfast City Hospitals. He is Clinical Director for Belfast Trust for Gastroenterology and Endoscopy at the Trust. He has been a consultant since 2006 initially in Altnagelvin Hospital in Derry but moved to Belfast in 2009 where he is part of the Regional Intestinal Failure team for Northern Ireland. He is also Medical Director for Alliance Clinical Services, who run a comprehensive insourcing service for NHS in the UK.

Graham qualified from Queen's University Belfast in 1996 and completed his training in Northern Ireland and was awarded an MD degree at QUB in 2004. He has completed Fellowships in Perth Australia and then at University College Hospital in London with Prof Alastair Forbes.

His clinical interests are Intestinal Failure, Inflammatory Bowel disease and endoscopy including Bowel Cancer Screening.

Biographical Sketches

Dr Leanne Stratton

Dr Leanne Stratton has been a Consultant Hepatologist in the Royal Victoria Hospital in Belfast since 2019. She completed gastroenterology training in Northern Ireland, and sub-specialty training in hepatology in the Scottish Liver Transplant Unit in Edinburgh. She is clinical lead for hepatology and lead for paediatric transition care within the hepatology service. She has an interest in liver transplant and quality improvement.

Jessica Brown

Jessica Brown is a Hepatology Specialist Nurse at the Royal Victoria Hospital, specialising in the management of Metabolic dysfunction-associated steatotic liver disease (MASLD). With 20 years of experience in hepatology, she trained at the Robert Gordon University, Aberdeen before taking on key roles as a Staff Nurse and Deputy Sister in Ward 6D, RVH.

She also provides specialist nurse cover for the Liver Transplant Service, supporting patients through complex care pathways and has a keen interest in infection control & quality improvement.

Dr Justin Smyth

Dr Smyth is a radiologist at the Royal Victoria Hospital with a subspecialty interest in gastrointestinal and hepatopancreatobiliary (HPB) imaging. He completed a fellowship in HPB and liver transplant imaging and endoscopic ultrasound at Queen Elizabeth Hospital Birmingham.

Dr Carolyn Adgey

Dr Carolyn Adgey is a gastroenterology consultant working in the Belfast trust. She graduated from Queens University Belfast in 2008 and started speciality training in 2013 in Northern Ireland. She completed a 1 year clinical fellowship in small bowel transplantation, intestinal failure and nutrition in Addenbrookes Hospital, Cambridge in 2017. She has a specialist interest in intestinal failure, nutrition and disorders of gut-brain interaction.

Noelle Power, RD, BSc, PgD, AFHEA

Advanced Practice Level 1, Gastroenterology dietitian, with over 17 years' clinical experience in the NHS and private practice. Specialises in the dietary management of gastrointestinal disorders in adults. Vast experience in evidenced based, clinical management and teaching of diet related gastroenterology disorders. Public speaker on topics such as Low FODMAP diet, Small Bowel Bacterial Overgrowth, Gut Health, IBS and IBD.

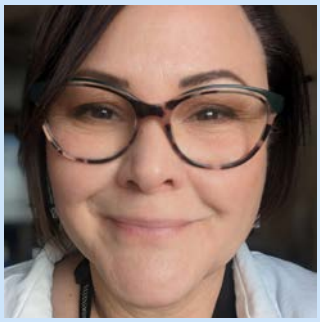
Andrew Sutherland

Andrew is a Chartered Psychologist, currently employed by the Belfast Health & Social Care Trust as a Specialist Psychologist in the field of Clinical Health Psychology.

He is a member of the multidisciplinary NI Regional Intestinal Failure team. This is a role involving inpatient and outpatient work in the Belfast City and Royal Victoria Hospitals and includes complex psychological work with various gastrointestinal conditions, such as Inflammatory Bowel Disease and Disorders of Gut-Brain Interaction.

Andrew has over 20 years' professional experience working in the public, private and not-for-profit sectors in both Northern Ireland and his native Australia. This experience has included assessment, formulation and delivery of psychological interventions for a wide range of presenting issues with individuals, groups and families throughout the lifespan. His clinical leadership experience has included leading several large multidisciplinary teams and achieving professional service accreditation for 3 different psychological services.

Andrew has a particular interest in psychological trauma and GI conditions and has lectured locally on this topic at Queen's University, Belfast; along with delivering trauma training internationally in Australia and Bosnia & Herzegovina



Annelies McCurley

Annelies McCurley is currently employed as Regional Hepatitis B & C Managed Clinical Network Manager with 16 years' experience in hepatology and liver specialist nursing. She plays a key role in strategic planning, service coordination, and healthcare policy implementation to enhance hepatitis B and C care across the region.

Additionally, she co-ordinates the Regional Hepatocellular Carcinoma (HCC) screening program, ensuring early detection and improved access to treatment for at-risk populations.

Sianan MacParland

I am the Lead Genetic Counsellor for the Northern Ireland Regional Genetics Service. I completed a Bachelor of Science (BSc) at Queen's University Belfast and a Master of Science (MSc) in Genetic Counselling at the University of Manchester. With extensive experience working as a genetic counsellor in several departments and also currently sit on the Molecular tumour board.

Dr Grant Caddy

Consultant Gastroenterologist in the South Eastern Trust. Special interests include upper and lower endoscopy, ERCP, small bowel capsule and device assisted enteroscopy. Outside work my interests include travel, food and all things cycling.

Biographical Sketches

Kevin McCallion PhD, FRCS, Consultant Colorectal Surgeon

Kevin undertook undergraduate and postgraduate training at QUB. ASCRS clinical fellowship at Mount Sinai Hospital, Toronto. Appointed Consultant Colorectal Surgeon at the South Eastern Trust in 2004. Previous CCrISP Convenor NI, Joint Advisory Group (JAG) assessor, faculty member of DoH sponsored National Training Programme in Laparoscopic Colorectal Surgery at Nottingham University and NICaN Colorectal Clinical Lead 2013-2015.

Rachael McBride

Rachael McBride is a consultant colorectal surgeon working in the Belfast Trust. She is the Irish representative for the Pelvic Floor Society.

Alison Robinson, Bsc Hons Physiotherapy GCert in professional development in health: continence

Alison currently assesses patients with Rachael McBride Consultant colorectal surgeon at the pelvic floor clinic. She is also involved with treatment of anal and rectal cancer patients who have bowel issues following cancer treatments. She is passionate about improving and extending the physiotherapy pelvic health service for patients.

Alison developed an interest in the treatment of colorectal patients during the completion of the Gcert in continence back in 2003. Due to this a local Consultant colorectal surgeon, started referring patients for treatment and with good results and patient satisfaction the service has grown year on year since this.

There was initially no dedicated funding for colorectal patients, due to growth and demand for the service an audit was completed in 2018-19, which resulted in 2 full time physiotherapy posts specifically for colorectal patients.

Today's presentation outlines physiotherapy treatment options available for patients who suffer from poor bowel control, prolapse or constipation.

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NEW

3-in-1 combination capsule with synergistic effect delivering >90% *H. pylori* eradication rate[1-3]

Bismuth containing quadruple therapy is recommended as first-line in areas of high (>15%), low, or unknown clarithromycin resistance [4]

Importance of bismuth in quadruple therapy [3,5]:

- Bactericidal in its own right
- Demonstrates synergism with antibiotics
- No resistance has been reported

References 1. Pylera SmPC. (Accessed July 2024). **2.** Malfertheiner P, et al. *Lancet.* 2011;377:905–13. **3.** Malfertheiner P, et al. *Nat Rev Dis Prim.* 2023;9:19. **4.** Malfertheiner P, et al. *Gut.* 2022;71:1724-1762. **5.** Kateralis, P, et al. *J Clin Gastroenterol.* 2023;57:111-126.

PYLERA® 140mg/125mg/125mg. PRESCRIBING INFORMATION: Please refer to Summary of Product Characteristics before prescribing. **ACTIVE INGREDIENTS:** 140mg bismuth subcitrate potassium, 125mg metronidazole, 125mg tetracycline hydrochloride. **INDICATIONS:** In combination with omeprazole, for the eradication of *Helicobacter pylori* and prevention of relapse of peptic ulcers in patients with active or a history of *H. pylori* associated ulcers. **DOSAGE and ADMINISTRATION: Adults:** One dose (3 capsules) to be taken 4 times daily, after food, for 10 days. Capsules should be swallowed whole. One omeprazole 20mg capsule/ tablet morning and evening, after food, for 10 days. Pylera and omeprazole should be taken while seated with 250mL of water. Patients should not lie down immediately after taking Pylera and omeprazole. **Older people:** Limited experience. **Children 12-18 years:** Not recommended. **CONTRAINDICATIONS:** Pregnancy, breast-feeding, paediatric populations (< 12 years), renal or hepatic impairment, hypersensitivity to the active substances, other nitroimidazole derivatives or any excipients, patients with Cockayne syndrome. **SPECIAL WARNINGS AND PRECAUTIONS:** Avoid alcohol during, and for 24 hours after treatment. Consider potassium content in patients with reduced kidney function or controlled potassium diet. Contains lactose - avoid use in patients with hereditary problems of galactose intolerance, Lapp lactose deficiency or glucose-galactose malabsorption. **Bismuth** - Rare reports of encephalopathy with excessive doses and prolonged treatment, reversible with discontinuation. May interfere with x-ray diagnostic procedures of the gastrointestinal tract. May cause temporary and harmless darkening of stools. **Metronidazole** - Very rare reports of encephalopathy. Reports of peripheral neuropathy usually when given for long periods. Reports of peripheral neuropathy with Pylera -promptly discontinue if abnormal neurologic signs appear. Administer with caution in patients with central nervous system disease. Caution in patients with evidence, or history, of blood dyscrasia. Rare cases of mild leukopenia with prolonged use. May prolong prothrombin time requiring reduced dose of oral anticoagulants (e.g. warfarin) during treatment -monitor prothrombin times. No interaction with heparin. Reports of QT prolongation when administered concomitantly with medicines with both potential for QT prolongation and potential for increased plasma levels secondary to drug-drug interactions with metronidazole. May interfere with certain serum chemistry values. **Tetracycline** - Oral candidiasis, vulvovaginitis, and pruritus ani may occur and require treatment. Overgrowth of resistant coliform organisms, such as *Pseudomonas spp.* and *Proteus spp.* may occur causing diarrhoea. Occasional reports of enterocolitis due to superinfection with resistant staphylococci and pseudomembranous colitis due to *Clostridium difficile*. Discontinue if superinfection occurs. Some observations of photosensitivity - advise patients apt to be exposed to direct sunlight or ultraviolet light of this reaction. Discontinue treatment at first evidence of skin erythema. Administer with adequate amounts of fluid, particularly bedtime dose, to reduce risk of oesophageal irritation and ulceration. Association with pseudotumor cerebri. Rarely myasthenic syndrome -care in patients with myasthenia gravis, who may be at risk of worsening. Avoid concomitant use with methoxyflurane. **Omeprazole** - May delay elimination of warfarin -a reduction of the warfarin dose may be necessary. **INTERACTIONS:** No studies with Pylera. Caution in patients on a high number of concomitant medications who are generally at higher risk of undesirable effects. **Bismuth** - Ranitidine and omeprazole enhance absorption. Take Pylera and omeprazole after food in order to reduce the absorption. **Metronidazole** - May precipitate signs of lithium toxicity -strict monitoring of lithium levels recommended. Disulfiram-like reaction with alcohol. Reported psychotic reactions in alcoholic patients using metronidazole and use of disulfiram within previous 2 weeks. Reported to potentiate anticoagulant effect of oral coumarin anticoagulants, resulting in prolongation of prothrombin time - monitor and adjust anticoagulant dose during Pylera treatment. Simultaneous administration with microsomal liver enzyme inducers (e.g. phenytoin or phenobarbital) may accelerate metronidazole elimination and reduce plasma levels. Impaired clearance of phenytoin reported. Reduces clearance of 5-fluorouracil potentially increasing 5-fluorouracil toxicity. Risk of elevated cyclosporin levels - closely monitor serum cyclosporin and serum creatinine. May increase plasma levels of busulfan leading to severe busulfan toxicity. Avoid use with compounds metabolised by CYP3A4 or CYP2C9 and prolonging the QT interval (e.g. ondansetron, amiodarone, methadone, domperidone). **Tetracycline** – Fatal renal toxicity reported with concurrent use of methoxyflurane. Decreases plasma prothrombin activity- monitor and adjust anticoagulant dose is with initiation of Pylera. Avoid use with penicillin, antacids containing aluminium, calcium or magnesium, preparations containing iron, zinc, sodium bicarbonate, or dairy products. Avoid concomitant use with retinoids due to reported increased incidence of benign intracranial hypertension. Consider discontinuing retinoid therapy during Pylera treatment. May decrease plasma atovaquone concentrations. **PREGNANCY, LACTATION AND FERTILITY**: Contraindicated during pregnancy and breastfeeding. Evidence of impaired male fertility in animal studies. **DRIVING:** Warn patients about the potential for convulsive seizures, dizziness and transient blurred vision and advise not to drive or operate machinery if these symptoms occur. **UNDESIRABLE EFFECTS**: **Very common:** dysgeusia, diarrhoea, nausea, abnormal faeces. **Common:** Vaginal infection, anorexia, decreased appetite, headache, dizziness, somnolence, vomiting, abdominal pain, dyspepsia, constipation, dry mouth, flatulence, alanine aminotransferase increased, aspartate aminotransferase increased, rash, chromaturia, asthenic conditions. **Other side-effects:** Pseudomembranous colitis, aseptic meningitis, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell syndrome), DRESS syndrome, encephalopathy, convulsive seizures, anaphylaxis, pancreatitis, cholestatic hepatitis, hepatic failure, haemolytic anaemia, thrombocytopenia, thrombocytopenic purpura, neutropenia, eosinophilia, peripheral neuropathy, oesophageal ulceration. **Consult SmPC for all side effects. PHARMACEUTICAL PRECAUTIONS:** Store in original pack. **LEGAL CATEGORY:** POM

Product	NHS List Price	Pack Size	Marketing Authorisation Number
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Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/. Adverse events should also be reported to Flynn Pharma Ltd. Medical Information: Tel 01438 727822.

FLYNN PHARMA LTD

UK/PYL/2024/3228 August 2024

Afternoon Symposium
Biographical Sketches

Dr Inder Mainie

Dr Manie works as a Consultant Gastroenterologist for the Belfast Trust. Qualified as a consultant in Gastroenterology in February 2007. He completed an advanced Therapeutic Endoscopy, Endoscopic Ultrasound and Oesophageal Motility fellowship in Medical University South Carolina, Charleston, SC, USA 2003 -2006. Trained in the interpretation of motility studies including High Resolution Impedance Manometry and Impedance pH testing. Regular endoscopy includes Upper GI therapeutic endoscopy and Endoscopic Ultrasound. He is interested in Research and currently involved in both International and National studies including Eosinophilic Oesophagitis, Cytosponge, Endosign (including Delta), BOSS and SPIT. Part of UK HALO and Hemospray registry. Secretary of the Oesophageal section of the BSG.

Oral Abstract 1

Facilitating Hepatitis C Treatment For Addictions Patients In Belfast

Authors:	A. Teeney, O. McCormick, G. Wasson, A. McCurley, K. George, H. Toal, N. McDougall
Departments/Institutions:	Regional Liver Unit, Royal Victoria Hospital, Belfast Addictions services, Belfast Health and Social Care Trust
Publication Date:	March 2025

Introduction

Hepatitis C (HCV) is a health condition that is highly prevalent in people who use drugs, which if left untreated can lead to liver failure, cancer and death. Unfortunately, patients open to addictions services often struggle to attend the Regional Liver Unit for assessment and treatment.

Aim

The Regional Liver Unit and Belfast Addictions Services have engaged in a joint project to improve access to treatment for those patients presenting with HCV who have found it difficult to attend a hospital clinic.

Methods

HCV patients have their assessments completed in addictions services (including bloods and a fibroscan). This assessment is sent to the Regional Liver Unit and their medications are delivered to the addictions service to be supplied to the patient. Patients bloods are undertaken at 12 weeks post-treatment to determine if they have had a sustained virologic response (SVR).

Results

Between March 2021-2025, 121 treatments facilitated within addictions services. 53 patients (42%) attained SVR at 12 weeks with a further 11 having completed treatment and awaiting SVR. 15 patients (12%) are currently in treatment with 6 due to start. 6 patients commenced but did not complete treatment. 6 patients completed treatment but were lost to follow-up (3 no longer open to addictions and 3 died). 1 patient died during treatment. 20 (16%) patients did not achieve SVR after completing treatment.

Conclusion

By facilitating assessments and treatment within the addictions service, with no requirement to attend the Regional Liver Unit, we have been able to improve the assessment and treatment pathway for this group of patients.

Oral Abstract 2

The Safety and Efficacy of Mirikizumab Treatment in Patients with Ulcerative Colitis in the Belfast Trust

Authors: K. Small, S. Boyle

Departments/Institutions: Gastroenterology Department, Royal Victoria Hospital, Belfast Trust

Introduction

Mirikizumab has been approved by NICE for treatment of moderate to severe UC who have inadequate response to advanced therapies. Randomised-controlled-trials demonstrate long-term clinical and endoscopic remission in responders.

Aim

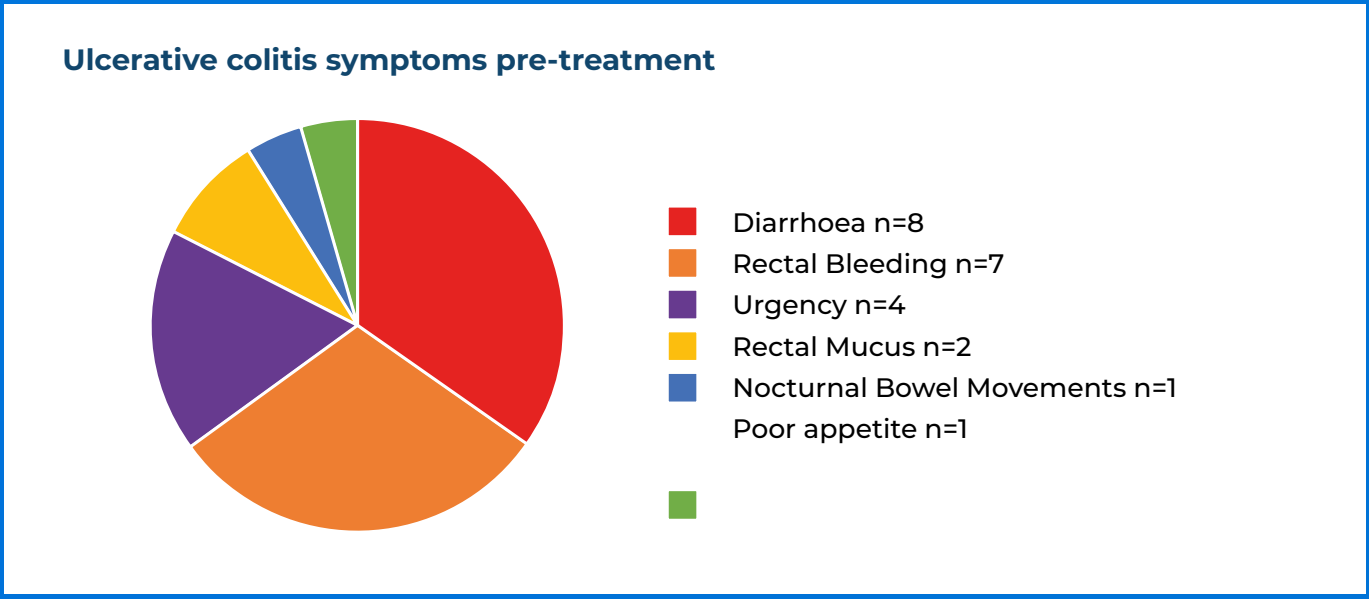
Assess the safety and efficacy of Mirikizumab use in UC patients within the Belfast Trust.

Methods

Data was collected on all UC patients currently on Mirikizumab. Demographics were collected including age and gender, details of previous treatments for UC and reason for failure, symptoms, CRP and faecal calprotectin (FCP) pre and post treatment, endoscopy findings pre-treatment and adverse events.

Results

11 patients are currently receiving treatment with Mirikizumab. Most patients have received 3 mirikizumab induction doses (n=6). Symptoms reported pre-treatment are demonstrated in the chart below.



So far, 4 (36%) patients have noted clinical improvement, whilst 3 (27%) were experiencing similar symptoms. Of these 3, 1 is planned to complete an extended induction regime, 1 is awaiting surgical review and 1 is being bridged with cortiment. Inflammatory markers data indicate that of those with raised CRP pre-treatment (n=3), all had normalised CRP 1 month after initiation. For 5 patients who had FCP samples analysed after starting treatment, 4 (80%) show a reduction. No adverse events have been reported.

Conclusions

Initial data suggests mirikizumab is a safe and effective treatment for those with UC who have failed other advanced therapies. Clinical improvement has been demonstrated in the majority of patients, but further data is required to confirm maintenance of remission after induction therapy. Safety is demonstrated with no adverse events.

Oral Abstract 3

An evaluation of the day case laparoscopic cholecystectomy service in a single HPB unit.

Authors: Ms Julie Scoffield, Miss Jessica Lockhart

Departments/Institutions: Mater Infirmorum Hospital, Belfast

Introduction

Benign biliary pathology generates a large proportion of both planned and unscheduled work for surgical services. Laparoscopic cholecystectomy is a commonly performed operation which has been proven as a safe day case operation. The aim of our study is to evaluate the day case laparoscopic cholecystectomy service in our unit and determine the rate of unplanned inpatient stays and unscheduled contact with medical services following discharge.

Methods

Data was collected retrospectively on all patients (daycases and inpatients) undergoing cholecystectomy in the HPB Unit in a 12-month period, as identified from the unit's operative database. Further patient details and encounter history were obtained by review of the Electronic Care Records. Open surgery and bile duct explorations were excluded from our study.

Results

257 patients underwent a laparoscopic cholecystectomy; 66% were performed as day case surgery; 28 patients had inpatient stays for no documented reason. Forty patients (15.6%) sought unplanned medical advice after discharge, either from GP or at hospital, within the first 30 days. Fifteen patients (5.8%) were readmitted to hospital; the median length of stay on readmission was 3 days. The most common reasons for unscheduled care were pain and wound infection.

Conclusion

There is room for improvement in day case rate as there continues to be unplanned overnight stays without clear reason. Readmission rates are low. Further work on counselling patients about post-operative pain and wound infections may reduce unscheduled post-operative contact. Day case laparoscopic cholecystectomy is carried out safely in our unit.

Oral Abstract 4

Experience of PTC in a district general hospital – a 5 year review (2020-2024)

Authors: K O'Donovan[1], K A Abdul Halim[1], P Hughes[2], D Campbell[2], G Caddy1, T Garvey[1], J Doyle[1]

Departments/Institutions: [1] Department of Gastroenterology, Ulster Hospital Dundonald, South Eastern Health and Social Care Trust

[2] Department of Radiology, Ulster Hospital Dundonald, South Eastern Health and Social Care Trust

Introduction

Percutaneous transhepatic cholangiography (PTC) is an invasive procedure used to access the biliary tree and primarily used to achieve biliary drainage in obstruction due to malignant stricturing. Cases include those in which the biliary tree is not accessible at ERCP or adequately drained then, and in anatomy where PTC is preferable. Improvement in serum bilirubin levels to allow patient to undergo systemic therapy and/or for palliative purposes, e.g. pruritus secondary to hyperbilirubinaemia, is the usual aim.

Aim

Although PTC is generally safe, it does carry risk. We sought to evaluate the data relating to PTCs in recent years to determine risks locally and analyse rates of systemic therapy post-PTC.

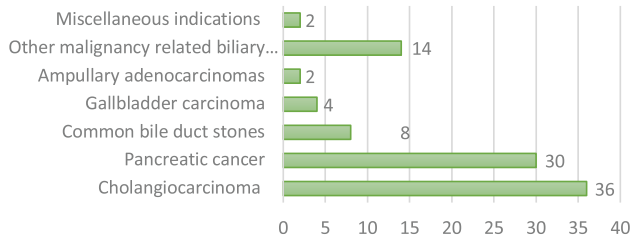
Methods

A retrospective analysis of medical records of all patient who underwent PTC for the years 2020-2024 inclusive was completed.

Results

96 patients underwent PTC in this time period with an average age of 71.5 years for all cases. 86 of the cases (89.5%) were for a malignancy related biliary stricture (see Figure 1). The average length of stay for malignant cases was 29 days with 79% (68/86) being discharged home after PTC. Patients who received systemic therapy after PTC intervention (majority palliative chemotherapy) was 24/86 patients (29%).

Figure 1 - Causes of biliary obstruction requring PTC



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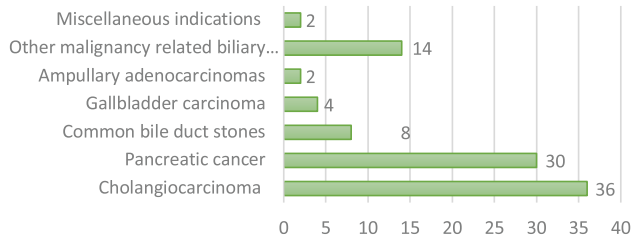

Of the deaths within 30 days of PTC (23/86) (see Figure 2), 13/23 (56.5%) had cholangiocarcinoma as a primary diagnosis. The average age of patients who died within 30 days of a PTC procedure was 69.5 years. Of the patients with hilar or intrahepatic strictures involvement in their disease process (all malignant cases), 20/42 (47.6%) had died (17) or had an adverse event within 30 days associated with PTC.

Conclusion

PTC in our institution appears to be relatively safe. Risk appears greatest to those with hilar and/or intrahepatic malignant strictures, however this may relate to disease phenotype than PTC directly. Our data is limited by a retrospective analysis and a pre-selected population. Less than a third of patients proceeded to systemic therapy after PTC.

Poster Abstracts

Endoscopic Management of Bouveret Syndrome: A Case Report

Author: Anna Murray

Introduction

Bouveret syndrome (BS) is an uncommon form of gallstone ileus characterised by impaction of a migrated gallstone in the pylorus or proximal duodenum via a cholecystoduodenal fistulous tract. Symptoms can be non-specific and presentation benign. Imaging for gallstone ileus typically demonstrates an ectopic gallstone, pneumobilia and small bowel obstruction with laparoscopy and/or laparotomy recognised treatment options. Surgical management of BS however can be challenging with risk of significant morbidity depending on a number of factors. We present the case of an 84-year old lady with BS managed endoscopically and discuss the current diagnostic and therapeutic options available to ensure timely and effective intervention in this often frail group of patients.

Case

An 84-year old lady with significant co-morbidity presented to the Emergency Department with a two-week history of generalised malaise, vomiting and right upper quadrant pain. She had a known history of gallstones confirmed on previous ultrasound. Examination demonstrated right upper quadrant tenderness. Liver function tests were deranged and inflammatory markers elevated. CT imaging diagnosed a cholecystoduodenal fistula with a biliary stone impacted at level of D2. A gastroscopy was undertaken and targeted lithotripsy performed. A defect was created in the obstructing stone to enable intestinal continuity and facilitate break-up and distal migration of the stone. Post-procedure imaging revealed resolution of the obstruction. The patient was later discharged without need for an operation.

Conclusion

Surgical management of BS is associated with significant risk. Overall mortality approaches 30% in some patient groups. We have demonstrated a non-operative technique which may provide therapeutic benefit in carefully selected patients thereby avoiding the need for formal surgical intervention.

Home Subcutaneous Fluids Can Be a Safe and Effective Therapy For a Small Subgroup of Patients With Intestinal Insufficiency Managed By a Multidisciplinary Nutrition Support Team

Authors: K. Small, G. Turner, G. Rafferty, C. Adgey

Department/Institution: Intestinal Failure Unit, Belfast City Hospital, Belfast Trust

Case Introduction

Within the Belfast Trust Intestinal Failure (IF) team, we have a small number of patients with fluid and/or magnesium (Mg) deficiencies despite maximum medical therapies. Indications for SCF vary, but aims of treatment are to support fluid and magnesium balance.

Aim

To review the use of SCF in our IF patient cohort to assess their safety and efficacy

Methods

Data was collected on all patients under the care of the IF team. Those using home SCF were identified, and further data analysed including demographics, underlying diagnosis, indication for SCF, blood results, other medications and hospital re-admissions with complications.

Results

As of January 2025, there are 17 patients receiving SCF. Inflammatory bowel disease, namely Crohn's was the commonest underlying diagnosis. Hypomagnesaemia was the commonest reason for initiating SCF, accounting for 88% of cases.

Bag volumes ranged from 250-1000ml (all containing 4mmol Mg). All patients had improved Mg levels one year after starting treatment. 11.7% of patients (n=2) had hospital admissions for cellulitis at needle sites, occurring within first year of initiation, giving one episode of cellulitis per 83.5 patient years. 35% of patients (n=6) required hospital admissions for fluid balance related issues. The majority of patients had no hospital admissions after commencing treatment (53%).

Conclusions

Home SCF provides a safe and effective treatment option for intestinal insufficiency patients. Side effects are minimal and the majority of our patients had either none or only one hospital admission.

From Tumour to Germline: A New Approach to Identifying Cancer Predisposition Syndromes

Authors: McKenna C., MacParland S., Mckee S., Logan A., Flannagan C., DonnellyD., Tracey, E., Johnston L., Duffy S., Tucker, L., McArt L., Catherwood M., Logan P., Heggarty, S., James J. Hegarty S.

Department/Institution: The Northern Ireland Regional Genetics Service, Belfast City Hospital BT97AB

Introduction

The integration of molecular tumour profiling into clinical practice offers a novel approach to identifying individuals with cancer predisposition syndromes, such as Lynch syndrome. This initiative aims to prevent future cancers in patients and their relatives through early detection and intervention.

Aim

To leverage tumour DNA profiling to uncover germline variants in colorectal cancer patients, facilitating the identification of patients with cancer predisposition syndromes.

Method

As part of the NI Cancer Strategy, Action 27, a molecular tumour board (MTB) was established. The MTB meets weekly to discuss genetic variants of interest found in tumour samples. Variants are identified according to guidelines from the European Society for Medical Oncology (ESMO) Precision Medicine Working Group, focusing on variants within actionable genes. The MTB follows the intermediate conservative approach, examining variants in “most actionable genes” (MAGS) such as BRCA1, BRCA2, MLH1, MSH2, MSH6, and PALB2, and “standard actionable genes” (SAGs) such as PMS2, POLE, PTEN, and APC in colorectal cancer.

Results

Since October 2024, 1,512 tumour samples have been processed, identifying 1,732 potential variants of interest in 857 patients. Of these, 87 patients were discussed at the MTB, and 61 were selected for confirmatory germline testing. For the 19 variants identified for germline confirmation where testing is complete, 11 were present in the germline (58%)

Conclusions

This initiative has demonstrated the potential to identify cancer predisposition syndromes in colorectal cancer patients that might be missed by traditional methods. Continued efforts are needed to integrate this approach into routine clinical practice.

I am already presenting on a different topic but would like to submit this abstract for consideration for a poster please.

The Dark side of the Esophagus: A Case report of Acute Esophageal Necrosis

Authors: Z. S. Jafar, M. Kharief, M.A Hasabalrasoul, A. Elsadig, Dr Mujahid Rasheed

Institution: Department of Medicine and Gastroenterology, University Hospital Waterford, Ireland

Abstract

Acute Esophageal necrosis (AEN) is a rare clinical entity, with fewer than 150 reported cases in literature and endoscopic prevalence ranging from 0.01 to 0.28%. Initially identified by Goldenberg and subsequently characterized by Gurvits in 2007, this condition primarily involves the distal esophagus, leading to its distinctive necrotic, black discoloration. AEN predominantly affects male patients with underlying risk factors, including chronic liver and kidney disease, alcoholism, sepsis, malnutrition, and cardiovascular comorbidities. It carries a high mortality rate. Upper Gastrointestinal Endoscopy remains the gold standard of diagnosis. Given the rarity of AEN, the standardized management guidelines are not well defined and primary therapeutic focus remains on optimizing medical condition. We report the first documented case in Ireland of an 81year old female presenting with septic shock, profound hypoglycemia, and hypothermia, with subsequent evaluation confirming the diagnosis of AEN. Its development was multifactorial with esophageal ischemia secondary to septic shock induced hypotension playing a key role. The condition may have been exacerbated by reduced cardiac output and vasoconstriction of splanchnic blood vessels secondary to hypothermia. Furthermore, gastric reflux likely contributed to additional mucosal injury. The patient was managed successfully with conservative yet aggressive approach with inotropic support, antibiotics and total parenteral nutrition. We conclude that AEN should be considered in any patient with predisposing risk factors, particularly in presence of critical illness. This case highlights the urgent need for development of standardized guidelines to ensure timely diagnosis and optimal management for this rare but serious condition.

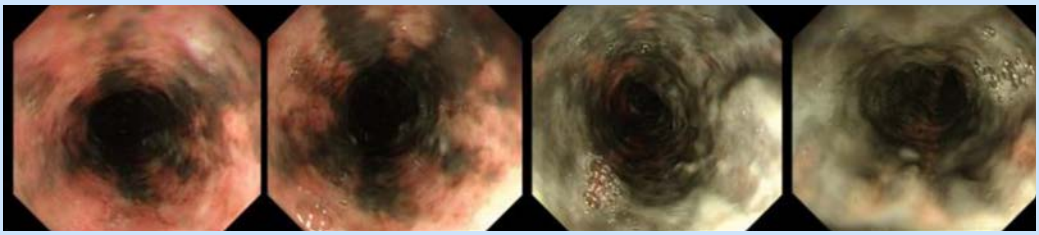

Figure 1: Esophagogastroduodenoscopy showing Acute Esophageal Necrosis (AEN)

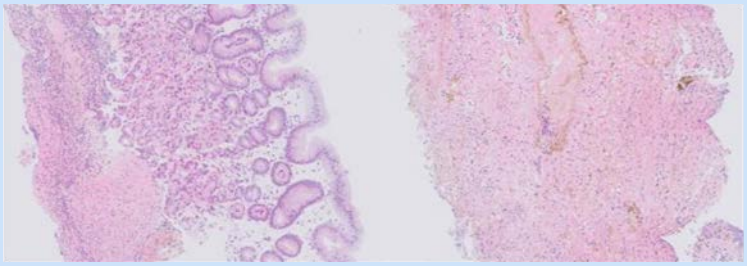

Figure 2: Hematoxylin and Eosin stain (10X magnification) showing gastric cardiac mucosa with ulceration (left), and ulcer slough, acute inflammation and fibrin , No esophageal mucosa (Right)

Ulster Society of Gastroenterology

Spring Meeting

13th March 2025
Europa Hotel, Belfast

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Thank you for attending our 2025 Spring Meeting, we hope you enjoyed it and we will be in touch in the next few weeks with our feedback survey and your CPD certificates

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