

# Ulster Society of Gastroenterology

Spring Meeting

13th March 2026

Europa Hotel, Belfast



In partnership with headline sponsors

**Johnson & Johnson**  
Innovative Medicine



# Welcome to USG Spring 2026 Meeting



## Thank you for joining us for this year's Spring meeting.

We have put together a clinically focussed programme spanning several topics that we all find challenging. Given the expertise and range of speakers we have with us today in person, we hope you enjoy and learn from our conference and please take the opportunity to ask questions and engage in the sessions as you always do.

Covering complex polyps, early cancers, managing over and under active bowel function and moving onto liver disease in pregnancy, the programme covers a vast array of gastroenterology and hepatology with widely respected experts and we hope you will all find benefit from the sessions.

There are two industry sponsored symposia with well known authorities in IBD-care delivering talks on new and emerging strategies for managing IBD that really enhance the programme. In addition, we have had a fantastic response to abstract submissions this year with a large number of excellent quality abstracts. The top four will present their findings today and please take time to visit the posters for selected abstracts between sessions. Thank you to all who submitted their work.

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 for their invaluable contributions in shaping this programme. 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, it is always helpful if you have topics you would like to see covered in future meetings that you include them in your feedback.

Most of all, we hope you enjoy your day!

**Graham Turner**

President, Ulster Society of Gastroenterology

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## USG Executive Committee

**Dr Graham Turner**

**USG President**

**Dr Darragh McCullagh**

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**Leanne McWha**

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**Trainee Representative**

**Maeve Maguire**

**Executive Manager**

# Programme



08:30 – 08:55	Registration & Breakfast	Exchange Entrance
<b>Morning Symposium (Takeda – Sponsored)</b>		
09:00 – 09:30	A Decade of Gut-Selective Therapy for UC	<b>Chair:</b> Dr Graham Morrison <b>Speaker:</b> Dr Oliver Brain, Consultant Gastroenterologist
09:30 – 09:40	Opening Remarks	Dr. Graham Turner
<b>Session 1:</b> Precision staging of early GI cancer (pT1): integrating optical endoscopy and histopathology to guide endoscopic versus surgical management <b>Panel Chairs:</b> Dr. Darragh McCullagh & Dr. Shakir Zaman		
09:40 – 10:25	Optical diagnosis of advanced adenomas and selection of endoscopic resection techniques	Dr Georg Spaun Director of Surgical Endoscopy, Ordensklinikum Linz
10:25 – 11:00	Complex polyps and pT1 cancers: defining curative resection and identifying high-risk pathological features	Professor Maurice Loughrey
COFFEE BREAK: 11:00 – 11:15		
<b>Session 2:</b> Multidisciplinary Case-Based Session <b>Panel Chairs:</b> Dr. Darragh McCullagh & Dr. Ryan Doherty		
11:15 – 12:40	From scope to slide to scan: multidisciplinary decision-making in early (pT1) GI cancer Cases: Oesophageal, Gastric, Rectal, Colonic Followed by a panel discussion	<b>Chair:</b> Dr Darragh McCullagh <b>Panel:</b> Dr Georg Spaun (Endoscopy), Dr Maurice Loughrey (Histopathology), Mr. Damien McKay (Colorectal Surgeon)
LUNCH: 12:40 – 13:25		
<b>Afternoon Symposium (Johnson &amp; Johnson – Sponsored)</b>		
13:30 – 14:00	Latest Treatment update in IBD	<b>Chair:</b> Dr Graham Turner <b>Speaker:</b> Dr John Paul Seenan, Consultant gastroenterologist
<b>Session 3:</b> Afternoon Clinical Session <b>Panel Chairs:</b> Dr. James Doyle & Dr. Kyle ODonovan		
14:00 – 14:20	Management of high-output stomas in intestinal failure	Dr Gerard Rafferty
14:20 – 14:40	A practical approach to the constipated patient	Dr Graham Morrison
COFFEE BREAK: 14:40 – 14:55		
<b>Session 4:</b> Oral Abstract Session <b>Panel Chairs:</b> Dr. Lisa McNeill & Dr Rebecca Reid		
15:00 – 15:40	Oral Abstract Session	Selected abstracts across gastroenterology and hepatology
<b>Session 5:</b> Guest Lecturer <b>Panel Chairs:</b> Dr. Lisa McNeill & Dr Rebecca Reid		
15:40 – 16:15	Approaching liver disease in pregnancy	Professor Michael Heneghan
CLOSING		
16:15 – 16:25	Panel Q&A	
16:25 – 16:30	Conference Close	Abstract Winner Announced

Sponsors have no input to the agenda or selection of speakers. Sponsored sessions are not included in the CPD Credit

# Biographical Sketches

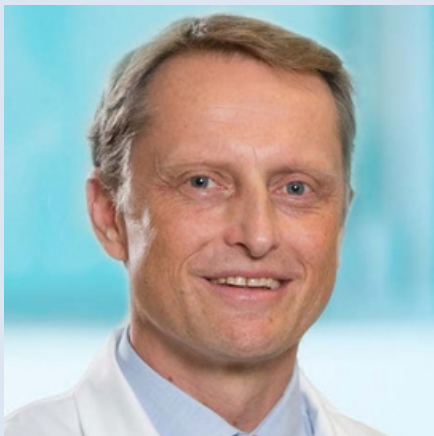
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## **Dr Oliver Brain** DPhil FRCP Consultant Gastroenterologist

Dr Oliver Brain is a Consultant Gastroenterologist and Clinical Director for Gastroenterology, Hepatology and Endoscopy in the Translational Gastroenterology and Liver Unit (TGLU), OUH NHS Foundation Trust. In addition, he is an Honorary Senior Lecturer at Oxford University.

Dr Brain's postgraduate training in Gastroenterology and Internal Medicine was at the John Radcliffe Hospital, Oxford. His immunology research training and DPhil was undertaken at the Weatherall Institute of Molecular Medicine and TGLU. He has a subspecialist interest in Inflammatory Bowel Disease, and is PI and CI to multiple clinical trials. He also has an interest in mechanisms of gastrointestinal inflammation, including the pathogenesis of cancer immunotherapy-induced enterocolitis.



## **Priv. Dozent Dr Georg Spaun** Director of the interdisciplinary Endoscopy Center at Ordensklinikum Linz, Austria.

He is a senior surgeon specialising in advanced diagnostic and therapeutic gastrointestinal endoscopy with a strong focus on minimally invasive techniques. His work emphasises interdisciplinary collaboration, clinical research and education in modern endoscopic care.

Georg was a tutor for anatomy and ultrasound anatomy at the University of Vienna until 1995. Following his specialist training in Salzburg he undertook a fellowship for EUS and ERCP in Salzburg (now Paracelsus Medical University of Salzburg) in 2004.

2005 followed a short term fellowship at the interdisciplinary endoscopy unit of Prof. Nib Soehendra at the University of Hamburg, Germany .

2007 to 2009 Georg undertook a Fellowship in Portland, Oregon, USA mentored by Prof. Lee Swanstrom for minimally invasive surgery and interventional luminal and transluminal endoscopy.

He was appointed head of interdisciplinary endoscopy unit at the Sisters of Charity Hospital in Linz, Austria in 2012, which later became the Ordensklinikum Linz.

2018 to 2024 he was invited Faculty of IHU, University of Strasbourg, France for the Institute of Image-guided Surgery for surgical endoscopy.

He has been an invited speaker to national and international conferences in France, Germany, Switzerland, Brasil, USA, China, Croatia and Czech Republic.

# Biographical Sketches

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## **Dr JP Seenan** Consultant Gastroenterologist in NHS Greater Glasgow and Clyde

I am a Consultant Gastroenterologist with a specialist interest in Inflammatory Bowel Disease (IBD). I am Clinical Lead for IBD in a large University Teaching Hospital with an active Clinical Research programme. I have more than 12 years experience of all aspects of Clinical Research and previously undertook a formal period of research leading to the award of an MD. I am currently involved in a number of single and multi-centre academic and clinical trials with a variety of roles including national Chief Investigator, Principal Investigator and Sub-investigator. Through my NHS Research Scotland Career Research Fellowship I have 2 dedicated sessions for clinical research.

In addition to my clinical role, I am an Honorary Clinical Associate Professor. As such, I am active in teaching and involved in the supervision of students working towards both undergraduate and postgraduate research qualifications. I am a member of the European Crohn's and Colitis Organisation (ECCO), the British Society of Gastroenterology IBD Section and the Scottish Society of Gastroenterology.



## **Dr Gerard Rafferty** FRCP MSc Nutrition

Graduated from QUB in 2000. Completed specialist training in 2010 in N Ireland Deanery including 6 months of out of program registrar training at St Mark's Hospital London and Salford Hospital Manchester. During registrar training I completed a Nutrition MSc at University of Ulster. Works as Gastroenterologist and co-leads the regional IFU based in Belfast City Hospital. Nutrition Lead for Belfast Trust.

# Biographical Sketches

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## **Graham Morrison**

Dr Graham Morrison is a Consultant Gastroenterologist in the Belfast Trust. He graduated from Queens University Belfast in 2000. He completed gastroenterology training in NI and completed a fellowship at Monash University in Melbourne specialising in Inflammatory bowel disease (IBD) and disorders of gut-brain interaction (DGBI) and irritable bowel syndrome. Graham was a consultant in the Western Trust based in Altnagelvin before moving to the Belfast Trust in 2016. His subspecialty interests include IBD and DGBI. He is the lead for IBD and has established a functional gut service within the trust. He is currently the Clinical Director for Gastroenterology in the Belfast trust.

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## **Mr Damian McKay**

Mr Damian McKay is a Consultant Colorectal Surgeon based at the Ulster Hospital Dundonald.

He has a high volume laparoscopic surgical practice for benign and malignant Colorectal Disease.

Mr McKay did fellowship training as the CSSANZ Fellow at Royal Adelaide Hospital in 2011 and developed a practice in Trans-anal minimally invasive surgery (TAMIS) for rectal cancer in the Southern Trust.

Mr McKay acted as Northern Ireland Colorectal Cancer CRG lead from 2017 to 2021 and in Summer 2024 was appointed to SPPG / Dept Of Health as Medical Director for the Northern Ireland Cancer Network / Cancer Programme.

# Biographical Sketches

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## **Professor Michael Heneghan** MD MMedSci FRCPI

Prof Heneghan MD MMedSci FRCPI is a professor of Hepatology and Consultant Hepatologist with an interest in autoimmune liver disease and liver transplantation at King's College Hospital London. He currently runs the autoimmune liver disease service and has pioneered the women's health program in liver disease at KCH. He graduated from medical school at University College Hospital Galway before pursuing fellowship in hepatology and liver transplantation at King's College Hospital London. He joined the faculty at Duke University Medical Centre Durham North Carolina and subsequently was Assistant Professor of Medicine and Medical Director of Liver Transplantation. He returned to London in 2003 where he has focused on his clinical and research interests of autoimmune liver disease, pregnancy related liver disease and liver transplant outcomes. He has authored over 300 manuscripts and book chapters. He has served on the editorial boards of the Journal of Hepatology, Liver Transplantation, Liver International and others. He has been an education and training counsellor for BASL, as well as Secretary General. He has contributed to clinical practice guidelines for the British Society of Gastroenterology and the European Association for the Study of the Liver in autoimmune hepatitis, pregnancy related liver disease and transitional hepatology. He also contributed to the chapter on AIH on up-to-date. He has an active clinical trial portfolio in the field of PBC, AIH and liver transplantation. He serves as a medical advisor to the British Liver Trust and to the PBC foundation

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# Oral Abstract 1

## The Impact Of Artificial Intelligence In Digital Pathology On The Diagnosis Of Barrett's Oesophagus: A Systematic Review

### Authors

Murray, R1; McManus, DT2; Coleman, HG3; Turkington, RC2,3; Craig, SG1.

### Departments/Institutions:

1. Johnston Cancer Research Centre, Queen's University Belfast, Belfast, Northern Ireland;
2. Belfast Health and Social Care Trust, Belfast, Northern Ireland;
3. Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland.

### Introduction

Barrett's oesophagus (BO) presents with a diagnostic dilemma for pathologists. High interobserver variability is noted particularly for diagnosis of dysplasia. In the UK histopathological diagnosis is transitioning to interconnected digital systems and advanced artificial intelligence (AI) techniques for image analysis of BO slides may offer a solution to streamline diagnosis.

### Aim

Conduct a systematic review to assess the performance of AI using digital pathology (DP) at predicting the presence of BO.

### Method

PROSPERO was used for protocol registration (CRD420251065866). Three electronic databases were searched for terms relating to BO, DP and AI. Studies included participants with a previous diagnosis of BO with interventions of AI using DP to detect BO. Diagnostic reference standards were based off the opinion of a qualified pathologist, and outcomes assessed the diagnostic performance of these models at predicting BO grade.

### Results

Eleven studies were included in this review. Eight studies based their models on deep learning approaches and three used morphometric based predictions. Most studies focused on Non-dysplastic BO (NDBO) and low/high grade dysplastic BO. Due to heterogeneity of study design and reporting only five studies were brought forward for pooled analysis for dysplasia against NDBO detection. The overall summary estimate for dysplasia detection produced a sensitivity of 0.930 (95% CI: 0.900 – 0.953) and specificity of 0.769 (95% CI: 0.717 – 0.816).

### Conclusions

AI produced a high standard of prediction when discriminating between dysplastic BO and NDBO. However, tissue heterogeneity in BO presents a potential challenge to performance as displayed by some multiclass model systems.

# Oral Abstract 2

## The Capsule Sponge in Barrett's Oesophagus and Gastro-Oesophageal Reflux: An Implementation Pilot in Northern Ireland

**Authors** D.N. Johnston<sup>1</sup>; D. Concannon<sup>2</sup>; F. Gregg<sup>3</sup>; N. Milligan<sup>3</sup>; I. Mainie<sup>3</sup>; J. McGoran<sup>2</sup>; R.C. Turkington<sup>1</sup>.

**Departments/Institutions**

1. Centre for Public Health, Queen's University Belfast, Belfast, United Kingdom;
2. Department of Gastroenterology, Western Health and Social Care Trust, Londonderry, United Kingdom;
3. Department of Gastroenterology, Belfast Health and Social Care Trust, Belfast, United Kingdom.

### Introduction

Capsule sponge testing combined with immunohistochemical biomarkers can prioritise patients with Barrett's oesophagus (BO) and gastro-oesophageal reflux for oesophagogastroduodenoscopy (OGD).

### Aim

To assess the feasibility of capsule sponge testing to triage patients with BO or gastro-oesophageal reflux for OGD in Northern Ireland.

### Method

Patients with BO under surveillance and patients referred to gastroenterology due to reflux were eligible. Patients were recruited from 2 sites, undergoing the test in nurse-led clinics between December 2024 and March 2025. Pathology samples were processed centrally, examining for TFF3 (suggestive of intestinal metaplasia), p53 and atypia (high-risk findings associated with dysplasia). Patient feedback was collected.

### Results

94 patients underwent capsule sponge testing (50 BO, 44 reflux). 45 BO samples (90%) were adequate. 8 (18%) were positive/equivocal for atypia/p53 and deemed high-risk, undergoing urgent OGD. 37 (82%) were negative for atypia/p53, continuing usual surveillance. 30 samples (68%) from patients with reflux were adequate. 2 (7%) were positive/equivocal for atypia/p53 and were prioritised for urgent OGD, 4 (13%) were TFF3 positive only and were booked for routine OGD, and 24 (80%) were negative for all 3 biomarkers and were managed as per usual practice.

Feedback was collected from all 94 patients. The mean self-reported Gloucester comfort score was 2 (minimal discomfort). When asked for their preference between capsule sponge and OGD, 63 (67%) would prefer capsule sponge, 5 (5%) would prefer OGD, and 26 (28%) were unsure.

### Conclusions

The capsule sponge could successfully triage patients under BO surveillance or with reflux for OGD in Northern Ireland.

# Oral Abstract 3

## Impact of Lowering the qFIT Threshold on Colorectal Cancer and High-Risk Polyp Detection in an Asymptomatic Screening Population

**Authors** O'Brien H<sup>1,2</sup>; Johnston D<sup>2</sup>; Ings G<sup>3</sup>; Loughrey M<sup>4,5</sup>; Khosraviani K<sup>2</sup>.

**Departments/Institutions**

1. Queens University Belfast, Belfast, UK;
2. Department of Surgery Belfast Health and Social Care Trust, Belfast, UK;
3. Public Health Agency, Linum Chambers, Belfast, UK;
4. Centre for Public Health Queens University Belfast, UK;
5. Department of Cellular Pathology, Belfast Health and Social Care Trust, Belfast, UK.

### Introduction

The Bowel Cancer Screening Programme (BCSP) in Northern Ireland (NI) aims to detect colorectal cancer (CRC) and high-risk polyps using quantitative faecal immunochemical test (qFIT) with the aim of early intervention.

### Aim

In April 2023, the BCSP reduced the qFIT threshold for asymptomatic individuals from  $\geq 150$   $\mu\text{g Hb/g}$  to  $\geq 120$   $\mu\text{g Hb/g}$ . This study evaluated the effect of this change on detection rates of CRC and high-risk polyps within a population-based screening programme.

### Methods

A retrospective analysis of Public Health Agency data was performed for individuals with qFIT values between 120–149  $\mu\text{g Hb/g}$  over a 12-month period (01/05/2024–30/04/2025). Screening outcomes included CRC, high-risk polyp, low-risk polyp, biopsy only, no abnormality detected (NAD), CT colonography only, unsuitable for investigation, declined screening, or positive qFIT non-responder.

### Results

A total of 297 individuals fell within the revised qFIT threshold. CRC was detected in 10 patients (3.4%), while high-risk polyps were identified in 68 (22.9%). Low-risk polyps were detected in 85 patients (28.6%). Overall, 78 patients (26.3%) had either CRC or high-risk polyps. Twenty-five individuals (8.4%) declined further investigation and 15 (5.1%) were positive qFIT non-responders.

### Conclusions

Lowering the qFIT threshold significantly increased identification of clinically relevant colorectal pathology, supporting earlier diagnosis and prevention. In the context of rising colorectal cancer incidence in younger patients, these findings support consideration of lowering the age threshold for screening alongside optimisation of qFIT-based triage pathways to balance diagnostic yield and service capacity.

# Oral Abstract 4

## Development Of A Hepatology “Hot Clinic”: A Cost-Neutral Ambulatory Model To Improve Patient Flow, Reduce Bed Pressures And Expedite Care

**Authors** P.D MacAllister; B. Layard; N. McDougall; H. McDowell.  
**Departments/Institutions** Regional Liver Unit, Royal Victoria Hospital, Belfast Health and Social Care Trust.

The Regional Liver Unit at the Royal Victoria Hospital provides hepatology care for patients across Northern Ireland. Pressures on bed capacity frequently results in cancelled elective admissions for cancer treatments and therapeutic procedures. In November 2025, an ambulatory service—the Hepatology Hot Clinic—was established with the following aims;

1. Facilitate early discharge from hospital.
2. Enable rapid assessment of referrals potentially requiring admission.
3. Provide timely review of existing outpatients with abnormal results.

### Methods

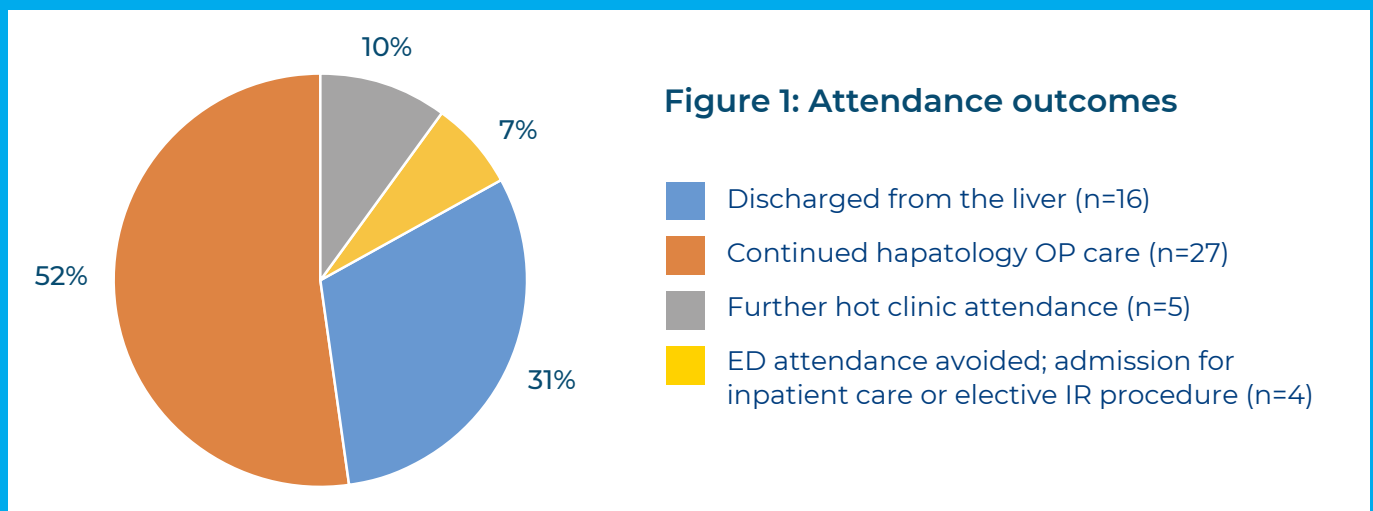
The clinic operates twice weekly, with referrals vetted by a consultant hepatologist. A retrospective review of the first six weeks was undertaken, evaluating referral source, indication for attendance, diagnoses and clinical outcomes.

### Results

52 of 72 available appointments were utilised by 48 patients. Four patients required two appointments.

Eighteen patients (35%) were seen via triage or referral; all were managed through ambulation alone. Eight were discharged from hepatology. Four required admission or day procedure, avoiding an ED attendance in each case.

Seventeen patients (33%) were existing outpatients referred for enhanced monitoring. Thirteen (25%) had early discharge facilitated through Hot Clinic. Overall discharge rate from hepatology following hot clinic was 31%. Forty patients (83%) achieved their intended visit outcome, including improvement in biochemical parameters and safe diuretic titration.



### Conclusion

Early data demonstrates that a cost-neutral ambulatory service, delivered through reallocation of existing resources, supports earlier discharge, reduces admissions and improves patient flow. Accepting appropriate referrals from ED represents an important next step to further reduce unnecessary admissions and outpatient waiting times.

# Poster Abstract 1

## Understanding the malignant potential of gastric metaplasia in patients with Barrett's oesophagus: a population-based study

### Authors

V Child<sup>1</sup>; M Toal<sup>1\*</sup>; A Blair<sup>1</sup>; A Sharma<sup>1</sup>; R Turkington<sup>1</sup>; B Johnston<sup>2</sup>; DT McManus<sup>3</sup>; D Bennett<sup>4</sup>; HG Coleman<sup>1,4</sup>.

\*presenting author

### Affiliations

1. Centre for Public Health, Queen's University Belfast, Belfast, Northern Ireland, UK;
2. Department of Gastroenterology, Belfast Health and Social Care Trust, Belfast, Northern Ireland, UK;
3. Department of Pathology, Belfast Health and Social Care Trust, Belfast, Northern Ireland, UK;
4. Northern Ireland Cancer Registry, Belfast, Northern Ireland, UK.

### Introduction

Debate continues on whether gastric metaplasia (GM) alone warrants a diagnosis of Barrett's oesophagus and surveillance entry.

### Aim

We compared the risk of neoplastic progression by metaplasia subtype.

### Methods

Pathology reports for 14,285 Barrett's oesophagus patients diagnosed between 2011 and 2020 were categorised into four metaplasia groups (GM only, Intestinal Metaplasia (IM) only, Mixed (GM and IM) and unknown and were followed-up to end 2022. Demographic and clinical characteristic differences were assessed by Chi-square. Linkage to Northern Ireland Cancer Registry (NICR) and General Register Office (GRO) identified individuals progressing to oesophageal or gastric cardia cancer (excluding squamous cell carcinoma) or high-grade dysplasia (HGD) or who died during follow-up. Cancer/HGD incidence was calculated per 100 person-years. Individuals (n=381) with prior OG cancer, HGD at index or unknown emigration status were excluded.

### Results

39.2% had GM only, 28.0% IM only, 14.4% mixed and 18.5% unknown. The IM group were more likely male (65.7% vs 50.5%;  $p < 0.05$ ) and GM only group were younger (50% < 60 years vs 34.7%;  $p < 0.05$ ). During 88,239 person years, 149 patients progressed to oesophageal or gastric cardia cancer or HGD with mean follow-up (6.31 years) comparable across groups. Those with GM only had combined cancer/HGD incidence of 0.04%/year (95% CI 0.02-0.06), 0.35% (95% CI 0.28-0.43)/year for IM only, 0.26%/year (0.18-0.37) for mixed and 0.11%/year (95% CI 0.07-0.17) for unknown.

### Conclusion

These results add further population-based evidence to reassure patients and clinicians of the low progression risk for those with GM only and highlight the need to further risk-stratify patients to optimize surveillance strategies.

# Poster Abstract 2

## Emerging Patterns In Early-Onset Gastrointestinal Cancers: Insights From Population-Based Data In Northern Ireland

**Authors** AC Russell<sup>1</sup>; A Jeyaraj<sup>1</sup>; D Donnelly<sup>2</sup>; HG Coleman<sup>1,2,3</sup>.  
**Affiliations** 1. Centre for Public Health, Queen's University Belfast, Northern Ireland;  
2. Northern Ireland Cancer Registry, Queen's University Belfast, Northern Ireland;  
3. Patrick G Johnson Centre for Cancer Research, Queen's University Belfast, Northern Ireland.

### Introduction

Rising incidence of specific types of early-onset cancers, particularly colorectal cancer (CRC), has been observed internationally.

### Aim

The aim of this study was to comprehensively profile early-onset gastrointestinal (GI) cancers in 18-49 year olds in Northern Ireland, including trends over time.

### Methods

Data on GI cancer cases diagnosed between 1993 and 2022 were extracted from the Northern Ireland Cancer Registry. Incidence, stage, treatment and survival were investigated and compared in individuals aged 18-49 years, 50-59 years, 60-74 years and 75 and over.

### Results

Early-onset GI cancers increased in Northern Ireland from 1993 to 2022 in Northern Ireland, driven by a 36% rise in early-onset CRC (European age-standardised incidence 9.7 to 13.2 per 100,000).

From 2013-2022, early-onset cancers comprised 5.8% (n=959) of all GI cancers (n=16,419), with 74% of early-onset cases occurring in 40-49 year-olds. Individuals under 50 were more likely to present with stage IV disease than those over 50 (32.4% in <50-year-olds vs. 23.6%-29.3% in ≥50-year-olds).

Individuals diagnosed with early-onset GI cancers received more surgery, systemic treatment and radiotherapy than older age groups. However, five-year net survival did not significantly differ between early-onset cases and those aged 50-59 or 60-74 in stage I, II, III or IV disease.

### Conclusion

Early detection efforts in younger adults are crucial, including increasing awareness of relevant symptoms in healthcare professionals and the public, to reduce the proportion of late-stage diagnoses. Guidelines for optimal treatment of early-onset cancers are needed, to ensure the best possible outcomes while avoiding unnecessary treatment.

# Poster Abstract 3

## Risk Of Neoplastic Progression Does Not Differ In Barrett's Oesophagus Patients With Or Without Reflux Symptoms Population-Based Data Linkage Study

### Authors

EB McGrattan<sup>1</sup>; V Child<sup>1</sup>; BT Johnston<sup>2</sup>;  
DT McManus<sup>3</sup>; RC Turkington<sup>1</sup>; HG Coleman<sup>1,4</sup>.

### Affiliations

1. Centre for Public Health, ICS- Building, RVH Site, Grosvenor Road, Queen's University Belfast, Belfast, Northern Ireland, BT12 6BA
2. Department of Gastroenterology, Belfast Health and Social Care Trust, Belfast, Northern Ireland
3. Damian T McManus, Department of Pathology, Belfast Health and Social Care Trust, Belfast, Northern Ireland
4. Patrick G Johnston Centre for Cancer Research, Queen's University Belfast, Belfast, Northern Ireland

### Background

Patients without reflux symptoms are not eligible for Barrett's oesophagus (BO) screening clinical trials. This study aims to define a proportion of BO patients with or without reflux symptoms, to compare characteristics and risk of progression to high-grade dysplasia (HGD) or oesophageal adenocarcinoma (OAC).

### Methods

A population-based cohort study was conducted analysing patients from the Northern Ireland Barrett's Register (NIBR) diagnosed between 2010 and 2021, linked to the Northern Ireland Enhanced Prescription Database to identify date of first prescription of an anti-reflux medication as a proxy for symptom status. NIBR patients diagnosed 2009-2018 were linked to the Northern Ireland Cancer Registry for outcomes up to end 2018, including progression to HGD/OAC, calculated as events per 100 person-years follow-up (% per year).

### Results

Of n=16,283 BO patients, 16% were coded as BO patients without reflux symptoms at incident diagnosis. Patients without reflux symptoms were more likely to be younger, male, but less likely to have diabetes, hiatus hernia, specialised intestinal metaplasia or long-segment Barrett's. During over 70,164 person years of follow-up, n=73 BO progressed, equivalent to a risk of neoplastic progression in BO patients with reflux symptoms of 0.16% per year (95% CI: 0.01-0.19) and 0.15% in BO patients without reflux symptoms (95% CI: 0.10-0.24).

### Conclusions

No difference in risk of neoplastic progression was observed in BO patients with or without reflux symptoms. These findings suggest that screening or surveillance risk stratification for BO should not focus solely on reflux symptom experience.

# Poster Abstract 4

## Evaluation of Adherence to Guidance on Biopsy Sampling During Upper Gastrointestinal Endoscopy

**Authors**

K. Abdul-Hakim; M. Furtado; M.B. Loughrey.

**Affiliations**

Department of Cellular Pathology,  
Institute of Pathology, Royal Victoria Hospital,  
Belfast BT12 6BA

### Introduction

Recent joint guidance has been issued by the British Society of Gastroenterology, Association of Upper Gastrointestinal Surgery of Great Britain and Ireland and Royal College of Pathologists on recommended biopsy sampling during upper gastrointestinal endoscopy, following a Delphi consensus process.

### Aim

We aimed to assess local adherence to this guidance by retrospectively evaluating a cohort of specimens submitted for histopathology assessment, against the recommended clinical and endoscopic indications for biopsy.

### Method

Consecutive, unselected upper GI tract endoscopic specimens received for processing by the Belfast H&SC Trust in September/October 2025 were individually reviewed, based on information recorded on associated endoscopy reports, and the indication for biopsy at each site (oesophagus/stomach/duodenum) assessed as "valid" or "invalid", according to guidance criteria.

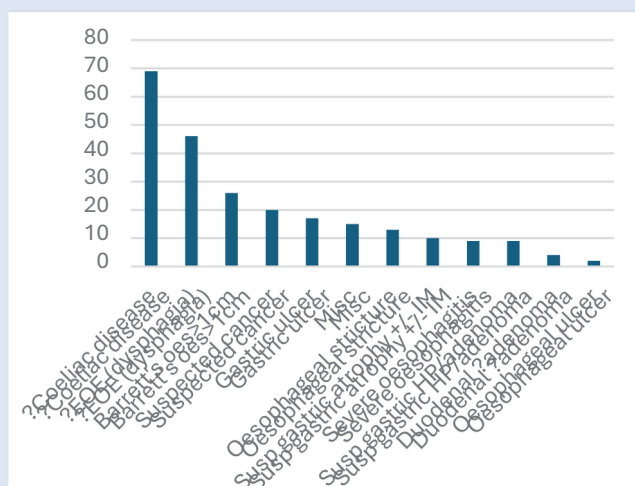
### Results

332 OGD specimens procured from 254 adult patients were reviewed. Eight specimens were excluded on the basis of no or inadequate endoscopic information provided. Of 324 specimens, 240 (74.1%) had a valid indication and 84 (25.9%) an invalid indication, based on available information. The commonest valid indication was duodenal biopsy to exclude coeliac disease (69, 28.8%). The commonest invalid indications were "gastritis, NOS" +/- for H. pylori assessment (44, 52.4%), anaemia and normal gastroscopy (9, 10.7%), gastric fundic gland cyst polyps <1cm (9, 10.7%) and Barrett's oesophagus <1cm (5, 6.0%). Mild GORD, oesophageal candidiasis, CLO-positive gastritis, duodenitis and duodenum with strongly positive coeliac serology were rarely biopsied.

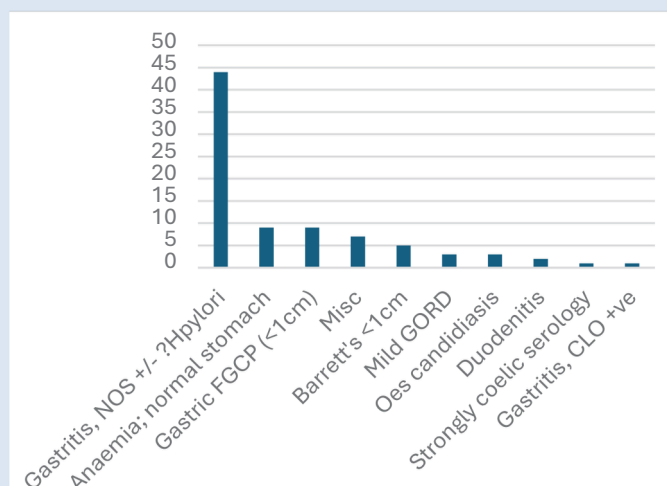
### Conclusion

Approximately 25% of upper GI endoscopic biopsy specimens are not indicated by current guidance, placing an additional burden on overstretched pathology services.

Valid Indications for UGI Bx (n=240)



Valid Indications for UGI Bx (n=84)



# Poster Abstract 5

## A Systematic Review of the Association Between Body Composition and Age-Specific Oesophageal Adenocarcinoma Risk

### Authors

Abigail Jeyaraj<sup>1</sup>; Helen G. Coleman<sup>1,2</sup>;  
Ashleigh C. Russell<sup>1</sup>.

### Affiliations

1. Centre for Public Health, Queen's University Belfast;  
2. Northern Ireland Cancer Registry,  
Queen's University Belfast.

### Introduction

Excess bodyfatness is an established risk factor for oesophageal adenocarcinoma (OAC) as a disease. However, whether the association between overweight/obesity and OAC risk varies between age groups is unclear.

### Aim

This systematic review aims to investigate the association between measures of body composition and OAC risk by age group.

### Methods

The study protocol was registered on PROSPERO (CRD420251047948). Embase, Medline, Web of Science and CINAHL were searched for relevant studies published from 2000 to June 2025. Eligible studies included observational studies reporting on OAC among  $\leq 50$ -year-olds. The quality of included studies was assessed using the Newcastle-Ottawa Scale. Results were analysed according to Systematic Reviews and Meta-Analyses and Synthesis Without Meta-analysis guidelines.

### Results

After screening 6,149 abstracts and 128 full texts, three unique studies were eligible (pooled case-control study  $n=1$ , cohort study  $n=1$ , ecological study  $n=1$ ). All studies presented results (risk estimates  $n=2$ , age-standardised incidence rates  $n=1$ ) for body mass index (BMI), and defined obesity as  $\text{BMI} \geq 30 \text{ kg/m}^2$ . Based on two studies presenting risk estimates, the statistical association between obesity and OAC risk was stronger among  $< 50$ -year-olds compared to all ages ( $< 50$ -year-olds Odds Ratio [OR]=4.19, 95% Confidence Interval [CI]=2.23-7.87, All Ages OR=2.83, 95%CI=2.36-3.40;  $< 50$ -year-olds Hazard Ratio [HR]=2.21, 95%CI=1.24-3.97, All Ages HR=1.33, 95%CI=1.23-1.43).

### Conclusions

Findings from studies included in this review suggest stronger association between obesity and OAC risk among  $< 50$ -year-olds compared to all ages. The striking lack of studies investigating body composition measures and OAC risk among  $< 50$ -year-olds highlights the urgent need for further research in this area.

# Poster Abstract 6

## Impact of Comorbidity Burden on Outcomes Following Colonoscopic Polypectomy for Benign Disease A Retrospective Audit Using the Carlson Comorbidity Index

**Authors**

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### Introduction

Colonoscopy with polypectomy is central to colorectal cancer prevention. As the population ages, increasing comorbidity among patients undergoing endoscopic therapy may influence outcomes, yet its impact following benign polypectomy is unclear.

### Methods

A retrospective audit was performed of 194 consecutive patients undergoing colonoscopy with polypectomy for benign colorectal polyps at the South Eastern Health and Social Care Trust, Northern Ireland. Patients with malignant polyps or colorectal cancer were excluded. Data collected included Charlson Comorbidity Index (CCI), post-procedural bleeding, hospitalisation, polyp recurrence at surveillance colonoscopy, and all-cause mortality. Patients were stratified into low (CCI  $\leq 2$ ), moderate (3–5), and high ( $\geq 6$ ) comorbidity groups. Associations were analysed using chi-square testing.

### Results

Median CCI was 3 (range 0–10); 33.5% were low-CCI, 52.5% moderate-CCI, and 14% high-CCI. During follow-up, 18 patients (9.3%) died, all with CCI  $\geq 3$ . Mortality increased significantly with comorbidity (0% low-CCI, 7.8% moderate, 37.0% high;  $\chi^2=31.6$ ,  $p<0.001$ ).

Post-polypectomy bleeding occurred in two patients (1.0%), and nine (4.6%) required hospitalisation, predominantly in moderate and high-CCI groups. Polyp recurrence occurred in 21 patients (10.8%), rising from 6.2% in low-CCI to 37.0% in high-CCI patients ( $\chi^2=11.0$ ,  $p=0.004$ ). Persistent recurrence across surveillance procedures was observed exclusively in patients with CCI  $\geq 4$ . Despite representing <15% of the cohort, patients with CCI  $\geq 6$  accounted for one-third of recurrences and over one-third of deaths.

### Conclusions

Higher comorbidity burden is strongly associated with increased mortality and polyp recurrence following benign polypectomy. A CCI  $\geq 6$  may represent a threshold beyond which repeated surveillance offers diminishing benefit. Integrating comorbidity and frailty assessment into colonoscopy pathways may support more individualised decision-making.

# Poster Abstract 7

## Determining Individual Factors, Features, and Aetiology in Reflux Symptom DIFFERS Experience In Oesophageal Adenocarcinoma Patients An OCCAMS Cohort Real-World Data Analysis

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### Introduction

The UKBEST4 screening trial is underway with the aim of evaluating if screen-detected Barrett's oesophagus (BO) leads to reduced mortality from oesophageal adenocarcinoma (OAC). However, inclusion criteria for BEST4 is restricted only to participants who have reflux symptoms. The aim of this study is to determine if OAC patients have distinct characteristics according to their reflux symptom experiences.

### Materials/ Methods

Data from the Oesophageal Cancer Clinical and Molecular Stratification (OCCAMS) UK Consortium, recruited since 2010, were analysed. Logistic regression models were applied to compare characteristics between OAC patients with and without reflux symptoms.

### Results

Of n=3,964 OAC patients in OCCAMS, n=3,055 (77%) had known information for reflux status, of whom n=562 (18%) were classified as OAC patients without reflux symptoms. OAC patients without reflux symptoms were more likely to be of a non-White ethnicity (3.0% v 1.3%,  $p < 0.01$ ), to have had liver failure/cirrhosis (OR: 2.83, 95% CI: 1.17-6.84) and more likely to be underweight/normal BMI than overweight (OR: 0.73, 95% CI: 0.58-0.92) than OAC patients with reflux. In comparison, OAC patients without reflux symptoms were 24-30% less likely to smoke 10-20 cigarettes per day (OR: 0.76, 95% CI: 0.58-0.99) and to have diabetes (OR: 0.74, 95% CI: 0.56-0.98) than OAC patients with reflux symptoms.

### Conclusion

Approximately one in five OAC patients (18%) were classified as without reflux symptoms in this large cohort and would be missed through current screening trial eligibility. In addition, this study identified various characteristics that are significantly different between OAC patients with and without reflux, warranting further investigation.

# Poster Abstract 8

## Timing of Reversal after Hartmann Procedure for benign indication and Its Impact on Outcomes: A Systematic Review

### Authors

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### Background

Hartmann's Procedure (HP) is commonly performed procedure for various indications. The optimal interval between index procedure and stoma reversal remains uncertain. Surgeons balance risks of operative difficulty and complications against the morbidity of prolonged stoma.

### Methods

A systematic review of 7 studies was conducted. Studies comparing different reversal intervals or reported outcomes stratified by timing were included. Primary outcomes were overall morbidity. Secondary outcomes included anastomotic leak, mortality, reoperation, readmission, and stoma-free survival.

### Results

Of 668 screened articles, 7 studies involving 2622 patients underwent stoma reversal following HP for benign causes were included. Across the studies, "early" reversal was commonly defined as early as 45 days to 6 months after index surgery, and "delayed" as beyond that threshold. Early reversal was commonly associated with reduced length of stay, and higher probability of patients becoming stoma free within 12 months. Overall complication rates were similar or lower with early reversal in most series. Major complications and anastomotic leaks were low overall and did not show a consistent increase with early reversal when patients were clinically optimized. Delayed reversal correlated with older age, higher comorbidity burden, pelvic sepsis at index surgery, and difficult abdominopelvic planes. Smoking, diabetes and chronic kidney disease were repeatedly identified as predictors of postoperative morbidity following reversal.

### Conclusions

However, definitions of "early" reversal vary, for appropriately selected patients, reversal within 45 days to 6 months, as evidenced, is as safe as later reversal and could improve recovery metrics and stoma-free time. Patient factors and individual operative expertise should guide individual timing decisions.

# E-Poster Presentations

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# Ulster Society of Gastroenterology

Spring Meeting

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