Abstracts

Autumn Meeting Ulster Society of Gastroenterology Thursday 18th November 2010

Hilton Hotel, Templepatrick

PROGRAMME

Approved for 3 external CPD credits (RCP)

13:30 – 14:00 Registration & Tea / Coffee
14:00 – 14:05 Welcome
14:05 – 14:45 Free paper presentation (4 papers)
14:45 – 15:00 NICAN Regional Colonoscopy Audit Results
15:00 – 15:15 Can’t scope, won’t scope!
15:15 – 15:30 Coffee / exhibition stand
15:30 – 16:00 Nonalcoholic Steatohepatitis
Dr N McDougall
Consultant Hepatologist
Royal Victoria Hospital
16:00 – 17:00 IBD and its Complications
Dr Stuart Bloom
Consultant Gastroenterologist
University College London Hospitals
17:00 – 18:00 Business meeting
18:00 Meeting close & USG Dinner

ORAL PRESENTATIONS

Prize Winning Presentation: Investigation for Biomarkers of Barrett’s Oesophagus
Jawad Ahmad, Ken Arthur, Andrew Kennedy, Helen Mulholland, Perry Maxwell, Liam Murray, Brian Johnston, Damian McManus

Introduction: The incidence of oesophageal adenocarcinoma (OAC) has increased dramatically over recent years and Barrett’s oesophagus (BO) is the most established risk factor for its development. Endoscopic surveillance of BO has been widely advocated but hinges on assessment of repeated endoscopic biopsies, which is problematic. The use of biomarkers presents an opportunity to reduce sampling bias and improve our ability to risk-stratify these patients.

We evaluated three novel biomarkers namely P504S, CD133 and Twist, in the setting of BO, low grade dysplasia (LGD) and OAC.

Materials and Methods: After ethical approval, the biomarkers were immunostained on an automated Ventana immunostainer. The archived biopsy materials were assessed for biomarkers expression by two independent observers using a QScore method. 25 cases each of BO, LGD and OAC were included along-with 25 cases of oesophagectomy for OAC. Any inter-observer score discrepancy of ≥ 2 was settled at a case meeting.

Results: P504S did not express in BO. Its expression was significant in cases of LGD (56%), OAC (40%) and resections (60%). CD133 also did not express in BO or LGD. It was up-regulated in cases of OAC (24%) and resections (68%). Twist expression was weak in BO and LGD. However, it was significantly over-expressed in cases of OAC (56%).

Discussion: This cross sectional study has shown increased expression of P504S, CD133 and Twist in the metaplasia-dysplasia-adenocarcinoma sequence and has suggested their possible role as potential biomarkers of Barrett’s progression. Further longitudinal and prospective studies are required to validate these results.

Laparoscopic repair of para-oesophageal hernias
R Lambon, R Kennedy, G Irwin, Z Bell, A Kennedy

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Background: Para-oesophageal hernias (POH) are rare but potentially lethal disorders of the oesophageal hiatus. Laparoscopic repair is a recently introduced minimally invasive surgical innovation. We aimed to assess the efficacy and safety of this approach at our institution.

Methods: A prospective cohort study was performed. Patients who underwent laparoscopic POH repair were included. Data regarding operative time, conversion to open rate, repair method, operative and post-operative complication rate, symptomatic assessment and hernia recurrence rate was collected.

Results: Over the 4 years study period, 26 patients had surgery. The mean age was 63.1 years (37-82) and 60.9% were female. Most patients had co-morbidities with American Society of Anaesthesiology (ASA) grade I (3), II (14), III (9). The most common presenting complaint was with recurrent chest pain (39.1%). Emergency presentation with gastric volvulus and acute abdominal pain occurred in 4 patients (17.4%). Conversion to open was necessary in 1 patient, who had 2 previous repairs at another institution. Mean operating time was 165 minutes (64-240) and repair of hiatus achieved with biological mesh in 13 (56.5%). Mean postoperative stay was 3.7 days (1-8 days, median 3). At mean follow-up of 24.3 months, complications encountered were mortality 1 (due to pulmonary embolism), pneumonia 1, acute recurrence requiring re-operation 1, dysphagia requiring gastroscopic dilation 3, mediastinal collection treated with percutaneous drainage 1.
Conclusion: Laparoscopic repair of para-oesophageal hernias is safe and efficacious.

Gerard Rafferty, Mary Kane. Peri Gillespie, Graham Turner.

Introduction: Public and client involvement is essential in trying to improve the quality of a service. There had previously been no regional IBD patient satisfaction survey performed in Northern Ireland.

Methods: A patient satisfaction survey was designed with NACC input. 410 questionnaires were posted to NACC members. Categories included: information given to patients at any stage during illness, IBD nurse specialists, out-patient care, care during flare-up of IBD and overall rating of IBD service currently provided.

Results: 42.2% questionnaires were returned. 36.8% male.

38.5% patients were given written information about IBD. 50.0% total patients were given information about the medications they were prescribed. 37.9% total patients were given explanation about how illness was likely to affect them in future. 24.2% total patients felt they received sufficient information about illness and treatment available. 5.2% have access to IBD nurse specialist and 88.8% felt it would be beneficial to have access to IBD nurse specialist. 69.5% patients have regular OP appointments with 40.2% have 6 monthly or more frequent appointments.

44.8% patients felt that they have access to a satisfactory contact with IBD service during a flare-up. 77.4% were satisfied with in-patient care. 50.6% satisfied with out-patient care.

Conclusion: IBD service can be improved and need more patient and client involvement. Immediate fixes include: better information to patients, advice regarding joining NACC, written info sheets including medicine and spend more time discussing future. In the long-term we need better management of chronic disease (including community care) and increase IBD specialist nurse numbers.

If it walks like Crohn’s and talks like Crohn’s, it must be……..

Hall PSJ 1, Allen PB 1, Patterson J 2, Manikure G 1, Djong K 1, Varghese A 1

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A 30 year old male presented with a six month history of nausea, vomiting and diarrhoea. He experienced almost daily episodes of vomiting with abdominal pain, and had lost over 25 kilograms of weight during this time. He had intermittent diarrhoea, occasionally with bloody stools, and a migratory abdominal colic often localising to the right side. He was lethargic, had anorexia, and complained of profuse sweating. He had been provisionally diagnosed with Crohn’s disease 6 months previously and treated with budesonide and mesalazine. This provided minor relief from his diarrhoea, but had no effect on abdominal pain or weight loss. There was nil other past medical history of note. He had no allergies and did not drink alcohol or smoke. On examination he had no rashes, lymphadenopathy, anaemia or jaundice. He had mild tenderness in his right lower flank. There were no abdominal masses palpable and no ascites. Bowel sounds were present. Investigations including C-reactive protein, white cell count, coeliac antibodies, fasting gut hormones and faecal elastase were all normal. Colonoscopy and ileoscopy was normal macro- and microscopically. Small bowel series and labeled white cell scan were both unremarkable. A computerised tomography (CT) scan of the abdomen demonstrated the presence of mild right sided lymphadenopathy which raised the possibility of small bowel pathology. Laparoscopy of entire small bowel and colon was normal and an appendicectomy was performed. But was there something that had been missed?