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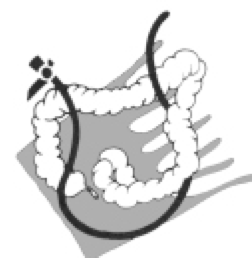
Abstracts

Ulster Society of Gastroenterology, Spring Meeting, 15th March 2012



Hilton Hotel, Templepatrick

President	Dr A Varghese
Secretary	Dr P Lynch
Treasurer	Dr G Caddy

PROGRAMME

1:30pm	Coffee/ Registration
2 – 3:30pm	Free papers
3:30 – 3:45pm	Coffee/ exhibition stand
3:45 – 4:15pm	*The Regional Endoscopy Reporting System* Mr K Khosraviani Consultant Colorectal Surgeon Royal Victoria Hospital
4:15 – 5pm	*Alcohol, Society and the Doctor's Role* Prof Sir Ian Gilmore BSG President-Elect Consultant Gastroenterologist Royal Liverpool University Hospital
5pm	Business meeting
6pm	Dinner
	USG Free Paper Abstracts

AN EARLY EXPERIENCE OF LAPAROSCOPIC RECTOPEXY

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Introduction

Laparoscopic rectopexy for rectal prolapse has come into vogue in recent years with advancements in laparoscopic surgery. This is a retrospective audit of patients who underwent laparoscopic rectopexy in a single centre, comparing outcomes with previously published data.

Method

All patients who underwent laparoscopic rectopexy over a three-year period were included. Patients were retrieved from computerised operating records, searching for the term 'laparoscopic rectopexy'. Patient notes were retrieved, and data regarding patient demographic, operative details, short-term complications and long-term outcomes collected.

Results

Seven patients (6 female, 1 male) were recorded as having undergone laparoscopic rectopexy. Two were excluded, one patient underwent an open redo rectopexy and another had an EUA only. Five patients were included with median age 75 (33 - 83). Four had a laparoscopic rectopexy and the fifth had a laparoscopic-assisted resection rectopexy. The operation lasted a mean of 124 minutes (range 64 -164 minutes). The patients had a median inpatient stay of 8 days (range 6-17 days). No mortalities were reported. One patient required a post-operative blood transfusion and another had a laparoscopic port wound infection requiring oral antibiotics. Patients were followed for a median of 6 months (range 4 to 12 months). Two patients reported occasional faecal incontinence at first review; all patients reported improvement in symptoms by second review. There were no incidences of prolapse recurrence or sexual dysfunction.

Conclusion

This study demonstrated promising early experience with laparoscopic rectopexy in keeping with previously published data.

PROTON PUMP INHIBITORS - ARE WE PRESCRIBING THEM CORRECTLY?

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Introduction

Proton pump inhibitors (PPIs) are one of the most frequently prescribed medicines worldwide. However in many cases they are inappropriately prescribed in both primary and secondary care.

Objective

The aim of this audit was to examine the PPI prescribing practice of junior doctors in a large teaching hospital and to assess patient knowledge with regard to their medication.

Method

A questionnaire was distributed to junior doctors, general medical inpatients and nursing staff with respect to PPI administration. Junior doctors were asked further questions regarding IV PPI therapy.

Key findings

There were 50 inpatients in this study (21 males, 29 females)

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with an average age of 66 (range 28-90). The main indication was for symptoms of gastro-oesophageal reflux in 38%. Only 10% were taking the medication at the correct time in relation to meals, and most had never been trialled off their PPI.

Of 50 doctors questioned, few gave lifestyle advice to their patient (36%) and less than half were aware of the timing of PPI administration (48%). Knowledge of IV PPI prescribing was poor. 81% of nursing staff recognized that PPI should be given before a meal.

Discussion

Overall knowledge with respect to all aspects of PPI prescribing, both oral and IV, appears to be very poor amongst junior medical staff. Education for both patient and doctors is paramount to ensure correct prescribing and that maximum efficacy is achieved.

ADENOCARCINOMA OF THE SMALL INTESTINE - CASE SERIES AND LITERATURE REVIEW

Neely D, Ong J, Skelly R, Patterson J
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Aim - To identify patients diagnosed with small intestinal adenocarcinoma in our institution and to review the current literature regarding investigations and management strategies.

Methods – A chart review was conducted of all patients diagnosed with small intestinal adenocarcinoma over the last two years; highlighted from the electronic patient database. Nature of presentation, presenting symptoms, investigations and treatment received were noted. A review of the recent literature on recommended investigation and management was then conducted via medline.

Results – Three patients were diagnosed with small intestinal adenocarcinoma (mean age of 64 years) in the allocated time frame. Each presented with non-specific GI symptoms and required multiple imaging modalities prior to surgery. Investigations used were OGD (2), CT Abdomen (3), SBS (2), Enteroscopy (1) and CT PET (1). Each of the lesions were located within the proximal jejunum and were amenable to surgical resection with one patient requiring adjuvant chemotherapy. All three patients remain under surgical follow-up.

Conclusion – Adenocarcinoma of the small intestine is rare and often presents at an advanced stage due to non-specific symptomatology. A high index of suspicion combined with multiple imaging methods is essential for a prompt diagnosis. More recent advances in small intestinal visualization facilitate accurate diagnosis in patients with suspected small intestinal neoplasia. These include MR enteroclysis, double balloon enteroscopy and video capsule endoscopy. Surgical resection remains the only treatment modality with curative potential. The role of adjuvant chemotherapy is unclear however; combination of oxaliplatin and 5FU appears to confer survival benefit.

SPONTANEOUS SPLENIC RUPTURE IN INFECTIOUS MONONUCLEOSIS

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Spontaneous splenic rupture (SSR) is an uncommon but potentially life-threatening complication of infectious mononucleosis and is also seen in other pathology affecting the spleen. While splenomegaly itself is common in the setting of infectious mononucleosis, the incidence of SSR is thankfully low, with studies reporting 1-2 cases per 1000. There is however a high mortality associated with this condition, with misdiagnosis probably due to an absence of trauma in the patients history. We present the case of a 27-year-old man with spontaneous splenic rupture secondary to infectious mononucleosis as well as a discussion of possible aetiologies, diagnosis and management of this condition.

WHAT DO YOUNG PEOPLE AND PARENTS WANT FROM AN INFLAMMATORY BOWEL DISEASE (IBD) SERVICE?

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Introduction:

Presently, the UK Inflammatory Bowel Disease (IBD) Standards framework on optimal service provision for paediatric and adolescent patients offers guidance on the formation of transition IBD clinics. However due to a lack of data on what constitutes an ideal service this framework is based on opinion and intuitive reasoning.

Aim:

To develop a comprehensive understanding of the key service requirements for young people with IBD and their parents.

Methods:

Patients aged 6 – 18 years were identified from databases in two teaching hospitals and membership of the Northern Ireland branch of Crohn's and Colitis UK. Anonymous questionnaires regarding perceived quality of care, clinic care, specialist input, support and information plus any suggestions were sent to these patients and their parents separately.

Results:

105 questionnaires were sent and 51 participants responded (49% response rate). 84% were happy with the quality of care being received. Participants were reluctant to attend clinics due to: blood tests, specialist staff unavailable and lack of car parking. Nurse specialist, dietician, IBD surgeon, psychologist, skin / eye specialist input was deemed beneficial by 95%, 81%, 71%, 59%, and 45% respectively. Immediate contact, including via email, with healthcare personnel for disease flare, support groups, financial advice and knowledge about IBD research were deemed important for service improvement.

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Conclusions:

The majority of young IBD patients and their parents are satisfied with their care. The knowledge accrued, especially regarding specialist services support and rapid access to professional advice, is fundamental to designing an optimal IBD service.

PATIENT SATISFACTION WITH THE CONSENT PROCESS IN GASTROINTESTINAL ENDOSCOPY

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Aim

Patients undergoing elective gastrointestinal endoscopy are referred from many sources. Best practice dictates that patients are counselled and given information to read before returning to document written consent pre-procedure. Our study aimed to assess patient satisfaction regarding the timing of consent and how the process was performed.

Method

From September to October 2011, a prospective cohort of patients undergoing upper and lower gastrointestinal endoscopy, completed a questionnaire when attending for their procedure. Satisfaction with the consent process was assessed using a Likert scale.

Results

138 completed questionnaires were analysed in patients with a median age of 53 (IQR 42-68) years (male=65, 51%). Referral source was GP 38%; surgical 32%; medical 14%. Procedure counselling occurred at two intervals, pre-day of procedure 52.2%, or day of procedure 47.8%. Overall patient satisfaction was high with a median score of ten (IQR 9-10). There was no difference in satisfaction between pre-day of procedure versus day of procedure cohorts (p=0.66). Patients have no single preference regarding the timing of consent.

Conclusion

The practice of obtaining informed written consent for endoscopy varies. It is ideally performed when appropriate information is presented in a manner comprehendible to the patient and they are given time to make informed decisions. BSG guidelines suggest that such counseling should occur ideally at least 24 hours before the procedure, before the patient be asked to sign a consent form. This study suggests that patients are equally satisfied when consent is obtained either prior to or on the day of the procedure.

DOES ILEOCAECAL VALVE SHAPE DETERMINE EASE OF TERMINAL ILEUM INTUBATION?

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Background: Intubation of the terminal ileum and ileoscopy can be a useful diagnostic tool at colonoscopy to confirm completion of the procedure and to assess for terminal ileal pathology in e.g. suspected Crohns disease, as well as allowing therapeutic procedures such as dilatation of distal small bowel strictures. It has been noted during routine colonoscopy in this centre that the ileocaecal tends to be 1 of 3 shapes: circular, oval or sickle shaped. We sought to determine whether the shape of the ileocaecal valve has any effect on the ease of intubation of the terminal ileum.

Methods: 100 patients had full colonoscopy and attempt at ileocaecal intubation. The shape of the ileocaecal valve was noted as well as whether or not terminal ileum intubation was successful.

Results: 9 patients had circular IC valve, 34 had oval shaped IC valve and 57 had sickle shaped IC valve. The successful rate of terminal ileum intubation was 100%, 97% and 69% respectively.

Conclusion: Terminal ileum intubation is more challenging in sickle shaped valves which accounted for over half of the cases in this study. We also noted that intubation of the terminal ileum was easier if there was any pathology present.

COLONIC STENT USE FOR ACUTE BOWEL OBSTRUCTION

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Objective- Approximately 20% of malignant colorectal tumours will present with bowel obstruction requiring emergency treatment. Management options for these patients include emergency surgery or insertion of a self expanding metal stent (SEMS) with interval elective surgery. The purpose of this study was to assess the use of SEMS for colonic decompression in these patients.

Methods- Patients were identified for the study from the endoscopy database between October 2006 and January 2011. Regarding the SEMS insertion, data recorded included time to stent, Dukes staging, time to surgery (if applicable), location of tumour and outcome.

Results- 59 patients were recorded as having SEMS insertion attempted between these dates. 20 of these patients were admitted electively (33.8%). 44 patients had confirmed adenocarcinoma on biopsy, 5 had negative biopsy however a colonoscopic appearance of adenocarcinoma. Out of the 49 cancer patients there were 10 failures at insertion. Of the remaining 39 patients SEMS were inserted an average of 4 days from admission. The majority of the palliative patients died in within 3 months after SEMS. 12 of the 39 patients went on to have curative surgery following SEMS insertion (30.7%). 11 out of these 12 patients are alive post procedure (median 4 months). 10 of the 12 patients had primary surgery with anastomosis and the remaining 2 patients required a stoma.

Conclusion- SEMS for acute obstruction in our hospital is mainly palliative. The patients that have received SEMS as a bridge to surgery have positive outcomes and the majority have not required a stoma.

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