Welcome

Welcome to the October 2017 edition of NewWave.

If you have any relevant articles or papers that you would like to be included in future editions, please email them to steve.perring@poole.nhs.uk

Thanks to Prof Graeme Duthie for all his work over the years as outgoing President and welcome to Dr Rami Sweis as the new President

We are also privileged that Prof Stephen Atwood will be on the committee as 'AGIP Upper GI Clinical Lead'

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*** Exciting news about AGIP bursaries in 2018 ***

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See Page 16 for more details

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### Forthcoming Events 2017/2018:

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BREATHE TESTING

Hydrogen and Methane Breath Monitoring to help detect gastro-intestinal disorders

GASTROGENIUS
Desktop breath monitor for combined methane, hydrogen and oxygen measurement.

Highlights:
- Hydrogen and methane breath testing with instant results
- Breath Bag option makes it possible to test multiple patients at the same time
- Automatic O₂ correction for more accurate results
- Real time traffic light dial and smiley face system to motivate patients
- HYDROCHART software, fast warm up and simple monthly calibration

HYDROGENIUS
Compact hand-held hydrogen monitor with multiple patient testing up to 10 patients per session. It can be used to detect disorders like food malabsorption, sugar intolerances and small intestinal bacterial overgrowth in a non-invasive manner.

Highlights:
- Easy to use interface
- No start up time and instant results
- Large touch screen
- HYDROCHART software, built in protocols, simple 3 month calibration

For more information please contact info@ardmorehealthcare.com or call 01494 721820

Ardmore Healthcare
AGIP [2018] Upper GI Physiology Masterclass

Thursday 1st March 2018

Post Graduate Education Centre, Queen Elizabeth Hospital, Birmingham, B15 2GW

10.00 – 10.30 Registration and coffee

10.30 – 10.40 Welcome (AGIP Chair) Warren Jackson

10.40 – 11.20 Hydrogen and Methane Breath Testing USA Consensus Document: Implications for the UK Anthony Hobson

11.20 – 12.00 BSG guidelines for oesophageal manometry and reflux monitoring Stephen Attwood

12.00 – 12.40 Current Treatment Options for Chicago Classification Disorders Phil Woodland

12.40 – 13.30 Lunch

13.30 – 15:00 Tailored Learning Breakout Session

[Delegates pre book 3 x sessions and rotate around the individual work stations 30-minutes per station]

1. Basic HRIM Interpretation John Hayman

2. Advance HRIM Interpretation Andres Vales

3. Basic pH/Impedance Interpretation Steve Perring

4. Advance pH/Impedance Interpretation Caroline Race

5. Question & Answer Session with the expert Rami Sweis

6. Bring your own cases studies to analyse with the expert Anthony Hobson

15.00 – 15.40 'HRM and Chicago, Seeing the Wood from the Trees' Rami Sweis

15.40 – 16.00 Coffee break TBC

16.00 – 16.15 IQIPS Accreditation Process TBC

16.15 – 16.30 RCCP Update Paul Sharpe

16.30 – 16.40 Accredited Scientific Practice Programme (AGIP Education Secretary) Sarah Kelly

16.40 – 16.50 AGIP Membership & Accreditation (AGIP Accreditation Officer) Tanya Miller

16.50 – 17.00 Completion of Feedback Forms & Receive Attendance Certificates
AGIP Upper GI Physiology Masterclass in Good Practice
Thursday 1st March 2018
Post Graduate Education Centre, Queen Elizabeth Hospital, Birmingham,
B15 2GW

Name: .................................................................................................................Title: ........................................
Institution: ...............................................................................................................
Address (Include postcode): .......................................................................................
Current position: .......................................................................................................
E-mail: ......................................................................................................................
Telephone: ............................................................................................................... 
Special dietary requirements: .....................................................................................

Tailored learning [13.30pm – 15:00pm]... pre book 3 x sessions to rotate around [30-minutes per station]
Please circle 3 sessions below that you would like to attend on the day:

Basic HRiM Interpretation .................................................................................. John Hayman
Advance HRiM Interpretation ........................................................................... Andres Vales
Basic pH/Impedance Interpretation .................................................................. Steve Perring
Advance pH/Impedance Interpretation ................................................................. Caroline Race
Question & Answer Session with the expert ....................................................... Rami Sweis
Bring your own cases studies to analyse with the expert ................................... Anthony Hobson

Please turn over and complete the rest of the registration form...
AGIP Upper GI Physiology Masterclass in Good Practice
Thursday 1st March 2018
Post Graduate Education Centre, Queen Elizabeth Hospital, Birmingham, B15 2GW

Payment:
Registration fee is £50 for AGIP members, £90 for BSG Members and £100 for non-members, includes lunch and coffee breaks.

Please complete application form, attach a cheque (relevant amount) made payable to the ‘BSG’ and post to...

Warren Jackson, GI Physiology, Castle Hill Hospital, Castle Road, Cottingham, East Yorkshire, HU16 5JQ

Any questions please email: warren.jackson@hey.nhs.uk or telephone: 01482 622155 (direct line)

Your place will not be reserved until your cheque and registration form is received. Please note there will be no refunds for non-attenders.

I agree to the above and enclose my cheque made payable to the BSG

£50 for AGIP members  £90 for BSG Members  £100 for non-members  (please circle as appropriate)

Date:..................................................  Signature: ..................................................
September has been a busy month for development of the Accredited Scientific Practice (ASP). In discussion with the National School for Healthcare Science (NSHCS), two new ASPs have been developed in Upper and Lower GI Physiology.

From September 2017 we have three ASP trainees starting the pilot – one for Lower GI and two for Upper GI.

Workplaces are able to choose from the existing Lower and Upper GI Physiology ASPs, (details below) or propose their own if they require a different mix of skills. For example, a department with a heavy research focus may wish to propose an ASP which includes the STP module Research Methods. For each module, there will be assignments set by the University, work place assessments to be completed in an e-portfolio, and Observed Structured Final Assessments (OSFA) appropriate to the ASP. If an individual completes 60 credits, they would qualify for a Postgraduate Diploma from the University of Newcastle.

Below is a summary of the ASP courses available, Academic modules are via Newcastle University and the workplace aspect is via NSHCS:

**Upper GI Route: Accredited Scientist Programme in Upper GI Physiology**
- Introduction to GI Physiology (10 credits)
- Upper GI Specialist course - Upper GI Physiology (30 credits)

**Lower GI Route: Accredited Scientist Programme in Lower GI Physiology**
- Introduction to GI Physiology (10 credits)
- Lower GI specialist course- Lower GI Physiology and Endoanal Ultrasound (10 credits)

Any combination of STP modules can be proposed to form an ASP to meet the needs required by the workplace. More details of modules which may be of interest can be found here;
- Gastrointestinal Physiology- [https://curriculum.nshcs.org.uk/programmes/stp/SPS3-1](https://curriculum.nshcs.org.uk/programmes/stp/SPS3-1)
- Urodynamic Science- [https://curriculum.nshcs.org.uk/programmes/stp/SPS3-2](https://curriculum.nshcs.org.uk/programmes/stp/SPS3-2)

The cost per 10 credits is £435 (therefore a 30 credit module is £1305) Cost for the workplace based assessment and OSFA examinations have not yet been confirmed. None of these costs include travel and expenses.

Of note should an individual undertake 60 credits they would qualify for a Postgraduate Diploma from Newcastle University.

Please remember that AGIP will be making the above compulsory for those individuals seeking Independent Accreditation through AGIP. For those departments undertaking IQIPS accreditation it is a requirement to have all members of the team appropriately qualified.
**Introduction**

Hydrogen and methane breath testing has become an increasingly common investigative tool for assessing carbohydrate mal-absorption, small intestinal bacterial overgrowth and gut dysbiosis. Despite hundreds of hospitals and several commercial laboratories offering breath testing services in the UK, there is little consensus as to how to perform and interpret these tests.

This situation is not peculiar to the UK. A recent review of 13 clinical trials showed that 13 different methodologies were used to acquire and interpret breath test data. In science, one needs to develop models that can be tested by experiment in order to control for known variables with as much certainty as is possible. To develop a model, parameters need to be agreed upon as a starting point so that new discoveries can be made disease understanding improved and more effective treatments developed.

In order to address this in the US, an expert panel of clinicians and scientists with experience in the use of breath testing was recently assembled to review existing practices and to try to construct and initial consensus document for the use of breath testing in gastrointestinal disease. The group developed a series of 28 questions based on existing data and voted independently on whether they agreed or not with the statements. The domains covered were clinical indications, preparation, performance, interpretation of results, and knowledge gaps.

The consensus findings were first presented at DDW in 2016 and the subsequent paper has just been accepted for publication in the American Journal of Gastroenterology. I was recently lucky enough to spend a few days at the GI Motility laboratory of two of the main authors of the document, Dr Mark Pimentel and Dr Ali Rezaie at the Cedar Sinai Hospital in Los Angeles have published extensively on breath testing in recent years and made several leaps in our understanding of its utility. The lab has performed over 50,000 breath tests and this was a great opportunity discuss some of the nuances and scientific reasoning around generation of consensus document, assess the impact on how my own service at The Functional Gut Clinic is delivered and look to disseminate these finding to the UK community.
The breath test controversy

Breath testing can be an evocative subject with investigators at different ends of the spectrum both extolling and refuting its usefulness. Two of the main controversies exist around the type of substrate that should be used and the relationship between the timing of peaks in breath gases and location of the substrate within the bowel. There are few 100% accurate tests available to physiologists and thus a pragmatic approach has to be taken which incorporates knowledge of the physiological processes and clinical conditions under which a test is performed in order to both maximise and restrain interpretation.

If we think back to the first Chicago classification for oesophageal motility disorders, this was the starting point of a process where certain standardised methods could be used across centres so that variability in acquisition was minimised and further advances made. As new data has been added to the model certain aspects have been modified and new discoveries added to improve the classification. This is a process of evolution with a defined start point. With such pragmatism in mind the US consensus group have taken into account differences in equipment, for example to provide this starting point. Below is a brief overview of some of the suggestions from the consensus document.

Preparation:

Preparation for a breath test has several aims. The first is to reduce the amount of fermentable residue in the colon before the test so that baseline gas levels are low. To do this a restriction of complex carbohydrates the day before the test and an 8-12-hour fast before the start of the test are recommendations commonly used and these were upheld by the committee.

The second is to reduce variability that may be caused by medication which might affect gut motility or the microflora. There really isn’t a great deal of objective data to support the rationale for this decision making and therefore pragmatic recommendations of waiting 4-weeks after antibiotic before testing and stopping laxatives / prokinetics for 1-week before the test (if tolerable) were given. Slightly more controversial were the suggestions that PPIs and probiotics / prebiotics do not need to be stopped and I believe this is an area where further study would be beneficial to provide a more definitive recommendation. In the case of probiotics and prebiotics, no consensus was obtained and therefore no guidance given but we will continue to ask patients to stop for 1-week until further studies are completed.
Indications:

Whilst the culturing of small bowel aspirates has been considered the ‘gold standard’ for investigating small intestinal bacterial overgrowth, limitations in availability of the technique, lack of consensus on normal values and sampling error associated with jejunal aspiration limits its usefulness. Therefore the consensus group recommended that breath testing should be the test of choice for investigating small intestinal bacterial overgrowth.

Breath testing should also be used to assess methane production in patients with symptoms of constipation, to assess carbohydrate mal-absorption (fructose and lactose) and in patients with symptoms of bloating (this will be the subject of a further review). One interesting recommendation was that lactulose breath testing should not be used to measure oro-caecal transit time due to high variability.

With the advent of new techniques such as the wireless motility capsule which can measure compartmental gut transit much more accurately without the use of radiation and possible false readings due to hydrogen sulphide sequestering hydrogen to produce flat line responses, this seems to be a reasonable position to take.

Performance and interpretation of breath tests:

The controversy of whether to use glucose or lactulose to assess SIBO is somewhat of a moot point. Glucose is absorbed within the first few feet of the small bowel and therefore if the overgrowth is distal to this then a false negative result is obtained. Lactulose travels all the way through the entire small bowel and a major criticism has been that a peak observed with lactulose may represent fermentation in the caecum (i.e. a false positive response). Data from imaging studies have not really helped answer these questions due to disconnect between imaging parameters and fermentation characteristics such as the lag time between the substrate reaching the bacteria and the onset of the fermentation process.

What was agreed was that 75g of glucose should be used and 10g of lactulose with a positive test for both being considered as a rise in gas levels of 20ppm above baseline at 90-minutes. My concern with this value and time-point is that it may be too sensitive at one end (i.e. at 90-minutes in some patients the substrate may be in the caecum) and not sensitive enough at the other end (i.e. a rise of 10-19 prior to 90-minutes could easily be positive for SIBO but would be determined negative using these parameters).

In discussion with Dr’s Pimentel and Rezaie, they explained that difference in the sensitivity of equipment across centres meant that lesser values were felt to be not easily attainable and that the time-point was chosen based on scintigraphic data and consideration of the time-lag involved in the fermentation process. From a personal perspective, I would still like to introduce caveats into our reporting process which would classify an earlier rise between 10-19ppm as ‘borderline’ positive especially in the presence of typical symptoms and a rise of 20ppm at 90-minute in the absence of symptoms as a potential false positive.

Clinical judgement is always required when interpreting physiological test results and perhaps the most valuable data to help guide this will come from outcome studies which look at whether these cut-off values can help to predict the efficacy of treatment. For example, Rifaximin is supposed to work predominantly within the small bowel and therefore if a higher proportion of patients did not respond to Rifaximin when their peak occurred at 90-minutes compared to 60-minutes (at values between 10-19ppm) then this would provide valuable information about ‘re-drawing’ the boundaries for a positive test.
We have always considered breath testing as a provocation test and carefully map symptoms during each test. However, symptoms did not play much of a role in the consensus document. This is because previous studies have shown that there is a fairly poor correlation between gas levels and symptoms (with the exception of methane and constipation). I think this slightly misses the point as symptoms may be influenced by other factors such as visceral hypersensitivity and if you can reproduce most of a patient’s typical symptoms with a small amount of carbohydrate then it provides greater confidence in the clinical translation of the physiological findings. We have previously shown that patients with SIBO have a higher incidence of nausea compared to those with colonic mal-fermentation whose provoked symptoms tend to be more bloating and distension. These data have only been published in abstract form and I think this is another area which can be developed to enrich the breath test model.

Methane is somewhat of an enigma in that baseline levels can be very high despite days of fasting, no one is completely certain of where the archaea are in the gut (i.e. colon and / or small bowel) and because the fermentation characteristics of methanogens are different to hydrogen producing bacteria then the timing of peaks is also difficult to interpret. In addition, methane sensors can be somewhat unstable and therefore less sensitive at the lower end of the detectable range. Therefore a pragmatic approach to methane was that a value of ≥10ppm should be considered abnormal and that the mere presence of methane was enough to be abnormal as opposed to trying to quantify levels and changes, although methane levels have been shown to correlate with constipation. What has also been suggested is that a single fasting spot breath test can be used to assess methane eradication after treatment with Rifaximin and Neomycin or statins.

With regard to fructose and lactose there was good evidence that 25g of each substrate was adequate and that both tests should be extended out to 3-hours post ingestion to ensure full coverage of the physiological curve as opposed to 2-hours for SIBO.

At The Functional Gut Clinic, we also like to consider values >60ppm generated in the latter parts of a lactulose study as evidence of excessive fermentation in the caecum (caecal mal-fermentation) most likely caused by colonic dysbiosis. We feel this is an important factor as the differences in the levels of hydrogen produced can only be due to difference in the types of bacteria producing the gas as the amount and type of substrate remains constant (i.e. 10g of lactulose). In our practice, patients with this type of profile tend to head down a low fermentable / low fibre dietetic pathway as opposed to antibiotic therapy, with good success. We have recently completed a clinical trial which will look at this in more detail and we hope this will add to future consensus statements.

**Gaps in knowledge:**

The consensus group identified several areas where further work is required to enhance the breath test model. These included the development of a sensor that detect hydrogen sulphide (the gas which provide the mal-odorous content of flatulence and sequesters large amounts of hydrogen to potentially cause ‘flat-line’ responses), examination of the influence of pre and probiotics, assessment of treatment efficacy and several other areas. We would certainly like to be contributing to this development and hope that the UK can play an important role in helping to drive this process further.
Implications for the UK:

The UK currently finds itself between a rock and a hard place in terms of breath testing and in particular with regard to SIBO. On the one hand it is great that we may be able to improve the technical quality and scientific understanding of breath testing methodology and interpretation for UK patients but, on the other hand we don’t have ready access to treatments such as Rifaximin when a positive SIBO test is identified.

Without larger scale trials of rifaximin in the UK it is going to be difficult to convince the medical community and regulatory bodies that this can be an effective treatment. Anecdotally, a secondary care US physician told me that their IBS-D referrals had declined by 60-70% since rifaximin was licensed and being used in primary care which could have potentially huge savings in healthcare cost in terms of inpatient, outpatient and colonoscopy costs which total over £250-million in the UK at present.

So for now, what we will do is to continue to acquire high quality data, look to perform some comparative analysis looking at different time points and thresholds, look to develop outcome studies with our clinical partners and contribute to the scientific literature through our clinical trials data. Next steps should be a review of existing UK breath testing and establishment of a consensus group of our own would be beneficial so that we can begin to close the gap that exists between ourselves and the US.

Take-home messages:

- Urgent need for consensus on methodology and reporting
- No clear consensus on glucose vs lactulose for assessment of SBBO
- Surprising lack of emphasis on contemporaneous symptoms in consensus document
- Urgent need for improving the evidence base for effectiveness of rifaximin
This lecture began by discussing the complex pathophysiology factors contributing to symptoms of IBS. It went into further detail where pathophysiology factors such as visceral hypersensitivity, gut dysbiosis and abnormal GI motility can create an abnormal interaction between the brain and the gut. Food and diet can affect or influence many of these pathophysiology factors which may explain why many patients suffer from food related symptoms. Pathogenesis and pathophysiology research in IBS is beginning to focus more on food and diet. New research is now being published exploring the importance of food and diet in symptom generation in patients with IBS. This new literature is providing us with a better understanding on how to manage food and dietary related symptoms, and furthermore provide dietary advice to IBS patients as part of a more complete management strategy.

Evidence of food and IBS symptom interaction

- Study one (meal test): Healthy controls and IBS patients were given a typical Swedish breakfast and symptoms where monitored over four hours looking at symptoms response. Symptoms clearly accelerate and worsened after a meal intake in IBS patients (Posserud et al, 2013).
- Study two (food intolerance): An association between the degree of perceived food intolerance and the severity of symptoms in IBS. Patients reported a number of food items which they consider responsible for their GI symptoms. 84% of these patients reported GI symptoms after at least one of the food items surveyed. This was especially true for foods containing incompletely absorbed carbohydrates and fat. (Simrén et al, 2001a).
- Study three (nutrition intake): As a group, IBS patients have an adequate nutritional intake despite excluding food items from their dietary intake. (Böhn et al, 2013)
- Study four: (colonic hypersensitivity): IBS patients showed increased colonic sensitivity after duodenal lipids. (Simrén et al, 2001b).
- Study five (gastro colonic response): Motor response to meal intake is accelerated in IBS patients compared to controls providing a link to urgency which is a common IBS symptom. (Törnblom H, 2014)

Mechanisms which may result in IBS

Primary effects (osmotic effects, chemical effects and mechanical effects) and secondary effects (interaction with bacteria, fermentation byproducts, change in pH and microbiome effect) can influence different pathophysiological factors, such as visceral sensation, abnormal bacterial flora and abnormal GI motility.
Dietary advice in IBS patients

- FODMAPs – Carbohydrates poorly absorbed in the small intestine can move into the large intestine, interacting with the bacteria causing fermentation and gas production leading to IBS symptoms.
- Traditional IBS diet vs low FODMAP diet – A diet low in FODMAPs reduces IBS symptoms as well as traditional IBS dietary advice. Combining elements from these two strategies might further reduce symptoms of IBS. (Böhn et al, 2015).

Dietary Management for IBS patients

The following section of the talk focused on dietary management of IBS patients. Professor Simrén referred to the British Dietetic Association guidelines for an effective approach in dietary management of IBS patients.

BDA guidelines for the dietary management of IBS patients (McKenzie et al, 2016).

Take-home messages:

- Food is central in IBS pathophysiology
- Multiple mechanisms are involved with food hypersensitivity in IBS
- Evidence of food and IBS symptom interaction
- Dietary advice is helpful in management of IBS patients
- There are no specific “IBS Diets”. Dietary advice needs to be individualised
Budding Reviewers

If you attend a meeting and wish to review a presentation at that meeting in a future edition of NewWave, please contact the NewWave editor (steve.perring@poole.nhs.uk)

Help-out the rest of us who did not manage to get to the meeting

References


The successful AGIP Bursary Scheme is being changed for 2018

There will now be three distinct bursaries being offered:

1. **Bursaries for BSG 2018, Liverpool**

   Up to 5 bursaries will be offered of up to £300 each. The grant will be conditional on submitting an abstract to BSG and writing a review article for a future edition of NewWave reviewing a talk at the meeting.

2. **Bursary for a European conference in 2018 (most likely EUG 2018, Vienna)**

   One bursary will be offered up to a maximum of £750. The grant will be conditional on an abstract being accepted for the meeting and writing an extended (3-4 page) review of the conference for NewWave.

3. **The Graeme Duthie International Award**

   **Bursary for an American conference in 2018 (most likely DDW 2018, Washington DC),**

   One bursary will be offered up to a maximum of £1500. The grant will be conditional on an abstract being submitted and accepted for the meeting and writing an extended (3-4 page) review of the conference for NewWave.

If you are interested in applying please submit an expression of interest to Steve Perring before 8th December 2017. You can contact him at:

   Steve.perring@poole.nhs.uk

You do not have to have all the elements in place by this date, but will be expected to have a draft proposal.
This was a useful introductory meeting to HRM and pH/impedance testing.

There was a helpful summary of the latest Chicago Criteria for categorisation of oesophageal motility, including a reminder that Chicago Criteria are not directly relevant in patients who have had upper GI surgery including anti-reflux surgery. The role of testing beyond the requirements of Chicago 3 were emphasised, including performing solid-meal swallows and free and/or rapid water swallowing.

Some very useful points regarding practical assessment of manometry and pH/impedance were provided including the following:

- Where it proves difficult to pass a catheter through the LES, try twisting the catheter on each step down from about 5 cm above the LOS and have the patient in the left lateral position
- In patients where the wet swallows appear effective but solid swallows not, volume water swallowing may help to clarify the condition of oesophageal motility.
- Symptom Association Probability (SAP) is useful in that it has a statistical justification for its threshold for significant association between symptoms and reflux (95%). However the sensitivity of SAP to just a few symptoms being coincidental with a reflux event is very high if the total number of symptoms recorded is low. It is advised that SAP is too sensitive to be relied upon if the number of symptoms recorded is below 12.
The Bristol Urological Institute does Florence!

In September this year the International Continence Society (ICS), once again, treated us to a momentous conference comprised of a stimulating scientific programme which evoked discussions and challenged current thinking. It facilitated a growth in learning and allowed individuals from across the world to share their work and knowledge for the overall good of ‘continence care’.

The conference was hosted in the beautiful city of Florence and in true Italian style we were made to feel welcome at every opportunity. The city and its people ooze pride and passion, they create the perfect location for kicking back in a local trattoria and absorbing the information of the day.

The scientific programme was varied and informative, although once again there was an evident focus on urinary continence. With such a large and varied audience it seems a wasted opportunity for those of us with an interest in bowel dysfunction not to be representing our work as well as our patients. I therefore encourage anyone with an interest in research and a love of exploring exciting new places to contribute to ICS 2018 which is being hosted in the charming city of Philadelphia.

Although slightly limited there were still multiple lower gastrointestinal (GI) sessions of interest. The “bowel dysfunction” session awarded its prize for the best piece of work to McClurg et al (2017) who demonstrated that a home programme of abdominal massage may reduce the symptoms of neurogenic bowel dysfunction in patients with Multiple Sclerosis. Other complimentary sessions gave us insight into areas of interest ranging from rechargeable sacral neuromodulation devices to developments within stem cells research post anorectal surgery.

The Bristol Urological Institute (BUI) were fortunate enough to be invited to run a hands on urodynamic workshop, which was well attended by delegates from across the world and also across multiple specialisms. A large volume of research was also presented by various members of the BUI. This research was varied in its topics of interest, looking at: urodynamics in patients with indwelling catheters, how differences in pressure measurement can affect a diagnosis of outlet obstruction as well as an evaluation of female stress incontinence surgery amongst many other things. Equipment talks and demonstrations were also rife and I have most certainly come away with a much better understanding of what is currently on offer to our patients as well as what may potentially be gracing our clinics in the not too distant future.

All in all the conference was an incredible opportunity to socialise with others individuals who have a similar love for their specialism. I would urge anyone who hasn’t already been or who feels they can contribute to the next ICS to sign up and be counted!
Have you renewed your RCCP registration?

If you are a registrant with RCCP, have you renewed your registration this year? Being a registrant of RCCP requires a little more effort than paying the annual fee. The terms of registration require every registrant to make a self-declaration that they comply with the requirements to be a registrant. This is a relatively simple declaration that is made online via the registrants account.
If you have not done this yet, PLEASE DO SO NOW otherwise your registration will be considered for inactivation. One a registrant is inactivated, to reactivate their registration will require submission of CPD records and the payment of a reactivation fee of £50.
To make your declaration and renew your registration, please follow the link below

https://www.rccp.co.uk/registrants/

RCCP application for PSA accreditation

The application for the RCCP Register to become accredited by the Professional Standards Authority under their accredited registers scheme is progressing nicely. PSA representatives have attended the RCCP administration offices to assess how the register is administered, they have sat in on an RCCP Council meeting and they have conducted telephone interviews with the Chairman, Chief Executive and Registrar.

The next stage is for the application to be assessed by an assessment panel at PSA and news on the outcome is expected by the end of the year.