Welcome

Welcome to the May 2019 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

In this edition we celebrate the life of Professor Graeme Duthie, 1959-2018

Contents:

Page 2: Forthcoming meetings
Page 4: A celebration and appreciation of the life of Professor Graeme Duthie
Page 7: A review of the AGIP Upper GI Masterclass
Page 9: An issue with calibration of water-perfused HRM Catheters
Page 13: A review of a talk at the 1st London Neurogastroenterology Course
Page 14: A case study by Jafar Jafari
Page 18: News from RCCP
Forthcoming Events 2019:

17-20 June 2019  BSG Annual Meeting  
Glasgow  

1-3 July 2019  ACPGBI 2019 Annual Meeting, Dublin  
https://www.acpgbi.org.uk/events/acpgbi-2019-annual-meeting/

3-6 September 2019  ICS 2019, Gothenburg, Sweden  
https://www.ics.org/2019

11 September 2019  HRM and Impedance/ pH Study Day  
Hamilton House, King's Cross, London  
Contact rachel@ardmorehealthcare.com

8-10 September 2019  GESA Australian Gastroenterology Week (AGW), Adelaide South Australia  

19-23 October 2019  United European Gastroenterology (UEG) Week  
Barcelona, Spain  

6-8 November  The Pelvic Floor Society Annual Meeting  
Crowne Plaza, Plymouth

25-28 March 2020  The Federation of Neurogastroenterology and Motility  
Adelaide Convention Centre, Adelaide, South Australia  

Early 2020  Ascona III Meeting on Advances in Clinical Measurement of GI Motility and Function
HRM & Impedance/pH Study Day  
Wednesday 11th September 2019  
Hamilton House, King’s Cross, London

Chaired by Professor Stephen Attwood

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30 – 9.55</td>
<td>Registration</td>
<td></td>
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<tr>
<td>9.55 – 10.00</td>
<td>Introduction</td>
<td>Prof Stephen Attwood</td>
</tr>
<tr>
<td>10.00 – 10.30</td>
<td>Analysis of 24hr Impedance/pH studies</td>
<td>Prof Arjan Bredenoord</td>
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<tr>
<td>10.30 – 11.30</td>
<td>Impedance/pH case studies</td>
<td>Prof Arjan Bredenoord</td>
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<td>11.30 – 12.00</td>
<td>Coffee break</td>
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<td>12.00 – 12.30</td>
<td>An introduction to HRM and Chicago 3.0</td>
<td>Prof Arjan Bredenoord</td>
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<td>13.00 – 14.00</td>
<td>Lunch</td>
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**Parallel Sessions – please see registration form**

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.00 – 15.30</td>
<td>HRM case studies for beginners</td>
<td>Mr Warren Jackson</td>
</tr>
<tr>
<td>14.00 – 15.30</td>
<td>Advanced HRM case studies</td>
<td>Prof Arjan Bredenoord</td>
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<td>15.30</td>
<td>Meeting close</td>
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</table>

Please contact Rachel Broome [rbroome@laborie.com](mailto:rbroome@laborie.com) for the registration form
Lasting tribute to Professor Graeme Duthie—A memorial bench unveiled at Castle Hill Hospital in front of family, friends and Colleagues

By Rachel Johnson

Friends and colleagues of the much loved and much respected Professor Graeme Duthie gathered at Castle Hill Hospital to celebrate his life and achievements in February.

Staff working across GI physiology, bowel screening and endoscopy, plus two of his three daughters, Wendy Duthie and Catriona Watts, gathered in the memorial garden for the unveiling of a new bench in his name. Colleagues had begun to raise money for the bench, which features a brass plaque and a dedication to the former colorectal surgeon, before their collection was supplemented with a generous donation from the Association of GI Physiologists.

Trust GI Physiology Manager, Warren Jackson, gave a short speech for those in attendance, where he recalled some of Professor Duthie’s achievements including establishing the Trust’s bowel screening service and the Yorkshire School of Endoscopy, plus the GI physiology service alongside Mr Kevin Wedgwood.

Friends and colleagues were also reminded of the lighter, more family-oriented side of the pro-

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**GI Physiologist – Band 7 (Inner London)**

We are looking to recruit an enthusiastic and motivated Clinical Physiologist to join our team in the GI Physiology Unit at University College Hospital. Ideally you will be an experienced GI Physiologist with a proven track record of undertaking GI investigations.

We are a multi-disciplinary team consisting of Gastroenterologists, GI Physiologists, Specialist Nurses and Nursing Assistants. We undertake a range of tests and treatments of upper and lower gut function, for patients with gastro-intestinal, neurological and pelvic floor problems. This includes ano-rectal and oesophageal physiology, hydrogen breath tests, biofeedback, percutaneous tibial nerve stimulation, trans-anal irrigation and pain management.

Your primary role will be to provide service delivery and contribute to the day to day running of the Unit. You will also help to co-ordinate and support further development of the service, and participate in education, audit and research.

Informal enquiries can be made to Dr Amanda Raeburn (GI Physiologist) on 0203 447 9130 or email amanda.raeburn1@nhs.net

To apply please search jobs.nhs.uk or contact us directly for further advice.
fessor when Warren recounted an occasion when the pair attended a conference and they had to ensure they had three bags of freebies, one for each daughter, before they could leave!

It was also touching to hear how the Association of GI Physiologists, in honour of Professor Duthie’s support over the years and his service more recently as Honorary President of AGIP, has established a bursary in his name. The Graeme Duthie International Award Bursary will be used to provide financial support to members and ensure his work and his memory lives on within the association.

After the speech, Warren unveiled the bench and presented Catriona, who also works in the Trust as a radiographer, and her sister Wendy, with a bouquet of flowers each. The group then reconvened for a lunchtime get-together to swap stories and fond memories of a great man.
Graeme Duthie was an academic colorectal surgeon based in Castle Hill Hospital. He was born and brought up in Aberdeen. He qualified in medicine in 1983. He was awarded FRCS from the Edinburgh College in 1987 and an MD with honours in 1993. In 1994, he was appointed Senior Lecturer/Honorary Consultant Surgeon in the newly created academic surgical unit at Castle Hill Hospital in Cottingham, near Hull. Graeme was awarded a personal Chair by the Postgraduate Medical Institute in Hull in 2005. The academic surgical unit rapidly established itself as one of the foremost colorectal units in England and a tertiary referral centre for complex colorectal conditions.

Graeme’s main clinical interest was in functional bowel disorders and incontinence. He established a first class GI Physiology department for the investigation of sphincter problems, which has now flourished into one of the largest GI Physiology units in the UK. He published extensively on this and related topics. Alongside this, Graeme was an expert colonoscopist. He was among the first in the UK to encourage and develop the role of the nurse endoscopist and was instrumental in the establishment of a bowel screening programme in Hull. He had a reputation for excellent colonoscopy training and was the Regional Director in Yorkshire for endoscopy training, establishing the East Yorkshire School of Endoscopy in 1995 which is now one of the largest training schools in the country.

Graeme was an avid supporter of the Association of GI Physiologists (AGIP). He first joined AGIP many years ago as the surgical representative on the Council, and was especially interested in supporting the development of the education pathway. In 2015 Graeme was appointed as AGIP Honorary President, a position which is held by “an international expert in the field at the invitation of the AGIP council. The Honorary President was also expected to “promote the Association within Gastroenterology in the United Kingdom and further afield”, requirements which Professor Duthie more than fulfilled.

Outside of work commitments Graeme was proud of being a Scotsman, was a keen philatelist and enjoyed various handicrafts such as stained glass making and woodturning. He was predeceased by his wife, Susan, and leaves 3 daughters Catriona, Debbie, and Wendy.
The AGIP 2019 Upper GI Masterclass was held on Friday 1st March, hosted in the stylish venue of the DoubleTree by Hilton in the centre of vibrant Manchester, chaired by Professor Stephen Attwood and Warren Jackson. The Masterclass included a variety of engaging presentations and workshops from experts in the field, providing a valuable opportunity to share knowledge and network with colleagues from GI Physiology centres across the UK.

During the first presentation of the day, “How to Investigate Reflux in 2019”, Rami Sweis gave a useful overview of the techniques used to investigate gastro-oesophageal disease (GORD). The importance of endoscopy prior to oesophageal physiology studies was recognised, to exclude mucosal or structural pathology. The pros and cons of catheter-based studies (pH and pH-impedance monitoring) were discussed, as well as the option of wireless pH monitoring, which can improve patient tolerability and increase diagnostic yield. Acid Exposure Time and Symptom Association Probability were highlighted as key predictors of outcome following anti-reflux surgery. Looking to the future, it was interesting to learn about a promising measurement index for post-reflux swallow-induced peristaltic waves.

Andres Vales followed with his presentation “How to Investigate Dysmotility using HRM”. He provided an eloquent summary of high-resolution oesophageal manometry, the key parameters of the Chicago Classification and examples of dysmotilities (including the three achalasia subtypes, outflow obstruction, absent contractility and minor disorders of peristalsis). The benefits of adjunctive tests (including a 200 mL rapid drink challenge and a 5 x 2 mL multiple rapid swallow) were highlighted, with the recommendation that a multiple rapid swallow is performed at least three times before “no response” is reported. Solid swallows (for example, using bread or a rice test meal) can help further assess symptom correlation with abnormal manometric patterns.
Anthony Hobson shared the AGIP ‘Standardised Testing Protocol’, which should act as a starting point to standardise how Hydrogen/Methane Breath Testing (HMBT) is performed in the UK. Crucially, technical standardisation will allow results from different UK testing centres to be directly comparable. Recommended dosages include 10g of lactulose for a full bowel assessment and identification of non-hydrogen producers, 75g of glucose for small intestinal bacterial overgrowth assessment, and 25g of lactose or fructose for assessment of carbohydrate mal-absorption, in or with 300 mL of water. All individuals who are undertaking HMBT are encouraged to adopt the ‘Standardised Testing Protocol’ and join the first ‘UK Breath Test Working Group’ (details of this are available through AGIP).

Adam Farmer discussed a variety of interesting techniques to measure gastric and small bowel motility. His presentation included an insight into gastric emptying scintigraphy, antroduodenal manometry, the wireless “Smart Pill” motility capsule, 13C octanoic acid breath testing and MRI / ultrasound imaging.

In the last presentation before lunch, Sarah Kelly provided a useful summary of the AGIP approved training routes for GI Physiology. Along with the well-established NHS Scientist Training Programme (STP), there is a new Accredited Scientific Practice (ASP) programme which provides specific GI Physiology training modules for in-service healthcare professionals. The Higher Specialist Scientific Training (HSST) programme is an opportunity for registered and experienced Clinical Scientists, who become eligible to apply for a role as a Consultant Clinical Scientist following successful completion of the programme. Equivalence routes for STP/HSST are also available and encouraged for accredited independent healthcare professionals in GI Physiology.

During his afternoon presentation, “How to Treat Upper GI Disorders in 2019”, Rami Sweiss critically appraised various available treatments for achalasia, including Botox therapy, pneumatic dilatation, myotomy and POEM. In terms of treatments for GORD, it was interesting to learn that weight-loss, bed elevation and small/low calorie meals are the lifestyle factors with the most supporting evidence for reducing acid reflux. Optimising PPI use was discussed, followed by an insight into newly developed therapy options, such as endoscopic fundoplication and STRET-TA.

Stephen Attwood provided an overview of key reporting standards for Upper GI Physiology investigations (including the value of meaningful recommendations from a clinical lead), and how HRM and pH-Impedance testing can support the decision for a patient to undergo anti-reflux surgery. His presentation also included an interesting examination of various surgical and endoscopic techniques currently used to treat GORD and motility disorders.

The afternoon concluded with a rotation of 30-minute breakout sessions covering a variety of topics, including example case studies, performing a technically correct HRM or pH-impedance study, expert question and answer sessions and a presentation on the UKAS (IQIPS) accreditation process.

The AGIP Upper GI Physiology Masterclass was a comprehensive summary of expert knowledge and fresh updates to current practice. This highly interesting and well-executed event is invaluable for anyone involved in performing or interpreting Upper GI Physiology investigations.
An issue with calibration of water-perfused high resolution manometry (HRM) catheters

By Ross Stephens and Steve Perring
Poole Hospital

Introduction

High-resolution manometry (HRM) provides improved spatiotemporal resolution than conventional manometry (CM) due to its closely spaced pressure sensors; enhancing the diagnostic yield in several oesophageal motility disorders (Roman et al., 2016). High Resolution Oesophageal Manometry (HROM) is common clinical practice for Gastro Intestinal (GI) investigations and is becoming more common in anorectal manometry (HRAM) examinations (Dinning, Carrington and Scott, 2015).

Water perfused manometry involves an extruded silicon or urethane catheter comprising of numerous individual channels. The individual channels all open through the catheter wall at a separate point along the catheter. Distilled water is perfused to each channel by a high pressure pneumatic perfusion pump passing through flow restrictors, resulting in a low flow rate at a high pressure. Obstruction of the port opening of any such channel results in very rapid increase in the pressure in the port as more incompressible water is entering the port lumen which is of fixed volume. When the pressure inside the port equals the pressure obstructing the port opening water begins to flow again. Thus the applied pressure to the port opening is reproduced at the external transducer sited between the flow restrictor and the port lumen.

Typically the pressure transducers are checked for calibration prior to use by raising the prepared catheter by a set height such as 68cm, the equivalent of 50mmHg of pressure applied at the level of the transducer by the hydrostatic differential of the water column inside the catheter.

We noted a consistent and systematic discrepancy in this calibration from what we were expecting when using water-perfused HRM catheters for HROM and HRAM investigations, with a height rise of 68cm, equivalent to a rise of 50mmHg, resulting in an actual rise of on average 45.7mmHg, which is an 8.6% underestimate in pressure. We wished to understand the causes for this discrepancy and correct for this error.

Understanding why there is an error

1. Is this due to inaccurate transducers?

We checked each transducer by isolating each transducer and connecting them directly in turn to a calibrated pressure sensor and applying a set air pressure. The measured pressures were accurate to within 1mmHg for each transducer.
2. Is the error reproduced when pressure is applied directly to the pressure ports rather than due to raising the catheter tip?

A HRARP catheter was enclosed in a pressure chamber and an external pressure was applied to the pressure chamber, again measured using a calibrated pressure sensor. Pressures from 30-70mmHg were applied. The average underestimate of the applied pressure was 5.5%, which was slightly different from the error noted from the hydrostatic differential technique but still a significant underestimate of pressure.

3. How does the error vary with applied pressure?

![Percentage Difference Between Recorded and Theoretical Pressure Change with Increased Height](image)

Changing the height of the end of the catheter with the sensor ports changes the applied pressure at the transducer. When we changed the height of the catheter we found a consistent percentage error in measured pressure over the height levels tested.

4. Is this error due to the small bore of the transducers?

A 10 channel HRARP catheter (S7-R10-1003 by Mui Scientific) was modified by removing the catheter tip balloon from the catheter. The diameter of the pressure port lumens in the catheter used was 0.6mm, with the diameter of the central lumen leading to the catheter tip balloon of 2.2mm diameter. The central lumen was connected to each pressure transducer in turn and the pressure due to a 68cm height differential measured.

The average measured pressure was 49mmHg, a 2% underestimate of applied pressure.

5. Is this error dependent on the length of catheter?

The catheter was then progressively cut to make it shorter and the pressure measured when applying a 68cm height differential (50mmHg hydrostatic pressure) was recorded. The graph below indicated clearly that the error in this pressure recorded was closely related to the length of the catheter lumen, the error reducing with a reduced lumen length.

![Effect of reducing catheter length on percentage error of pressure readings](image)
The effect of downstream flow resistance

The Darcy-Weisbach equation models how pressure is lost due to friction by a fluid flowing along a tube or pipe

$$\Delta P = f \frac{\rho L}{2D} V^2$$

\(\Delta P = \text{Pressure loss due to friction}
\D = \text{Pipe diameter}
\rho = \text{Density of Fluid}
V = \text{Velocity of the fluid}
\text{f = Darcy friction}

(Olsson, 2012)

The formula above indicates that there will be pressure loss along the length of a water perfused tube due to resistance to flow in the tube and that this will increase as length of the tube increases and diameter of the tube decreases. These very same patterns have been observed in this study, suggesting that it is very likely that the observed errors are due to resistance to water flow in the catheter lumens downstream of the flow restrictors and transducers.

Water perfused catheter lumens are both long and very narrow, indicating that a significant pressure loss between the source of the pressure at the catheter tip and the measurement point at the pressure transducer is essentially inevitable.

The principle of water perfused catheter operation assumes no downstream resistance due to the catheter itself. A practical HRM catheter requires a large number of channels and must be sufficiently thin overall to be of use in in-vivo studies, restricting the diameter of the individual pressure channel lumens. It is likely that the practical limit of the number of channels that can be used in a HRM is 24 as for higher number of channels the lumen diameters would have an excessive downstream resistance.

Correction for downstream resistance

The MMS Solar system used in Poole Hospital has a facility for correcting the calibration of the transducers to match the effect of downstream resistance of particular catheter designs. We have performed this for all catheters used. Following that the average measured pressure for all catheters used at a 68cm height differential (equivalent to 50mmHg pressure change) was 49.7mmHg.

How important is this correction?

The correction for downstream resistance changed the measured pressure by approximately 8%, which is at first glance a relatively modest change. However we reviewed a sample of 35 consecutive oesophageal manometry investigations prior to correction of the calibration for downstream resistance and 36 consecutive investigations following the correction. We found that the rate of identifying normal motility increased significantly following this correc-
We compared Distal Contractility Index (DCI) for patients examined prior to and following correction of the calibration for downstream resistance and the mean DCI was substantially higher after as compared with before the correction was made (mean +/- SD 724 +/- 725 mmHg.cm.s after versus 382 +/- 474 mmHg.cm.s before, P=0.02, unpaired t test). The large change in DCI measured in spite of a relatively modest change in the pressures measured is a result of DCI being an integral of pressure not just at one point but along the length of the distal oesophagus and the entire duration of the peristaltic wave. There was no significant difference in the percentage of peristaltic waves displaying abnormal propagation as defined by a distal latency <4.5s.

Take-Home Messages

- The effect of pressure loss due to downstream resistance to flow in water-perfused catheters is significant and should be corrected for. There should be the capability of making such correction imbedded in commercial manometry software
- High resolution water-perfused manometry has probably reaching the limit of the technology. No more than 24 channels are practical without resulting in crippling problems with downstream resistance
- A relatively small error in measured pressure due to failure to correct for downstream resistance has the potential to dramatically underestimate peristaltic vigour as measured by DCI

References

Hypermobile Ehlers-Danlos Syndrome (hEDS) is an inherited non-inflammatory connective tissue disorder characterised by hypermobile joints, skin fragility and musculoskeletal symptoms. hEDS is diagnosed via a set clinical criteria including a flexibility assessment using the Beighton score.

GI symptoms present in 86% of hEDS patients with the most common symptoms being dyspepsia and abdominal pain. There is a high prevalence of hEDS in patients with functional gastrointestinal disease (FGID) and hEDS patients have high prevalence of IBS and functional constipation. Slow transit is seen in 43% of female hEDS patients. There is an increased incidence of rectal hyposensitivity in hEDS patients with constipation over non hEDS constipation patients.

hEDS patients often have other comorbidities. These comorbidities can consist of: postural orthostatic tachycardia syndrome (PoTS), migraine, FGID, chronic fatigue syndrome, anxiety, chronic pain and mast cell activation disorder. hEDS patients with PoTS tend to have more constipation, pain, gastric and oesophageal dysmotility and experience a worse quality of life. Treating the PoTS by adjusting water and salt intake, amount of exercise and medication such as fludrocortisone can also improve GI symptoms. hEDS patients are also at an increased risk of developing anxiety disorders.

In summary hEDS is an increasingly common presentation in GI departments with a range of symptoms. Patients tend to have FGID and abnormalities in GI sensorimotor function. Treating these patients is difficult due to the keenness to get artificial feeding often driven by social media and online peer groups. The aim with these patients is to make every attempt to avoid artificial nutrition, opiate treatment and surgery. The initial treatment approach should be to evaluate the patients’ lifestyle and make improvements where possible. The second line treatment should be to treat comorbidities if possible. It is incredibly important to ensure a good rapport with these patients and always ensure positive language is used in order to ensure maximal cooperation.

Take-Home Messages

- hEDS is increasingly commonly seen in GI physiology
- Be aware of the possibility of hEDS and ask the patient about joint hypermobility if suspicious
Case Study

One Oesophagus with Two Faces!
By Jafar Jafari
Guy’s and St Thomas’ NHS Foundation Trust

Background

80 years old female
Symptom: difficulty swallowingsolid food, early satiety, suspicion of oesophagealdysmotility; regurgitation.
OGD: a very tortuous oesophagus.
Past medical history: polycystic kidney stage 5 due to Lithium toxicity, near to dialysis. Large vessel vasculitis being treated by prednisolone. Kyphosis; left limbs paralysis due to history of brain injury.

Procedure:
High resolution manometry and 24 hour pH-impedance Reflux Monitoring in April 2019

Water Swallows

Upper Oesophageal Sphincter: The UOS was normotensive and showed complete relaxation on wet-swallows.
Tubular oesophagus: The oesophageal body produced 3/10 weak and 5/10 large gap peristalses on wet swallows.
Lower Oesophageal Sphincter: The LOS was normotensive and showed complete relaxation on wet-swallows. There was No hiatus hernia.
- Technical difficulty during test: Patient was unable to avoid belching after swallows

Diagnosis based on Chicago Classification V3: ineffective oesophageal motility (IOM)
(alternative diagnosis: Fragmented peristalsis)(5/10 large gap + 3/10 weak peristalsis on wet swallows);
HRM while eating sandwich meal of brown bread and butter revealed:
- simultaneous contractions in mid-distal oesophagus
- significantly elevated distal oesophageal contraction (DCI<17500
- Increased intrabolus pressure.
- These all can be an indication of oesophagus struggling to overcome obstruction/resistance at the OGJ
- The patient perceived food going down slowly and also a feeling of fullness in the chest. Without the patient having symptoms all these findings can be “incidental findings” with “unknown clinical significance”.

Rapid Swallows of 200ml Water

Some temporary bolus retention on rapid wet swallowing

24 Hour pH-Impedance Assessment (Off PPI)
Results of 24 hour pH-Impedance Investigation:

- pH
  Number of refluxes 0, DeMeester Score 0.8
- Impedance
  Number of distal refluxes 11 (normal <73), number of proximal refluxes 0 (normal <31)

Discussion

This HRM in this case, revealed two faces for this patient’s oesophagus. On water swallows, based on the guidelines, you can only make the diagnosis of IOM which MUST be done. The IRP is within normal range at 14.1mmHg and the oesophageal body looks quite innocent and guiltless too. If a bread swallow would not have been done, the patient would have been labelled as having “functional dysphagia” and perhaps would be advised to take some nice holidays.

This investigation would have been incomplete without adjunctive testing with solid swallowing and rapid swallowing. Solid swallowing with comparison to normal values such as those published by Sweis in 2011 gives much more insight into the nature of the patient’s problems, particularly as the abnormal motility observed on solid swallowing was accompanied by symptoms.

If there was no reference for “normal ranges on solid swallows”, a physiologist could not claim that the findings on the solid swallows (CDI being high, rapid/simultaneous contractions, etc.) in this patient are abnormal. It could be that all these “strange looking” reactions to a sandwich meal are just normal behaviour of oesophagus against solid boluses.

Despite having a confirmation with symptoms and/or referring to relevant literature, a perfect diagnosis in such circumstances that are not described in the consensus guidelines requires further clarification. Complementary investigations in this case can be a Barium swallow with solid boluses and EUS. Often, the patient referred with dysphagia on solid food will show normal transit on liquid Barium swallow. This is very similar to the standard part of this HRM study as opposed to the solid swallows and can be misleading.

Throughout the section describing solid swallow findings, it is not correct to use any diagnostic term from Chicago Classification such as nutcracker oesophagus etc. The reason is clearly that the diagnoses in this consensus guideline are solely based on water swallows.

For this patient mean residual pressure on water swallows was well within normal range (Residual (mean) 13.7mmHg, normal <15.0). Median IRP on water swallows (14.1mmHg, normal<15) was slightly higher but not overtly abnormal (according to the CC). However, we can see that IRP is very close to mean Basal LOS pressure(=14.8). Although this high IRP at the GOJ during swallows can be partially due to background cardio-vascular compression, some intrinsic oesophageal impairment could be involved. Rapid swallowing of 200ml water also indicated some degree of retention but of course not much information about the oesophageal body contractility.

Another very useful finding in this case was the patient having zero degree of acid exposure on impedance-pH monitoring. This finding can further complement our suspicion of increased resistance at the GOJ.

One limitation of this HRM study was that the patient was unable to control their belching during water swallows. This is a common finding in patient with dysphagia which is indeed a learnt mechanism hich can shorten the oesophagus and reduce resistance at the GOJ to help with transit of bolus. Mostly this phenomenon is in fact supragastric belching. True belching may interrupt peristalsis leading to reduced DCI. Therefore, the IOM/fragmented peristalsis in this patient could indeed
be partly “created” by belching/ supragastric belching. However, since this is part of the patient’s swallowing habit and they could not control this during the test, we still can conclude the above diagnosis based on the Chicago Classification.

**Take-Home Messages**

- The value of extended testing beyond the water swallowing defined by the Chicago Classification is again demonstrated
- The function of the oesophagus can be dramatically different on adjuvant testing and may well provoke typical symptoms
- While solid swallows are not yet codified in the Chicago Classification, normal ranges have been published and can be used to classify oesophageal function


**Get Involved!**

- If you attend an interesting meeting
- If you see an interesting case
- If you have completed some research or an audit that has produced an interesting result

Why not share it with your colleagues and peers by publishing in NewWave.

E-mail Steve Perring (steve.perring@poole.nhs.uk) with your work
Dear New Wave Subscribers,

I am pleased to have the opportunity here to report on the developments which RCCP has been working on since my last update.

- Firstly, I am pleased to announce RCCP has appointed a new chair – Mr Paul Burgess MBE. Paul is an economist and business/organisation development expert with specific experience of the health service in the UK. Over the last 5 years he has been heavily involved in lobbying the government to regulate in the non-surgical cosmetic sector and as part of this process established a specialist register approved by the Professional Standards Authority (PSA).

- We have successfully completed the Annual PSA annual renewal process for 2019 - 2020. Maintaining the quality mark represents a key ongoing objective for the RCCP and we are proud to retain our accreditation for the Register, which indicates that lessons have been learned and applied in the way that we operate the register for our registrants.

The full report is accessible to read via the following link:

https://www.professionalstandards.org.uk/what-we-do/accredited-registers/read-our-assessments/panel-decisions

- We are in the process of recruiting more RCCP team members, including a treasurer and 2 additional Lay members. We hope to find people with experience and interest in the fields of legal, marketing, communications and PR.

- An extensive piece of work has also been completed on the RCCP’s new Complaints Procedure, approved by the Board of RCCP on 11th March 2019. These procedures represent a significant advancement in the way complaints are to be handled and are intended to promote the handling of complaints in an efficient, effective, transparent and proportionate way. These are available via the following link:

https://www.rccp.co.uk/articles/190/How-to-raise-a-concern-about-a-registrant

- We have conducted a full organisational and governance review, revisiting our mission, vision and values. This work will be considered by the RCCP board in June and we aim to adopt our new board terms of reference, Advisory Committee and further committee structures at that time. These committees will be key in reshaping the future of the RCCP. We are currently meeting with the leaders of individual modalities, seeking to co-design the agenda for the future of RCCP together. If you are interested in supporting us in our plans, please get in touch with us on chiefexec@rccp.co.uk We will publish full details of our organisational structure in a special edition of our newsletter in summer.
• RCCP is seeking to recruit and train assessors in all modalities. Details can be found here: https://www.rccp.co.uk/articles/278/RCCP-Recruitment

• If you have any comments on the work of RCCP or want to share ideas, then please contact us on rccpadmin@rccp.co.uk.